Injunctions Contra Mundum, Jurisdiction, and Standing

A gravely ill child is in hospital. A medical view might be taken that, though tragic, it may be in the child's best interests to die with dignity. The courts are asked to declare authoritatively the permissibility of withdrawing life-support. Should the courts also grant an injunction anonymising the child, or the hospital staff (hereafter the 'clinicians') caring for it? How might this be justified? Does the court have jurisdiction to order an injunction imposing duties on the world at large? Who has standing to seek it? The Supreme Court answered these and other questions in *Abbasi v Newcastle upon Tyne NHS Trust*, on conjoined appeal with *Haastrup v King's College Hospital NHS Trust* [2025] UKSC 15; [2025] 2 W.L.R. 815 (hereafter '*Abbasi*'). The judgment covers much ground, addressing *inter alia* open justice; the relationship between the European Convention of Human Rights and the common law; and whether doctors and nurses are "public figures" because they wear name badges. It is particularly noteworthy for the court's extensive reasoning on "the law governing such orders—jurisdiction and standing", on which this note will focus. These were "preliminary but essential'", to be considered before any other aspects of the law (at [53]).

In *Wolverhampton City Council v London Gypsies and Travellers* [2023] UKSC 47; [2024] A.C. 983*,* the Supreme Court held that it had the power to award injunctions against "persons unknown" (discussed Liau and Georgiou, 'Are Equitable Remedies Discretionary?' (2025) 18 Journal of Equity 246, 264-65). Taking reference to that landmark, a differently constituted panel in *Abbasi* conducted a "review from first principles" of anonymity injunctions of this kind (at [7]).

To understand their perceived need, some context is necessary. In 2017, baby Charlie Gard's case led to a campaign and became global news (*Great Ormond Street Hospital for Children NHS Foundation Trust v Yates (No 2)* [2017] EWHC 1909 (Fam); [2017] 4 W.L.R. 131). It was even commented on by the Pope and by President Trump. Unfortunately, publicity can take the form of abuse or harassment directed at the hospital or clinicians. This could occur at home, at protests staged outside hospitals, or through threats and vilification on social media (at [32], [52]). It might cause anxiety, affect the clinicians' quality of care for the child and other patients, and impair the ability of hospitals to recruit and retain paediatric staff (at [32], [36]). Judges of the Family Division in the High Court had hence developed a practice of issuing injunctions to prevent identification of institutions and persons treating the child, at the outset of proceedings for such declarations to allow withdrawal of the child's life-support (at [3]-[4]). These injunctions would last indefinitely, until someone applied to vary or discharge them.

In *Abbasi,* the parents of children who had died were applying to discharge such injunctions. They wanted to tell their story and name the clinicians who had cared for their child (at [13], [19]). In the first case, Zainab Abbasi was born with a rare and disabling neurodegenerative disease, but had died before the hearing of a declaration to withdraw her life-support could be completed. In the second case, Isaiah Haastrup was deprived of oxygen during birth and permanently dependent on a ventilator, which was switched off after a declaration was obtained.

Now that the children had died, should the injunctions be discharged? Their parents argued that the injunction illegitimately restricted their freedom of expression, protected under article 10 of the European Convention of Human Rights. The NHS trusts opposed the application, arguing that discharging the injunction would create an unacceptable risk of harassment and abuse, invading the clinicians' private life protected under article 8 of the Convention (at [31], [153]-[154]).

The hospitals won at first instance. Sir Andrew MacFarlane, the President of the Family Division, held that the injunctions should be kept in place. On appeal, the parents won. Lord Chief Justice Burnett, King LJ, and Carr LJ held that the injunctions should be discharged. The Supreme Court agreed with the Court of Appeal, but it differed significantly as to "the principles to be applied" (at [6], [165]-[166]). The High Court and Court of Appeal were quick to refer to and "balance" the parents and clinicians'

competing Convention rights. The Supreme Court held that this is not the correct approach. The European Court of Human Rights allows national authorities a margin of appreciation and domestic law is "determinative" of rights and obligations within that boundary (at [87]-[90], [190]). It is domestic law which should come first, and by reference to which any such injunctions should be ordered and justified (at [87], [127], [190]).

