IN THE SWINDON FAMILY COURT

B E T W E E N:

A LOCAL AUTHORITY

Applicant

and

MOTHER

First Respondent

and

FATHER

Second Respondent

and

CHILD X
(By the children's guardian)

Third Respondent

and

MATERNAL GRANDMOTHER

Fourth Respondent

and

MATERNAL GRANDFATHER

Fifth Respondent

**WRITTEN JUDGMENT OF HIS HONOUR JUDGE EDWARD HESS**
**SITTING AS A DEPUTY HIGH COURT JUDGE**
**PURSUANT TO SENIOR COURTS ACT 1981, SECTION 9(1)**

**(Delivered to the parties by email on 6th August 2019)**

## INTRODUCTION

1. I have before me an application brought by A Local Authority, to whom I shall refer in this judgment as "the local authority".

2. I heard the application over 12 days in July 2019.

3. The application formally relates to one child, Child X [born in 2016]; but a large portion of the facts giving rise to these proceedings relate to another child, Child Y [born in 2017], who very sadly died in June 2018.

4. The Respondents are:-

    (i) Mother [born in 1987, now aged 32], to whom I shall refer in this judgment as "the mother";

    (ii) Father [born in 1985, now aged 33], to whom I shall refer in this judgment as "the father";

    (iii) Maternal Grandmother [born in 1965, now aged 53], to whom I shall refer in this judgment as "the maternal grandmother";

    (iv) Maternal Grandfather [born in 1958, now aged 60], to whom I shall refer in this judgment as "the maternal grandfather" or, collectively with the maternal grandmother, "the maternal grandparents";

    (v) Child X herself, represented in these proceedings by the children's guardian from CAFCASS, to whom I shall refer in this judgment as "the guardian".

5. The representation before me has been as follows:-

(i) the local authority is represented by Mr Dylan Morgan (Counsel), leading Ms Katherine MacDonald (Counsel);

(ii) the mother is represented by Ms Susan Hunter (Counsel), leading Mr Iain Large (Counsel);

(iii) the father is represented by Mr Andrew Norton (Leading Counsel), leading Mr William Heckscher (Counsel);

(iv) the maternal grandparents have appeared before me in person; and

(v) the guardian is represented by Mr Sam Momtaz (Leading Counsel), leading Ms Louise MacLynn (Counsel).

I want to thank all the advocates for their considerable assistance in this sensitive and complex case. All parties have been represented at a first class level by advocates who have all worked assiduously and with great skill.

6. In considering this application I have considered a bundle which contains a large amount of material, running to more than 6,000 pages, which I have had in the form of an electronic bundle and which can perhaps be summarised (non-exhaustively) as follows:-

(i) Various material from the local authority, including a final schedule of findings sought and various responses to it and an extensive and helpful opening note.

(ii) A collection of applications and orders in these proceedings.

(iii) Material from Dr Amanda Jeffery, Forensic Pathologist

(iv) Material from Dr Elhassan Magid, Consultant Paediatrician,

(v) Material from Paramedic One.

(vi) Material from Paramedic Two.

(vii) Material from Dr Daniel Du Plessis, Consultant Neuropathologist,

(viii) Material from Dr Neil Stoodley, Consultant Neuroradiologist,

(ix) A Lextox hair strand test report on the mother

(x) A Lextox hair strand test report on the father

(xi) Material from Paramedic Three

(xii) Material from Professor David Mangham, Consultant Histopathologist,

(xiii) A witness statement from Consultant Paediatrician, who attended to Child Y in June 2018.

(xiv) Material from a treating Senior Sister

(xv) Material from a treating Senior Nursing Sister

(xvi) A statement from the mother's brother

(xvii) Statements from the father's sister

(xviii) Statements from paternal grandmother.

(xix) A statement from a neighbour of the mother.

(xx) Assessment Reports from the fostering assessor, Local Authority Social Worker

(xxi) An undated statement from the Health Visitor.

(xxii) Material from the allocated Local Authority Social Worker.

(xxiii) Material from KP the mother of the maternal grandfather

(xxiv) A statement from the mother's sister

(xxv) A statement from the partner of mother's sister

(xxvi) Statements from ER and AT, mothers to father's older eldest two children

(xxvii) Material from the parenting assessor Local Authority Social Worker.

(xxviii) Material from the maternal grandmother

(xxix) Material from the maternal grandfather

(xxx) Material from the father

(xxxi) Material from the mother

(xxxii) A report from Mr Ivan Burchess, Chartered Clinical Psychologist

(xxxiii) Material from the guardian.

(xxxiv) Extensive disclosure from the Police

(xxxv) A statement dated Summer 2018 from BN the mother of the maternal grandmother, who sadly died in 2018. Also, related to this subject, a statement from her daughter, a note of a meeting on 18th March 2019 with

the mother's cousin , a statement from a treating clinician for BN and a statement from a treating Nurse Practitioner for BN.

(xxxvi) Material from the earlier proceedings

(xxxvii) Various documentation disclosed by the local authority

(xxxviii) Various collections of text messages, facebook messages and photographs.

(xxxix) Various medical, hospital, Health Visitor and ambulance records.

7. I have also heard oral evidence from:-

(i) Dr Amanda Jeffery;

(ii) Dr Elhassan Magid;

(iii) Paramedic One;

(iv) Paramedic Two;

(v) Dr Neil Stoodley;

(vi) Dr Daniel Du Plessis;

(vii) Paramedic Three;

(viii) Professor David Mangham;

(ix) Mother's brother;

(x) Father's sister;

(xi) Paternal Grandmother;

(xii) Mother's neighbour;

(xiii) Fostering assessor;

(xiv) Social Worker;

(xv) KP Maternal great grandmother (mother of maternal grandfather);

(xvi) Parenting assessor;

(xvii) the maternal grandmother;

(xviii) the maternal grandfather;

(xix) the father;

(xx) the mother; and

(xxi) the guardian.

8. I have watched (outside the court room, by agreement of all parties) DVDs of two police interviews of the mother. There were no other DVDs made available to me. I was told that the other interviews were not video-recorded.

9. Since the conclusion of the live evidence I have had the benefit of full written submissions from all the advocates, submitted by email in accordance with the timetable laid down and (in Ms Hunter and Mr Norton's case, also a reply to the other submissions submitted by email.

10. I am delivering this judgment on 6th August 2019, having had the opportunity to consider all the representations made.

## BACKGROUND CIRCUMSTANCES

11. The circumstances leading up this hearing can be summarised as follows:-

(i) The following background circumstances emerged about the mother:-

(a) She is now 32, having been born in 1987.

(b) She had, for the most part, a normal and happy early childhood in a settled and stable family.

(c) She is not unintelligent, but left school at age 16 before briefly attending a sixth form college and then left without completing her course and moved into employment.

(d) Her PNC print shows that she received a police caution for common assault when in 2003, but that otherwise she has not been known to the criminal justice system until recent events.

(e) She had a relationship with for two years which she described as being abusive, involving drink, drugs, sexual assault and volatility.

(f) She then had a different relationship for seven years with CO from about 2007 to 2015, and the mother has described that as being abusive towards its end, with elements of violence and

drug and alcohol misuse. The relationship broke down, but the mother has continued to see him quite regularly despite the allegations she has made about his behaviour. The mother has said that CO is a drug supplier and that he has continued to supply her with cannabis until not long ago.

(g) The mother has admitted to using significant amounts of cannabis for a long period of time, starting from when she was a teenager. The Lextox report on the mother establishes that the mother was a 'medium level' user of cannabis in the three month testing period in 2018. The mother has admitted, and this is consistent with the test results, that she used cannabis on a daily basis in this period. The mother told the psychologist Mr Burchess (and the court) that she had been abstinent from cannabis since a date in early 2019; but she expressly declined to undergo a further hair strand test offered to her in the course of the hearing which might have established the truth of this assertion (I shall return to this issue below).