Lord Reed and Lord Briggs delivered the majority judgment, with which Lord Hodge and Lord Stephens agreed. They emphasised an "overlap" between the hospital's, clinicians', and child's interests (at [47], [182]). It was in the child's best interests that its quality of care not be affected by harassment of the hospital and its clinicians—their privacy could be protected as a means to the child's ends (at [47], [140]).

In an otherwise concurring judgment, Lord Sales disagreed. He thought the court should more readily protect the clinicians' rights, not as means, but as ends. This disagreement led to differing views on who should have standing at the outset of proceedings, discussed below.

The judgment divides into three main issues which will be taken in turn:

(i) the nature of these orders;
(ii) whether, and if so on what basis, the court has jurisdiction to make such orders; and
(iii) who has the standing to seek such orders.

On (i), the injunctions were described as "Reporting Restriction Orders" by the lower courts ([2023] EWCA Civ 331; [2023] 3 W.L.R.575 and [2021] EWHC 1699 (Fam); [2022] 2 W.L.R. 465). The Supreme Court held that this is a misnomer. It is "confusing and potentially misleading" because the order does not merely restrict reporting information emerging in open court, e.g. a witness' name. It covers events occurring outside a courthouse, and binds persons who have not participated in any proceedings (at [3], [50], [51])). These are "injunctions contra mundum"—they name some individuals but they are also addressed to unnamed individuals, indeed, to "the world at large" (see also *Venables v News Group Newspapers Ltd* [2001] Fam 430; [2001] 2 W.L.R. 1038).

Significantly, they bind persons not even likely to commit a wrong—the child's parents and media outlets would be bound, regardless of whether they themselves would likely abuse or harass the clinicians. Citing *Wolverhampton*, the court held that "The absence of a cause of action against a defendant is not in itself an insuperable objection to the granting of an injunction" (at [48]).

It should not go unnoticed that this goes beyond the "newcomer injunctions" granted in *Wolverhampton*. Those were ordered against "persons unknown"—unnamed gypsies and travellers who were not defendants—to restrain them from potential trespasses or breaches of planning laws. The "newcomers" in *Wolverhampton* would likely be tortfeasors.

So, (ii): on what basis did the courts have jurisdiction to grant these orders? The High Court granted them without opposition at the outset. The Supreme Court held that the court had jurisdiction—in the sense of "power" (at [6], [54]-[[55])—to grant such injunctions on three bases, each corresponding to a distinct interest.

First, and protecting the interest of the child, the *parens patriae* jurisdiction, which enables the court to protect those who cannot protect themselves (*In re Spence* (1847) 2 Ph 246, 262; 41 ER 937, 938). Interestingly, the court thought this to be alternative to the court's inherent jurisdiction to secure the administration of justice and integrity of its proceedings (*In re S* [2003] EWCA Civ 963; [2004] Fam 43). The *parens patrie* jurisdiction could justify an injunction anonymising also the parents, the hospital, and the clinicians, if disclosing their identity might harm the quality of the child's care (at [60]).

Second, and protecting the NHS trusts' interests as provider of a public service, the "*Broadmoor* jurisdiction", where necessary to prevent conduct interfering with performance of their statutory functions (*Broadmoor Special Hospital Authority v Robinson* [2000] Q.B. 775; [2000] 1 W.L.R. 1590).

In *Broadmoor*, the hospital authority had statutory duties to treat its patients, maintain the security of the hospital, and to provide a therapeutic environment. The hospitals in *Abbasi* did not rely on this line of authority, but the court thought that it could justify an injunction anonymising the clinicians, too, if not doing so might consequentially affect the hospital's care for its patients (at [77]).

Third, and protecting the interests of the clinicians, the clinicians' rights in tort law, which could protect them from conduct amounting to harassment and abuse. The list included defamation, trespass, breach of confidence, the Protection of Harassment Act 1977, and the GDPR and Data Protection Act 2018. The court noted especially the tort of misuse of private information or invasion of privacy (see eg *ZXC v Bloomberg LP* [2022] UKSC 5; [2022] A.C. 1158 at [45]).