(h) Mr Burchess opined that the mother presented as *"both depressed and anxious, crying easily…a history of unstable and intense interpersonal relationships…suicidal behaviour....self-mutilated…vulnerability to affective instability…in my opinion (the mother) presents with many of the clinical features of having a personality disorder…an Emotionally Unstable Personality Disorder…formalising a diagnosis would require a more detailed assessment*". My own observations of the mother in court were consistent with the opinions of Mr Burchess.

(i) She has lived in rented accommodation throughout the recent events.

(ii) The following background circumstances emerged about the father:-

(a) He is now 33 having been born in 1985.

(b) Like the mother, he had, for the most part, a normal and happy childhood in a settled and stable family.

(c) When the father was a teenager his own father died. He blames this for causing him some disruption and depression leading to excessive drinking and some drug taking (recreational cocaine) for a while ("*I bottled it up and I just spiralled*"); but he feels he overcame this troubled period in his life after a while. The hair strand test report found no evidence of cocaine use in the 9 months or so leading up to Summer 2018, but the father admitted to one isolated episode during that time.

(d) He left school at 16, attended sixth form college until 18 and then moved into employment. He has had a stable work record since then and has a supportive employer.

(e) His PNC record shows that he was convicted of assault occasioning actual bodily harm in 2005, but that otherwise he has not been known to the criminal justice system until recent events.

(f) He had a series of fairly short lived relationships before having a cohabiting relationship with ER. His eldest child is SR with whom he had regular staying contact until recent events, but continues to have some contact, came from this relationship. Father then had a relationship with AH. The father's second child DH with whom he has always had a good level of contact, came from this relationship. I note that the statements of both ER and AH, despite their respective relationships with him having broken down, speak highly of the father as a good person and a good father to their respective children by him, but have both spoken very negatively about the mother.

(g) He currently lives at his mother's house, having oscillated between this home and the mother's property for much of the past few years.

(iii) In 2015 the mother and the father commenced a relationship, even though she was still living in the same house as CO. The mother quickly became pregnant with Child X. When Child X was born there was a dispute about her paternity, but DNA tests established the father's paternity and this was not subsequently in doubt. For a while the father continued to have doubts, however, as to whether the mother's relationship with CO really had ceased and this led to a bad atmosphere in the home. Also, the mother was suspicious about the father's relationship with AH.

(iv) The relationship between the mother and the father was very often turbulent and it was also intermittent – they spent a good deal of time together but didn't really ever fully cohabit, or in so far as they did, their cohabitation was punctuated with periods of separation. I shall return to this issue below.

(v) Very shortly after Child X's birth, the mother became quickly pregnant again, this time with Child Y. This was unplanned. There were anxious discussions about a termination, initially more favoured by the mother than the father, but a decision was eventually taken not to terminate the pregnancy and Child Y was born in 2017. He was a premature baby. He had some early health problems, including a significant operation, and remained in hospital for a number of weeks after his birth, when he was discharged home.

(vi) In late 2017 one of the mother's pets died. This event appears to have caused the mother to be very unhappy and angry and the relationship between the mother and the father completely broke down for a period and he had limited access to Child Yin the next 7 days. On the same day KP heard the mother say about Child Y, after she had been dealing with the vet about the dead pet, "*I would rather have my pet back than him*", 'him' being Child Y. The mother denies saying this, but I accept the evidence of KP on this. This event was illustrative of a wider difficulty in the relationship between the mother and Child Y, to which I shall return below.

(vii) In late 2017 Child Y was seen in a routine clinic. It was observed that he had a bruise to his right eyelid and a subconjunctival haemorrhage in his right eye. This observation triggered normal safeguarding procedures and initial medical investigation suggested that these injuries, together with some mouth lesions and evidence of a metaphyseal fracture of the right distal femur, were "*highly suspicious of non-accidental injury*". Police protection powers were exercised seven days later and care proceedings were duly issued by the local authority. An interim care order (with removal of Child X and Child Y to foster care) was made. Dr Karl Johnson, a Consultant Paediatric Radiologist, was instructed to review the radiographs and, in a report, stated that "*In my opinion there is no metaphyseal fracture of the distal right femur. In my opinion the changes around the distal right femur are a consequence of the x-ray projection and overlying soft tissue changes…Child Y has not suffered any bony injury"*. There was also no clear paediatric opinion on the other injuries at that time, the case having focused on the suspected metaphyseal fracture. Accordingly, the local authority sought to withdraw the proceedings and, in early 2018 the court (Recorder Hyde QC) acceded to this request and the children were returned to the mother forthwith. Nobody in the current proceedings has criticised or challenged what happened in February 2018 (i.e. the opinion of Dr Johnson or the decisions of the local authority or the court), but the local authority are inviting me to reconsider the decisions made in 2018 not to pursue the right eyelid and subconjunctival haemorrhage issues.

(viii) In this hearing there were many events in the period between early 2018 and the Summer of 2018 which were touched upon or analysed in detail by the evidence. Where they are relevant to my determination I shall return to these events below. In particular I shall below analyse in detail what happened during the day Child Y died. For present purposes I shall record that at 8.06 p.m. on that day Child Y arrived by ambulance at the Hospital and at 8.25 p.m. on the same day, after all attempts at resuscitation had been unsuccessful, Child Y was declared dead.

(ix) Child X was placed (initially under Children Act 1989, section 20) in the care of the maternal grandparents. In July 2018 the local authority issued care proceedings. The proceedings were allocated to me, sitting as a Deputy High Court Judge. Twelve days later I made an Interim Care Order in relation to Child X and approved the local authority care plan for her to

remain living with the maternal grandparents. She has remained there to this day, and all reports of her day to day care are positive.

(x) I made the case management decision to conduct a combined fact-finding and welfare hearing in this case. In doing this I agreed with and followed the thinking of Ryder LJ in *Re S* [2014] EWCA Civ 25, when he said:-

*"the case raises yet again issues of case management relating to split hearings which ought to be addressed given that the social care context was missing from the consideration of the pool of perpetrators and from any consideration of factors that may have caused secondary facts to be found from which an inference of primary fact could have been made…It is by no means clear why it was thought appropriate to have a 'split hearing' where discrete facts are severed off from their welfare context. Unless the basis for such a decision is reasoned so that the inevitable delay is justified it will be wrong in principle in public law children proceedings. Even where it is asserted that delay will not be occasioned, the use of split hearings must be confined to those cases where there is a stark or discrete issue to be determined and an early conclusion on that issue will enable the substantive determination (i.e. whether a statutory order is necessary) to be made more expeditiously. The reasons for this are obvious: to remove consideration by the court of the background and contextual circumstances including factors that are relevant to the credibility of witnesses, the reliability of evidence and the section 1(3) CA 1989 welfare factors such as capability and risk, deprives the court of the very material (i.e. secondary facts) upon which findings as to primary fact and social welfare context are often based and tends to undermine the safety of the findings thereby made. It may also adversely impinge on the subsequent welfare and proportionality evaluations by the court as circumstances change and memories fade of the detail and nuances of the evidence that was given weeks or months before…It ought to be recollected that split hearings became fashionable as a means of expediting the most simple cases where there was only one factual issue to be decided and where the threshold for jurisdiction in section 31 CA 1989 would not be satisfied if a finding could not be made thereby concluding the proceedings…Over time, they also came to be used for the most complex medical causation cases where death or very serious medical issues had arisen and where an accurate medical diagnosis was integral to the future care of the child concerned. For almost all other cases, the procedure is inappropriate. The oft repeated but erroneous justification for them that a split hearing enables a social care assessment to be undertaken is simply poor social work and forensic practice. The justification comes from an era before the present Rules and Practice Directions came into force and can safely be discounted in public law children proceedings save in the most exceptional case…Social work assessments are not contingent on facts being identified and found to the civil standard…Social work assessments are based upon their own professional methodology like any other form of professional risk assessment. In care cases, an appropriate social work assessment and a CAFCASS analysis should be undertaken at the earliest possible*

*opportunity to identify relevant background circumstances and context. In so far as it is necessary to express a risk formulation as a precursor to an analysis or a recommendation to the court, that can be done by basing the same on each of the alternative factual scenarios that the court is being asked to consider*".