The Supreme Court held (at [97]) that:

> "There are at least three causes of action available under our domestic law under which the clinicians can be protected in the context of disputes over the withdrawal of life-sustaining treatment: their own cause of action, in particular based on the tort of invasion of privacy; the cause of action available to NHS trusts under the court's parens patriae powers; and the cause of action available to the trusts under the Broadmoor principle. The first of those causes of action is directly focused on the clinicians' right to privacy..."

The NHS trusts argued that—additionally—s.6(1) of the Human Rights Act obligated the court to exercise its "equitable jurisdiction", statutorily restated in s.37(1) of the Senior Courts Act, to grant injunctions protecting the clinicians' private life under article 8 (at [84], [98]). The Supreme Court firmly rejected this argument. There is no room immediately to rely on Convention rights where a relevant "cause of action" exists under domestic law (at [83], [86], [99]). That is why, if one seeks an injunction preventing publication of defamatory statements, one cannot simply ignore the tort of defamation and rely solely on s.6(1) HRA and "equity" (at [89]).

It is interesting to compare how in the recent landmark private nuisance case *Fearn v Tate Gallery* [2023] UKSC 4; [2024] A.C. 1 at [113], [206], both Lord Leggatt and Lord Sales regarded the leaseholders' attempts to rely on Article 8 to enjoin the Tate Gallery's use of its viewing platform as "unhelpful" and an "unnecessary complication and distraction".

Could the injunctions endure indefinitely, as typically framed? This was not "best practice" (at [152]). The *parens patrie* jurisdiction could justify an injunction lasting only so long as the child is alive (at [65]). The *Broadmoor* jurisdiction would be available "for as long as there is a risk of interference with the trust's performance of its functions" (at [78]). A quia timet injunction protecting the clinicians' various tort law rights depends on whether there is a "real risk" of "invasion of privacy or some other form of wrongful conduct" (at [181]).

After proceedings end and a declaration to withdraw life-support is granted, the child would die. But the risk of abuse and harassment might persist, affecting care to other patients. Thus these injunctions extend into a subsequent "cooling-off period"—"weeks rather than months or years"—to allow time for the trust to apply for a continuation of the existing injunction, or a new injunction, and for the clinicians to seek legal advice and do the same (at [66], [146], [182]).

This leads to issue (iii). The court thought that "standing follows from… jurisdiction" (at [112]). Who has standing (a) at the outset of proceedings and (b) after their end? The court was unanimous about the latter but not the former.

After proceedings end ((b)), the NHS trusts have standing to invoke the *Broadmoor* jurisdiction. But only the clinicians have standing to enforce their rights. A big difficulty in *Abbasi* was that "the only basis on which the continuation of the injunctions was sought was to protect the rights of the clinicians; but those rights were not being asserted by the clinicians themselves"; they were being asserted by the hospitals. (at [154], [181]).

How about at the outset of proceedings ((a)), when the child is being treated and there is "pressure" and "urgency" (at [42], [81])? The trusts have standing to invoke the *parens patriae* and *Broodmoor* jurisdictions. But who has standing to enforce the clinician's rights—whether under art 8 of the Convention, or as mediated through domestic tort law?

According to the majority, only the clinicians have standing. Lord Sales disagreed. It would be "completely unreasonable" to expect the clinicians to worry about taking legal steps to protect themselves at this critical stage, when their patients needed care (at [196]); "it is the trust who is best placed to do that on behalf of the clinicians while their attention is, for compelling reasons, elsewhere." (at [200]).

This "limited departure" is justified by "the pressurised circumstances" depriving the clinicians of a "fair opportunity" to consider and assert their legal rights (at [196]). It is temporary, lasting only for a cooling-off period "long enough to allow clinicians time to collect their thoughts and seek legal advice about their position" (at [202]).

The NHS trusts should have standing to "to assert the rights of the clinicians in their employment" (at ([185], [195], [197]) because, first, they had "responsibility for their welfare in relation to their employment", and second, they could make appropriate submissions on behalf of the clinicians, being in charge of managing the child's care. This ensures the clinicians' Convention rights were "practical and effective rather than theoretical and illusory", applying also to the clinicians' tort law rights, a form of protection "mediated through rights existing in domestic law" (at [198], cf [98]-[99]).