(xi) The case was listed for a combined fact-finding and welfare hearing due to run in early 2019. Unfortunately, not very long before the listed start date, some 55,000 pages of Police disclosure emerged as a result of the Police analysis of mobile phone records and the court had no alternative but to vacate those hearing dates. This has caused months of delay for the already anxious family members. There is perhaps a lesson to be learned for all of us involved in these type of proceedings that disclosure of this sort of material by the Police should be expedited as far as possible, but I do appreciate that this raises resource and other issues within the Police. In any event, new hearing dates were fixed for July 2019 and the hearing has proceeded in accordance with these re-fixed dates. The lawyers in the case have, it seems to me, worked appropriately and impressively hard to ensure the case has been ready for trial, including ensuring the timetabling and attendance of witnesses and complex bundle preparation.

## THRESHOLD

12. The first formal matter I have to decide in this judgment is whether or not the threshold criteria under Children Act 1989, section 31 are made out and, if so, on the basis of what facts. Accordingly I remind myself that this assessment must be made as of the date that the local authority intervened and first took protective measures. I remind myself that section 31 reads:-

*"(2) A court may only make a care order or a supervision order if it is satisfied –*
*(a) that the child concerned is suffering, or is likely to suffer, significant harm; and*
*(b) that the harm, or likelihood of harm, is attributable to –*
*the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him;*

*(9) In this section -*
*...*
*'harm' means ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill-treatment of another;*
*'development' means physical, intellectual, emotional, social or behavioural development;*
*'health' means physical or mental health; and*
*'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical."*

## FACT FINDING LAW

13. For me to decide whether or not the above test is made out I need to make some specific determinations of a fact-finding nature. Accordingly, it is important for me to remind myself of the case law relevant to fact-finding.

14. In this case the advocates have liaised between each other and produced a helpful and fully agreed note of the relevant law. This seems to me to be an accurate and comprehensive statement of the relevant law and I propose to adopt it in full and have accordingly included it as an Appendix to this judgment. Without wishing to detract from the full terms and effects of the note, I propose to extract a number of important principles which will particularly guide me as I consider the elements of fact-finding in my judgment:-

    (i) The formulation of "Threshold" issues and proposed findings of fact must be done with the utmost care and precision. The distinction between a fact and evidence alleged to prove a fact is fundamental and must be recognised.

    (ii) The true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from, say, negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of s 31(2) of the CA 1989.

    (iii) The burden of proof is on the local authority. There is no pseudo-burden or obligation cast on the respondents to come up with alternative explanations. It is for the local authority to prove its case. It is not for the mother to disprove it. In this case the guardian invites me to make findings which go beyond what the local authority has invited me to find. In this context the comments about burden of proof shift to the guardian, but the principles are the same.

    (iv) Findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation.

    (v) Evidence cannot be evaluated and assessed in separate compartments. A judge must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof.

(vi) The standard of proof is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies. As to the seriousness of the allegation, there is no logical or necessary connection between seriousness and probability.

(vii) In our legal system, if a judge finds it more likely than not that something did take place, then it is treated as having taken place. If he finds it more likely than not that it did not take place, then it is treated as not having taken place. He is not allowed to sit on the fence. He has to find for one side or the other.

(viii) Of course, it may be difficult for the judge to decide, even on the balance of probabilities, who has caused the harm to the child. There is no obligation to do so. If an individual perpetrator can be properly identified on the balance of probabilities, then it is the judge's duty to identify him or her. But the judge should not start from the premise that it will only be in an exceptional case that it will not be possible to make such an identification. Where a perpetrator cannot be identified, the Court should seek to identify the pool of possible perpetrators on the basis of the "real possibility" test. Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool'.

(ix) Where there are multiple injuries sustained at different times the court must consider separately the question of who is the perpetrator of each injury.

(x) Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. The roles of the court and the expert are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence.

(xi) The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others.

(xii) The evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them.

(xiii) It is common for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind

that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (the *Lucas* direction).

(xiv) Where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record-keeping or recollection of the person hearing and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as 'storycreep' – may occur without any necessary inference of bad faith.

(xv) There has to be factored into every case which concerns a disputed aetiology giving rise to significant harm a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities. The court must resist the temptation that it is always possible to identify the cause of injury to the child.

(xvi) Failure to protect comes in innumerable guises. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable, this is a threshold finding that may have important consequences for subsequent assessments and decisions.

(xvii) An obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory.

15. An additional, permissible but uncommon, feature of the present case is that the guardian has reached the conclusion that the local authority's proposed schedule of findings of facts is over-conservative:-

(i) Mr Momtaz, on behalf of the guardian, invites me to make some findings about the cause of Child Y's death which the local authority has specifically decided not to pursue.

(ii) Ms Hunter has countered this by challenging the procedural fairness of how this was dealt with at the hearing. She has said: "*It is the mother's submission that she was/is entitled to proper notice of the case against her including a fully particularised pleading with evidential references. The implications of a failure to provide this are significant – both with regard to process (the guardian avoids the evidential and procedural requirements that fall upon a party making an allegation) and with regard to the overarching requirement of fairness".*

(iii) Mr Momtaz has responded: "*It may be submitted on behalf of the mother that she has not had sufficient notice of any findings sought against her as to the cause of Child Y's death. We respectfully reject such a suggestion. We informed the court and the parties that we would be seeking to explore the possible causes of Child Y's death during this hearing in the position statement we filed before the hearing started. We have asked the relevant experts, Dr Jeffery and Dr Magid, about the possible and likely causes causes of death both in the form of written questions, which prompted addendum reports from them, and in their oral evidence. We made it plain before the mother began her evidence that we would be asking her about the 3 possible causes of death identified by Dr Jeffery i.e. SIDS, overheating/dehydration and non-accidental injury. The court will recall saying to mother's counsel that this can have hardly come as a surprise to her. We questioned the mother as to the possible causes of death and specifically asked her whether she had caused Child Y's death by smothering, strangulation or drowning…. We submit that the approach taken during this hearing is markedly different to that taken by the trial judge in Re W [2016] EWCA Civ 1140. The mother knew the critical points she was going to be asked about and was able to answer them. There has been nothing intrinsically unfair in the approach taken in these proceedings. The possible findings as to cause of death were certainly within the "known parameters" of this case."*

(iv) I shall deal below with the procedural and substantive issues arising from this.

## FACT FINDING IN THIS CASE

16. I now return to assessing the facts of this case against these legal propositions.

17. I propose to break my fact-finding analysis down by asking myself the following questions:-

(i) What is my overall assessment of the credibility and reliability of the mother?

(ii) What is my overall assessment of the credibility and reliability of the

father?

(iii) What has been established about the injuries to Child Y observed in late 2017?

(iv) What has been established in relation to the allegations that the mother left Child Y alone unattended on various occasions in June 2018, including on the day of his death in June 2018?

(v) What has been established about the head injuries to Child Y observed in June 2018?

(vi) What has been established about the soft tissue and mouth injuries to Child Y observed in June 2018?

(vii) What has been established in relation to the allegations that the parents failed to ensure that Child Y received appropriate medical attention?

(viii) What has been established in relation to the allegation that the parents' relationship contained domestic violence and/or abuse?

(ix) What has been established about the cause of Child Y's death?

**What is my overall assessment of the credibility and reliability of the mother?**

18. As the case developed it became clear that some of the people who know the mother best, including and perhaps in particular some of her own family members, have a strong opinion that she is, and has for a long time been, dishonest and unreliable. In a court setting it is always important to treat such allegations with considerable caution because sometimes they can arise out of some past conflict of interest in the family or some controversial event which might have generated exaggerated or inaccurate opinions within the family. I also note that not everyone in the family has shared the same negative opinion, or at least (perhaps with a degree of wisdom) have been prepared to express it so openly. Overall, however, my view here is that those family members who have reached this negative conclusion about the mother have done so with justification and correctness.

19. Amongst the most vivid and striking oral evidence in the case came from the mother's paternal grandmother, KP. She had given information to the local authority in early 2018, first anonymously and then a statement on the record. She gave a further statement after Child Y's death. She willingly and powerfully gave oral evidence before me. Her message was essentially this. The mother is a *"compulsive liar"* and is *"extremely manipulative"* and has for years been *"addicted to cannabis"*. She said *"I really believe she has a personality problem….and will fight it out to the bitter end"*. As it turned out, her opinion as to a personality problem is mirrored by the professional view of Mr Burchess, the psychologist, and her opinion as to the

mother's cannabis use became increasingly obviously correct as the case moved forwards, as did the fact that the mother's early accounts of her cannabis consumption proved to be inaccurate. For example, the mother told the police that "*I'm not going to lie about doing because…I can still function and I don't do it in front of the children…I don't smoke in my house. I never smoked in the house*" , but in her oral evidence before me described how she would very regularly smoke a bong of cannabis in her kitchen, justifying this behaviour by reference to the extractor fan in the kitchen, including having two bongs in the kitchen while she prepared brunch for the family in the mid to late morning on the day Child Y died. Other family members, for example the maternal grandfather, made criticisms about the mother's honesty more gently, for example saying *"I have reached the conclusion that maternal grandmother and I have to be very careful of everything mother says to us, it needs to be checked".*

20. In the end, though, I regard these family assessments as bolstering my conclusion rather than underlying it, because there has been a vast array of evidence before me, much of it ultimately conceded by the mother, which has made it straightforward for me to reach the same conclusions about the mother as did KP.

21. The most glaringly obvious example of the mother's dishonesty was the way she dealt with the issue of where Child Y had been in the hours leading up to his death. She developed and maintained a clear and detailed narrative that Child Y had been with her all that afternoon. She told it to the ambulance crew and to the treating doctors. She told it to the father (at 4.15 p.m.: *"now I've got two humans and one attached to me, the other in a pram I might die pushing*) and to the maternal grandmother (at 6.22 p.m.: "*been out in it all day with the kids"*). She maintained it right throughout her first police interview and a good way through her second interview, until confronted by unanswerable evidence from cctv footage. In fact the troubling truth was that she had left Child Y at home most of the afternoon that day, from about 3.45 p.m. to about 6.40 p.m., completely unattended, on a very hot summer's day, in a bedroom with closed windows. The mother's cover story was a very deliberate, very elaborate and very serious lie. I must give myself a *Lucas* direction and adopt due caution, but I really cannot avoid the conclusion that this lie goes to the heart of the case and cannot be excused on the grounds advanced by the mother (i.e. that it was a panic reaction or that she was in no fit state to be interviewed).

22. This was just one of many areas of evidence where there was a clear establishment of the mother's dishonesty. Others included:-

    (i) the mother's callous lie to the father that Child Y had died in surgery not long after his birth (I reject the mother's assertion that she had said that Child Y was 'dead to him' in the sense that he would not be allowed to see him again);

    (ii) the mother's lying to the father that she was pregnant in late 2018 – she admitted the lie, justifying it before me on the basis that "*I made up the pregnancy story to wind him up*";

(iii) the mother's lie to the father about having taken the children to the Zoo in May 2018 – she admitted the lie, justifying it before me on the basis that "*I just wanted him to feel bad*";

(iv) the mother's lie to Mr Burchess when she was interviewed by him in July 2019 that "*she was currently not in a relationship*", the evidence before me being clear that the parents were in a relationship until they had an argument over pornography internet searches ten days after mother's interview with Mr Burchess;

(v) the mother's hopelessly inconsistent accounts before me and in Police interviews of when she arrived at and when she left the paternal grandmother's house on an evening in mid June 2018 – it was painful to hear and see the mother's dishonest attempts at trying to reconcile what she had initially said with the concrete timings which emerged from the various text messages sent that night;

(vi) the mother's lie to the maternal grandmother to the effect that *"I took the kids to paternal grandmother*" in mid June 2018, which the mother accepted before me was simply not true;

(vii) the mother's hopelessly inconsistent accounts before me and in Police interviews of whether or not she took a friend to the supermarket in early June 2018; and

(viii) the mother's denial, for example to the Health Visitor, that she broke the father's nose in early 2018 – she accepted before me that she had previously admitted it, saying "*at the time I thought it was quite funny*".

23. Having heard the mother answer many questions over many hours, both on the DVD of the Police interview and in court before me I was left with the very clear impression that she is an extremely dishonest person whose instinctive reaction to confronting difficult allegations is to invent the most favourable cover story she can think of at that moment, regardless of whether it is true, and then, when confronted by compelling contradictory evidence, evade and lie her way to the next best alternative cover story, again regardless of whether that is true. It would not be right for me to say that I disbelieve everything she has told me; but where there are two available plausible answers to any dispute of fact I would be inclined to treat the mother's version of events with very great caution.

24. One obvious example of this is the mother's assertion before me that she stopped taking cannabis, suddenly and completely, in April 2019. She was offered the clear chance in the course of the hearing to undergo a further hair strand test, the result of which would have been available prior to her giving evidence, so that (if what she said was true) she could prove her point with scientific back up. She declined to go along with that plan, asserting that she regarded hair strand tests as being '*intrusive*'. I reject that excuse as a dishonest one. Mr Morgan's closing submissions assert: "*The*

*mother has not cooperated with the testing that was available during the trial and thus the Court is invited to draw the inference against her that she still uses cannabis to date*". I agree with his analysis and on a balance of probabilities find that she is still using cannabis to date and that she lied to Mr Burchess about this.

**What is my overall assessment of the credibility and reliability of the father?**

25. I shall make some criticisms below of the father, and I shall make some findings against him arising from these events, but in assessing his credibility and reliability I would put him in a very different category from the mother.

26. Mr Norton's closing submissions contain these observations:-

*"The court will no doubt assess the veracity of each parent when considering their respective evidence. Those for the father cannot submit that he is entirely truthful. By his actions, the father was dishonest in not seeking medical attention for Child Y in early June 2018. In his evidence in this hearing he accepted lying about where he had stayed on the first night that he separated from the mother. The court will no doubt take into account the legal principles at play when considering lies that individuals may tell and their reasons for so doing. The father has however also been honest. The father accepted drug use, disclosing that when being tested, even though the test came back as undetectable."*

27. In my view that is a reasonable summary, which I find myself agreeing with and approving. In marked contrast to the mother, the father's oral evidence did not include any significant examples of having to evade a difficult question or any dishonesty being established. A re-reading now of the various written statements he has made suggest that he has done his best at each stage in the proceedings to give an up to date and honest account of events. Where there is a direct contradiction of evidence between the mother and the father I have generally found the father's account significantly more credible.

**What has been established about the injuries to Child Y observed in late 2017?**

28. In relation to the events of and surrounding late 2017 the local authority have invited me to find:-

(i) that in late 2017 Child Y was *"seen at Hospital to have a bruising injury to his right eyelid and subconjunctival haemorrhages to his right eye*";

(ii) that "these injuries were non-accidental in origin";

(iii) that either the mother or the father was the perpetrator or that they should both be in the pool of perpetrators; and

(iv) that if one was the perpetrator then the other failed to protect Child Y.