The majority conceded that their view presented "practical difficulties". The clinicians "may be under pressure enough in caring for the child at that critical stage without having to undertake all that is involved in the bringing of legal proceedings". Hence they thought that, possibly, the clinicians could be joined to the trusts' proceedings under the *parens patrie* or *Broadmoor* jurisdictions, such that the trust would prepare for, and fund, legal proceedings "on the basis that the risk which [the clinicians] face has only arisen in consequence of the proceedings for a declaration brought by the trust, for which they are working". The case by the trust and the clinicians would likely be the same: an apprehended risk of abuse of the clinicians which would affect the child's care (at [81]-[82]).

Several points arise from this exchange.

First, standing was said to be a "power to bring proceedings" to "invoke the power of the court to grant an injunction…" (at [74], [76]; see also Liau, *Standing in Private Law* (OUP 2023) p.40, 56-58). Thus,

> "A court will not act to protect the clinicians' rights unless someone with standing to do so asserts that it should and presents submissions to persuade it to act" (at [200], cf [154]).

Second, a general standing rule that only the primary right-holder has the standing (ie power) to sue to enforce his rights (and no one else) was recognised. Lord Reed and Lord Briggs insisted that "The clinicians' cause of action in tort has to be asserted in a claim brought by the clinicians themselves" (at [81]). Lord Sales called this the "usual position" (at [196]):

> "Ordinarily an adult of full capacity who wishes to assert their rights in legal proceedings has the responsibility to do that for him or herself by commencing or participating in legal proceedings" (at [193]).

This rule explains why private law enforcement typically takes on a bilateral form; enforcement is generally exclusive to the right-duty relation. It also explains the exceptionality of "right-less enforcers", which are met with resistance within private law doctrine (Liau, *Standing in Private Law* (OUP 2023) at p.7, 80-91, 109, 158-60, 183-86, 193-96, 241-46).

Third, this explains why it was recognised that (at [76]):

> "the hospital authority does not have the power to bring proceedings on the *Broadmoor* basis in order to protect its patients' rights to privacy or confidentiality, or to protect the rights of *third parties*. Such proceedings normally have to be brought by or on behalf of those individuals themselves, since it is to them that the relevant duty is owed (*Fraser v Evans* [1969] 1 QB 349, 361)." (emphasis added)

Fourth, it also explains why the majority recognised (at [90]) that:

> "Our domestic law provides [the clinicians] with causes of action against persons who threaten those interests, and they must normally avail themselves of those causes of action if they wish to obtain a remedy from the courts. Third parties do not normally have standing to apply for a remedy to protect those individuals' interests… so far as the state is under a positive obligation arising from article 8 to intervene in relations between private persons in order to protect such interests, the obligation is usually satisfied by providing the person affected with the means of seeking legal redress."

One detects here traces of a "political principle of civil recourse" (Goldberg and Zipursky, *Recognising Wrongs* (HUP 2020), albeit in a different constitutional context.

Fifth, Lord Sales rightly observed that the interests of the child and hospital are inadequate substitutes for the clinicians' (at [183], [191]). There is no "overlap" where it is in the child's interest for publicity to raise money via crowdfunding for expensive treatments, where the clinician has left the hospital's employ, or where the child's family does not dispute that withdrawing life-support is in the child's best interests, yet third parties who feel strongly harass the clinicians (at [186]-[187]).

Sixth, Lord Sales' time-limited exception treats the clinicians' rights seriously as ends, while more straightforwardly resolving "practical difficulties". It is difficult to disagree that the hospital trusts had "proceeded in a laudable and appropriate manner" (at [185]) in wanting to protect the rights of their employees, unable to fend for themselves only because of pressures imposed by their employment. Had the clinicians' a "fair opportunity" to consider the matter, they would likely have wanted their rights enforced.

The general necessity of joinder (at [199]-[200]) and right-holder consent is important. With it, the clinicians have a veto over enforcement. Consent is normatively significant: it can defuse equality and autonomy-based objections to extending standing to "right-less enforcers" like the hospital trusts (Liau, *Standing in Private Law* (OUP 2023) at p.241-43, 279-85, 289).

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