29. Mr Morgan's closing submissions on this include the following passages:-

*"The eye injury, if it were confined to the conjunctival haemorrhage, would be limited in its impact on the case. The issue is that those haemorrhages have to be considered alongside the bruise to the eye lid. The experts do not demur from the prospect that the injuries were caused together by an external force which injured the eye lid and the eye underneath. This is the local authority's position. The parents produce no effective explanation for the injury…. The parents' view is that the injury is something that must have happened in some way that they did not therefore know of. How is this? The injury would have been painful and would have caused Child Y to cry out and be upset for a while afterward. This would have been obvious to any carer who was present/within ear shot. The injury would have been seen afterwards. A responsible carer would have needed an explanation and would have been concerned…. The list of perpetrators for that injury includes both parents as they had joint care leading up to the appointment".*

30. The expert reporting on these right eye injuries is, it has to be said, rather limited. It is dealt with, really, in one short paragraph of Dr Magid's report where he says this: *"the bruise to the right eyelid and subconjunctival haemorrhage were likely due to an injury by an object that hit his right eye, this could have been accidental or intentional like somebody throwing an object, however it was unexplained and consequently non-accidental injuries can't be ruled out"*. This was explored to some extent in the cross-examinations of Dr Magid, but I think it would be a fair criticism of his evidence that he did not bear down on these injuries in much depth, perhaps believing (with some justification) that the main focus of the court's enquiry was likely to be on what happened in June 2018.

31. In response to this Mr Norton's submissions include the following passages:-

*"The father accepts there was a mark to Child Y's eyelid and subconjunctival haemorrhage [SCH]. The parents drew the mark to the attention of medical staff when Child Y was taken to a planned medical appointment on that date. Dr Magid, in cross-examination for father, accepted that the nature of the injury was such that instant medical attention [such as by 999 call or immediate visit to hospital] was not required on identification of the injury and that it was reasonable for the parents to await the planned appointment that day. This injury has to be seen in the context of a previous bruise noted on Child Y's forehead caused by an accidental bumping by Child X of a toy – reported to medical professionals and for which the NICU outreach sister was willing to accept as an explanation. All professionals were prepared in early 2018 for proceedings to be discontinued, including the Children's Guardian, who did not consider that the significant harm threshold was met once the leg injury had been determined not to be present. In relation to Dr Magid's evidence on this issue, it is submitted he failed adequately or at all to consider possible differential diagnoses for the causation. For example he appears not to have clearly considered*

*the nature of the mark to the eyelid. He describes it solely as a bruise but makes no reference to the different descriptions of mark/bruise and colour given by the treating medics. He, without question, linked the mark to the eyelid and the SCH as having been caused by one and the same event, despite the ophthalmic evidence that suggested that the punctuate appearance of the SCH made trauma a less usual cause There was no mention of that ophthalmic evidence in Dr Magid's report nor within his reasoning in oral evidence. He, we say, inappropriately dismissed the suggestion that Child Y could have scratched or otherwise caused the mark to the eyelid, indicating that a child of that age would not move his arms around, despite evidence that Child Y was observed at least to place his hand in his mouth; In linking the mark to the eye lid to the SCH, Dr Magid failed adequately to consider differential diagnoses for the SCH alone, such as coughing or vomiting, straining to open bowels – Child Y being described as opening bowels every 2 days or congenital vascular changes. Dr Magid failed to consider the possibility of a non-witnessed accident. Had such an event occurred, neither parent could of course have reported it as they were not present. Dr Magid's conclusion that this was a non-accidental injury was founded purely, we submit, on the fact that there had been no explanation in relation to the mark on the eye lid. In his report he stated that the injuries are unexplained and consequently "non accidental injury could not be ruled out". In cross-examination for father he stated that "if any accident witnessed or offered I would accept it but nothing witnessed". The court should determine that this evidence is insufficient, on its own, for the local authority to establish a positive finding that the injury was indeed more likely than not to be non-accidental. It is accepted that the court is however, at this hearing, entitled to weigh this evidence in the balance with the other evidence now before the court in relation to the other injuries. The court however will no doubt be appropriately circumspect in drawing too much support from subsequent findings that may be made. Even in the event that the court determines other injuries were caused non accidentally, that of itself cannot, we submit, automatically elevate suspicion as to the cause of injury in late 2017 into a sound basis for a finding."*

32. The submissions made by Ms Hunter make some similar points to those of Mr Norton.

33. I find myself in agreement with Mr Norton's submissions and propose to adopt them. I have reached the conclusion that I should not make any findings of fact as to what happened in late 2017. The withdrawal of the 2017 proceedings does not (in any legalistic or procedural way) prevent me from looking again at the injuries then recorded, but on the evidence available now, including that of Dr Magid, I have reached the conclusion that I cannot safely make any findings about the late 2017 injuries and I shall not do so.

34. I do not consider it appropriate to take further the comments made in paragraph 6 of Mr Momtaz's closing submissions in relation to the leg injuries putatively sustained by Child Y in late 2017. At one stage in the current proceedings the guardian made an application for a pathological investigation of Child Y's putative 2017 leg injuries, and this application was listed by me before Cobb J; but, as Mr Momtaz records, this application was not in the end pursued because the possibility of a significant result was not high enough to justify "*a potentially invasive examination*". In so far as Mr Momtaz, in his closing submissions, is inviting me to reopen this issue, I do not

consider this to be justified on the evidence I have heard.

**What has been established in relation to the allegations that the mother left Child Y alone unattended on various occasions in June 2018, including on the day of his death?**

35. The local authority invite me to conclude on the evidence that the mother neglected Child Y by leaving him at home without any care or supervision on a number of occasions in June 2018.

36. I have already dealt above with the day of Child Y's death. Although, as I have said, the mother initially denied this, she has really had no alternative but to admit this. As I recorded above, "*the troubling truth was that she had left Child Y at home most of the afternoon that day, from about 3.45 p.m. to about 6.40 p.m., completely unattended, on a very hot summer's day, in a bedroom with closed windows*". Although she arrived home at about 6.15 p.m., the evidence suggests that it was not until about 6.40 p.m. that she went upstairs to check on him. She prioritised dealing with the pets, with some food and a nappy change for Child X, and a text exchange with her mother before checking on Child Y. I can add to this that she left him without a bottle or other source of fluid (notwithstanding that he had only drunk a quarter or so of his mid-morning bottle). I agree with the local authority that this left Child Y in the vulnerable position that there was no responsible person available to deal with any primary care or medical needs. Nobody else knew at the time that she had done this. In particular the father had no idea that she had done this, not least because she had texted him contemporaneous and dishonest messages about what she had done with Child Y during that day. The responsibility for this act of gross irresponsibility falls squarely upon the mother.

37. The local authority further invite me to conclude on the evidence that this was not the only time that Child Y had been so left by the mother. They suggest that she also did this on thirteen occasions in June 2018.

38. Before I go further I propose to exclude two of these dates from the list. The first, by reason of the matters I shall discuss in detail below. Secondly, I exclude a further date because I was unable to see on the relevant ccctv photographs whether or not Child Y was in the car. As far as the events in early June 2018 is concerned I have already said above that I accept that the mother's denial of having taken a friend to the supermarket on that day was dishonest.

39. As far as the other dates are concerned, it is possible to be confident that at all these times the mother was out and about with Child X and that Child Y was not with her. I am able to say this because the identification of these dates has been executed by a good deal of painstaking work carried out by the Police. The mother's response is not that the dates and times are wrong, but that somebody else (the father, BN or an unnamed relative or friend) had care of Child Y at the time. I have listened carefully to what the mother has said about this and I have reached the conclusion that her explanations are very likely to be untrue. A number of matters cause me to reach this conclusion:-

(i) Where the mother's and the father's accounts of this are different I prefer the account of the father. On at least one of the occasions he was identified as the carer he was at work.

(ii) I do not believe the mother when she tells me that Child Y was regularly left with BN in the relevant period, for example for several hours until the late evening in mid June 2018. Whilst it is correct to note that BN's death has prevented the mother being able to challenge her written statement dated July 2018, she did say in that statement "*I have not seen mother and the kids since April* ". Given that for some of this period she was in the midst of a period of home implemented medical treatment (I have read the various opinions as to the state of her health at the relevant time), it seems improbable that even this mother would have imposed Child Y on her, for example for several hours into the late evening.

(iii) The mother demonstrated by what happened on the day Child Y died that she was entirely comfortable with leaving Child Y unattended.

(iv) There is no credible identification of any other adult who might have been involved in Child Y's care on those occasions.

(v) The mother's behaviour is consistent with what others observed about her general attitude. In the words of KP, "*Mother loves Child X but has always hated Child Y*". Counter-intuitive though it is to accept that this can have been the case, there is a good deal of evidence to support it. The comment about her preference for her pet to which I have referred above is one. Another example is what mother's sister's partner records the mother as saying: "*He's being a little bastard. He's been crying a lot*" . Another example is of the mother writing about Child Y on social media "*little shit doesn't want to sleep*". In late June 2018 she texted the father saying "*I can't deal with this any more. I'm better just gone…there will be no-one else but u now"*. The mother has herself spoken of her difficulty in bonding with Child Y. Although the mother told me this problem was over by the time of Child Y's death, I am not satisfied that it was. I have a clear impression that the relationship between the mother and Child Y was very poor. It is possible this arose from the circumstances of his birth, but whether or not this was the case, things were not good between them.

(vi) Further, I heard a good deal of evidence as to why it was that the mother was not in possession of a double buggy which would have enabled her to take out both Child X and Child Y together. An objective observer might have expected such an acquisition to be a priority for a mother of two very young children, yet for the 10 months from the time he was discharged to the time of Child Y's death in June 2018 she had not acquired a double buggy. She had sent back the one given to her by the children's centre within days of its arrival. She had declined her parents' invitation to buy one. She had declined the father's invitation to buy an economy priced one, apparently insisting that only a £1,000 plus one from Silver Cross would do, which he said he couldn't afford. My observation on this as that she did not really wish to have a double buggy because she preferred

taking out Child X and not Child Y if that was a possibility.

40. As far as a formal finding is concerned my conclusion is that, on a balance of probabilities, the mother neglected Child Y by leaving him at home without any care or supervision on a number of occasions in June 2018, varying in length from a few minutes to a few hours. The mother is responsible for all of these events. I agree with the local authority that this left Child Y in the vulnerable position that there was no responsible person available to deal with any primary care or medical needs. I am satisfied that the father did not have sufficient or any knowledge of what was happening to justify any allegation of failure to protect.

**What has been established about the head injuries to Child Y observed in June 2018?**

41. The written evidence of Dr Stoodley, the Consultant Neuroradiologist asserts that:-

*"Frontal and lateral views of the skull have been obtained. There is now evidence of a linear right-sided parietal skull fracture running the length of the parietal bone from the lambdoid suture posteriorly to the coronal suture anteriorly. There appears to be some associated soft tissue scalp swelling. The presence of a skull fracture is evidence that there has been an impact injury to the head of sufficient severity to lead to the fracture".*

42. The written evidence of Dr Jeffery asserts that:-

"*The post-mortem confirmed the presence of a skull fracture. This was approximately 15 cm in length passing through the right parietal bone and crossing the lambdoid suture into the right side of the occipital bone…it is most likely that the head injury event that resulted in the skull fracture also caused a degree of traumatic subdural bleeding*".

43. These assertions are confirmed by the written evidence of Dr Mangham, the Consultant Histopathologist (subject to a modest debate about the precise length of the fracture, which Professor Mangham thought was "not significant" and nobody has suggested otherwise – in broad terms the length is apparent from the radiograph annexed to his report, the fact that the fracture crosses the suture being more significant than whether it is precisely 13 cm or 15 cm in length).

44. These assertions are accepted by the parents and have not been challenged before me, thus I am able without difficulty to find that Child Y sustained a skull fracture of approximately 15 cm in length passing through the right parietal bone and crossing the lambdoid suture into the right side of the occipital bone and that this was caused by an impact injury to Child Y's head which also caused a degree of traumatic subdural bleeding.

45. There has been a live debate before me as to the timing and mechanism of this injury. In part this debate has been informed by the opinions of the various medical experts as to the likely mechanism necessary to cause a skull fracture of the sort described

above and the radiological and pathological evidence on timing (based on hard science, for example the examination of neomembranes). In part this debate has been informed by descriptions of an event which is said to have occurred in early June 2018, the plausibility of this event as a likely mechanism being in challenge in terms of its timing and in terms of its creating the necessary force to cause the fracture and in terms of the credibility of its description (the mother's precise account being very much in challenge).

46. The submissions of Mr Momtaz include the following passages which deal with the interrelationship of these arguments:-

*"The court has the advantage of 3 expert opinions dating these injuries. Professor Mangham dates the skull fracture between 1-3 weeks but most likely the mid-point of this window. Dr Stoodley dates the skull fracture, by association with the soft tissue scalp swelling, between 7-10 days from the date of the skull radiograph the day after Child Y died. Dr Stoodley confirmed in his oral evidence that this means 0-10 days from the radiograph. Dr Du Plessis dates the subdural bleeding 1-3 weeks from death and said in his oral evidence that he was more "comfortable" in the middle of this range. Both Professor Mangham and Dr Du Plessis confirmed that dating at the beginning or end of their respective time windows was possible but very unlikely.* ***There is an obvious area of overlap between these 3 experts roughly mid June 2018****. These dates are also squarely in the mid-range that both Professor Mangham and Dr Du Plessis felt most comfortable. If all these injuries were caused at the same time, which we submit is the most likely scenario, we submit these overlap dates are by far the most likely time window for these injuries to have been caused. There was some challenge to Dr Stoodley's analysis of the significance of the deep tissue swelling. Dr Stoodley was clear that if the scalp findings recorded by Dr Jeffery were collections of blood he could conceive that a longer time window was possible. However, they were not and he was confident in his opinion as to timing. Dr Du Plessis, having listened to Dr Stoodley's evidence, agreed with his analysis on this issue. There is an alternative scenario i.e. that there were two separate events causing the injuries. One event which caused the fracture and the subdural bleeding, possibly nearer the margins of the time windows given by Professor Mangham and Dr Du Plessis, and another event which led to the soft tissue scalp swelling identified by Dr Stoodley. Dr Stoodley, Dr Magid and Professor Mangham all say that significant force is required to cause a skull fracture. Professor Mangham's email dated July 2019 further elucidated his opinion as to the degree of force required: "I agree with the comments made by Drs Stoodley and Magid. The causative force imparts energy to the skull tissue. The energy is dissipated in the process of fracturing and fracturing ceases when the energy has been expended. Therefore, a skull fracture that reaches a suture, runs along it and then exits to continue to fracture the bone on the other side of the suture has a higher level of energy (and therefore was caused by greater force) than a fracture that does not cross a suture to continue into the adjacent bone. The significance of this feature (crossing a suture and continuing) in this fracture is that it indicates that it was a high energy (i.e. caused by a high impact force) fracture." We submit that it is very unlikely that the alleged fall on to the patio on or around early June2018 caused <u>any</u> of Child Y's injuries for the following reasons:*

- *The alleged fall took place in early June 2018 as conceded by the mother during her evidence, which is at the extreme end of the margin in terms of*

*dating as far as both Professor Mangham and Dr Du Plessis were concerned*

- *The alleged fall was unwitnessed and it is unclear how Child Y could have sustained his injuries i.e. by falling backwards onto the patio. Dr Magid was asked several questions about how this might have happened and found it difficult, if not impossible, to conceive of a way that this might have happened.*
- *It is unclear whether Child Y was capable of pulling himself up in early June. References to him being able to do so are nearer the middle of June.*
- *The level of force required to cause a skull fracture, particularly one that crosses a suture, makes it more unlikely that this was an accidental injury*
- *The father has never seen any occasion when Child Y has fallen*
- *No person, whether a family member or any professional, observed Child Y with any bruise or swelling on or around early June 2018*
- *The court would have to find that the mother's account of what happened was reliable which is at best tenuous given that she lied to the health visitor about whether Child Y sustained any injury as a result of the fall and did not inform any family members about a significant fall other than the father. Further In her second police interview, the mother says the injury was very swollen there was bruising to the side of Child Y's face and the father said it was like a haematoma. The father has never described a large swelling, never saw any bruising on Child Y's face and denied saying anything about a haematoma in his oral evidence."*

47. I find myself broadly in agreement with these submissions, subject to these comments:-

(i) I have considered Ms Hunter's submission to the effect that *"the court should reject the timeframe asserted by Dr Stoodley in preference to the more accurate investigations and conclusions of the pathologist and histologist*", but take the view that this point has been dealt with in Mr Momtaz's submissions above – it is not here a question of preferring the radiological evidence over the pathological evidence, or *vice versa*, since in this case, in the clear conclusion of Dr Stoodley, which I accept, that both can be accommodated and both contribute to the overall timing evidence in their different ways.

(ii) I place less emphasis than Mr Momtaz on the issue of where the timing might lie within a normal distribution curve and have some sympathy with Ms Hunter's observations that "*The mother does not accept that taking the mid point of a 'normal distribution' pattern is probative of the date of Child Y's injuries.*" The fact remains that in the present case my acceptance of Dr Stoodley's 0-10 days diagnosis, and its mathematical combination with the other experts' 1-3 week diagnosis, places the timing in the most likely sector of the normal distribution curve.

(iii) The mother's various explanations as to what precisely happened in early June 2018 were, for me, internally inconsistent and ultimately unconvincing. Her account varied as to the date and time, not fitting well with the timing of the internet searches which seem to have been related to this event. Her explanation of the degree and location of the swelling on

Child Y's head seemed to me to adapt to the developing medical evidence and to be very different to what the father observed. The father did observe some swelling and redness, *"the size of a 50 p piece – a little bump, nothing massive. I certainly didn't see any swelling or bruise on his face. It is a lie that I said it was a haematoma*". I accept his evidence on this and much prefer it to that of the mother.

(iv) On the overall question of whether or not a one year old child reaching up, losing balance and falling down a 15 cm step falling on to this particular patio could have caused a skull fracture of the severity described, the medical evidence, including that of Dr Magid, was in my view clear and properly considered and to the effect that this was a most unlikely mechanism, even if it was within the diagnosed timeframe. In fact, not only is this mechanism most unlikely, but the mother's assertion of the date as early June 2018 falls outside the timeframe identified by the medical evidence. I have considered Mr Norton's detailed submissions on mechanism, and his promulgation of some research papers on this subject, but I do not consider they go far to undermine my overall conclusions.

48. One of the features of a skull fracture, which is perhaps counter-intuitive, is that it can have limited sequelae unless it causes brain injury and also that associated swelling may be visible by scan, but not by clinical examination. In the words of Dr Stoodley:-

*"Fractures are painful and so it is likely that Child Y would have cried at the time of the causative event but, in the absence of any associated brain injury, there may not have been any other symptoms or signs until and unless any bruising or soft tissue scalp swelling became evident. It follows from all the above in my view that an event which leads to a skull fracture is likely to be memorable to a competent carer present at the time but there might not be much in the way of change in demeanour of the child following the injury".*

*"It is also the case that when soft tissue bruising or marking is visible clinically, there may not be any scalp swelling visible on scans and the converse is also true in that we do see cases where no soft tissue swelling is evident clinically but where diffuse swelling is very obvious on scans".*

49. It is not suggested in this case that the skull fracture caused any brain injury (see, for example, Dr Stoodley's comments on this) so that an observer, such as the Health Visitor, who had an 80 minute visit to Child Y in mid June 2018, would not necessarily have noticed any change in Child Y's demeanour resulting from a skull fracture occurring in mid June 2018. Nor would she necessarily have observed any swelling from such a skull fracture, notwithstanding that it was visible to Dr Stoodley on the scan taken some 6 days later. Accordingly, the absence of symptom observation by the Health Visitor does not undermine the correctness of the expert diagnosis on timing.

50. I therefore reach the following conclusions:-

    (i) that the skull fracture was caused by an event which took place in the period in mid June 2018 (though these dates should represent soft rather than hard edges);

    (ii) that event must have involved a very significant impact force on Child Y's skull;

    (iii) there is no explained event which could account for the skull fracture; and

    (iv) that whilst Child Y undoubtedly suffered a head injury in early June 2018, it was not this injury which caused his skull fracture.

51. Having found that such an injury did occur I need to consider, on a balance of probabilities, who might have perpetrated it and whether it was accidental or non-accidental. I have in mind in the latter context the comments of Ryder LJ in Re S [2014] EWCA Civ 25:-

    "*the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from, say, negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of s 31(2) of the CA 1989."*

52. I cannot on the evidence say whether the mechanism for the infliction of the injury was in the nature of a deliberate or reckless impact (for example a strike with an implement) or a negligent impact (for example being dropped by a carer head first from a height on to a hard surface); but the evidence strongly suggests that the skull fracture was caused by a very significant force on Child Y's skull and was most unlikely to have been caused by Child Y himself, for example pulling up, losing balance and falling over (i.e. an event similar to the patio door incident said to have taken place in early June 2018) and, like Dr Magid, I find it hard to conceive of such an incident which would not involve some act or omission by a carer in one or other of these ways, i.e. it was inflicted in an unknown way, but in a way which involves some element of wrong.

53. In considering therefore who is the perpetrator I shall start by first considering *"whether there is a 'list' of people who had the opportunity to cause the injury*". There is no doubt that the mother is on this list, but is the father?

54. In this context it is appropriate to note that I heard a good deal of evidence about the extent to which the father went to the mother's home and/or had any contact with Child Y in mid June 2018. It is common ground that the mother reacted ferociously to the father seeing a friend in a pub at lunchtime eleven days before Child Y died and, on the face of it, told him she wanted no more to do with him ever again ("*Enjoy the memories you have. We don't need no-one messing us about no more*"). He was duly barred from visiting Child Y. There was something of a rapprochement with the mother taking Child X (but not Child Y) to see the father at the paternal grandmother's home, though this was an event which ended badly with a huge confrontation between the mother and the paternal grandmother. The father's case before me was that he thought he had not seen Child Y at all in mid June 2018. It is possible to examine the text messages in the bundle which passed between the mother and the father in that period and, on the face of it, these messages confirm the father's position. Certainly they do not contradict it. As with many other areas of her case, the mother's evidence as to how much the father had seen her and Child Y in that period was inconsistent and vague and unimpressive and it certainly sat ill with the content of the text messages. My provisional view was that the father was, on a balance of probabilities, correct.

55. The submissions advanced by Ms Hunter, however, included the following passages:-

*"GPS data from father's phone shows conclusively that father was at mother's property at 19:37 – with Child Y visible in photos taken at the time – within minutes of the time the mother was at the supermarket. The third column provides a location in the form of decimal degrees. This represents the location of the mobile device at the point various actions were taken (in this case, the taking of three images at 19:37). The location represented by the decimal degrees can be confirmed with a simple search on Google Maps. The images taken are themselves located on father's phone , and show Child Y pulling himself up on to a piece of furniture below the TV."*

56. This came as a surprise to me since neither pages were included in the trial bundle (so I have not seen them), nor were they referred to in the course of the hearing, nor was this point put to the father in cross-examination (as one might have expected). Mr Norton has responded to Ms Hunter's submissions in this way in his response document:-

*"Those for the mother have asserted that evidence demonstrates "conclusively" that the father was at the mother's property in mid June 2018 by reference to cell site information and reference to photos. Those for the mother did not identify these photos as part of the material that they wished to rely upon from the police disclosure, although did highlight the call log sheet. There was no reference to the page at any time in the trial. The court will be aware that the allegation of presence at the mother's home based on this evidence was not put to the father, nor was it raised with any other witness or with the advocates for the father.*
*The father's evidence was clear that he did not recall seeing Child Y in mid June 2018. Those for the father stand by the submissions raised on his behalf as to the mother's various assertions of the father seeing Child Y a great deal over this period*

*and indeed her, now retracted, allegation of him staying overnight most nights that week. If the father did visit on that date in mid June 2018, it is clear from the totality of the text message data that this could only have been for a limited period of time and a mere fraction of the wider window covering mid June. It can be seen from the text messages sent from the father to the mother thereafter [which we have cited in our submissions] that he was asking to see the children and enquiring as to their welfare. In any event, the mother has been clear that she at no time discovered Child Y to be unwell after any period of care from the father at any time."*

57. I think this is a fair response in the circumstances. I feel comfortably able to conclude that the father either did not see Child Y in the period in mid June 2018, or (if he did) his contact was limited to a few hours between about 4.00 p.m. and about 10.00 p.m. on one day in mid June 2018, during most of which the mother was present. The text messages confirm that he did not stay the night. The mother, even if she slipped out of the house briefly while the father was there, has not identified any event in the period he was there which might have caused a skull fracture. For the vast majority of the period in mid June 2018 the mother was the sole carer for Child Y.

58. Arguably this conclusion allows me to include the father on a possible list of perpetrators, but next, I need to consider this question: "*It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so".*

59. Having reflected carefully on this I have little hesitation in concluding that the perpetrator is, on the balance of probabilities, the mother and not the father. In reaching this conclusion the following matters have been in my mind:-

    (i) The father had very little opportunity to cause the injuries, in terms of time and access to Child Y, for the reasons I have set out above. There is absolutely no sense in the text messages immediately following the short period on the one date in mid June 2018, when he may have had access, that any incident had occurred.

    (ii) In contrast the mother had much greater opportunity to cause the injuries, being the sole carer for the vast majority of the relevant period. Further, many of her text messages in that period (though, in fairness, not all) demonstrate that she was experiencing anger and stress for at least parts of that period.

    (iii) She was smoking a good deal of cannabis in that period and this was likely to have affected her mood and ability to deal with day to day cares. For example, I note the text message she sent to a friend in early June 2018. I note that the mother wrote in her statement about her cannabis use: "*I can now see how it was affecting my emotional function but at the time I did not think it was affecting me at all…I know it was not a helpful tool*"."

    (iv) I bear in mind also the comments I have made above about how the mother had felt and was feeling about Child Y throughout his life, but also

in that period. I bear in mind the callous lack of care the mother felt for Child Y, especially on the day he died, but also on all the occasions she left him home on his own in the weeks leading up to that.

(v) In terms of propensity to violence, and/or at least the absence of concern for others being subjected to a violent incident, I bear in mind the violent incident which occurred in early 2018, when the mother deliberately hit the father on the nose, breaking it and leaving him covered in blood (I have seen the photograph which shows that it was a very unpleasant incident which would have shocked any reasonable person ). The mother told me that thought it was funny.

(vi) I bear in mind my lack of belief in a good deal of what the mother has told me and her propensity to dishonesty. For me, this makes it much more likely that it is the mother rather than the father who knows something and is declining to tell anybody about it.

60. In summary I conclude on a balance of probabilities that:-

(i) Child Y sustained a skull fracture of approximately 15 cm in length passing through the right parietal bone and crossing the lambdoid suture into the right side of the occipital bone and that this was caused by an impact injury to Child Y's head which also caused a degree of traumatic subdural bleeding.

(ii) The skull fracture was caused by an event which took place in mid June 2018 (though these dates should represent soft rather than hard edges).

(iii) The event must have involved a very significant impact force  Child Y's skull.

(iv) There is no explained event which could account for the skull fracture (and whilst Child Y undoubtedly suffered a head injury in early June 2018, it was not this injury which caused his skull fracture).

(v) The perpetrator was the mother.

(vi) I cannot on the evidence say whether the mechanism for the infliction of the injury was in the nature of a deliberate or reckless impact (for example a strike with an implement) or a negligent impact (for example being dropped by a carer head first from a height on to a hard surface); but the skull fracture was caused by a very significant force on Child Y's skull and was most unlikely to have been caused by Child Y himself (for example pulling up, losing balance and falling over). The skull fracture was inflicted in an unknown way, but in a way which involves some element of wrong, and in relation to which the mother has decided not to give an explanation.

61. I note that Mr Morgan has made a closing submission as follows:-

*"The Father has either been engaged in conduct which led to Child Y's injuries or shut his eyes to the risk posed by the Mother and her conduct. Either way, the Father is condemned by his actions and inactions. He contributed to the situation the children found themselves in and he cannot escape responsibility for that no matter what he says now."*

62. I would agree with Mr Morgan in one respect. The father was well aware that the mother was often caring for the children whilst under the influence of cannabis and he seems to have done not very much about that in terms of identifying the danger and drawing the local authority's attention to it. I am concerned, however, about the general proposition that he shut his eyes to the risks posed by the mother of inflicting physical injuries on her children. I have not been persuaded on the evidence that the father had sufficient warning of the likelihood of the mother inflicting injuries such as the skull fracture to justify a finding of failure to protect in this respect. My view is that to make such a finding would be running the sort of risk identified by King LJ to the effect that "*Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable".*

**What has been established about the soft tissue and mouth injuries to Child Y observed in June 2018?**

63. The local authority invite me to find that:-

(i) On the day he died Child Y was found to have suffered soft tissue injuries described as :-

(a) Three bruises to the right side of the forehead.

(b) Three bruises to the left side of the forehead.

(c) A widespread area of petechial bruising on the anterior area of the right shoulder.

(d) An area of petechial bruising on the right side of his neck.

(e) Bruising to the skin of his neck and within his neck muscles.

(f) A tear to the base of his tongue in the area of the frenulum.

(ii) These injuries were non-accidental in origin.

(iii) These injuries were inflicted whilst Child Y was in the care of his parents and that one or other was responsible for them, or that they should both be

in the pool of perpetrators or that, if one was responsible, the other has failed to protect Child Y from the first.

64. The parents have both accepted that these injuries were sustained by Child Y and all are clearly documented in the medical evidence and I find that they were so sustained.

65. I note that in selecting these injuries (as opposed to some other ones also observed) the local authority have faithfully followed the recommendations of Dr Magid, who said of the injuries identified above that they were "*more likely non accidental*", but said of the other injuries that they were *"likely accidental and related to CPR"*.

66. In terms of mechanism:-

    (i) The three bruises to the right side of the forehead, the three bruises to the left side of the forehead and the widespread area of petechial bruising on the anterior area of the right shoulder were attributable to "*hitting with a solid object or falling into a solid object*" (Dr Magid). Since these bruises are on different sides of the head, different planes, they are most unlikely to have been caused in one accidental fall (Dr Magid, oral evidence).

    (ii) The area of petechial bruising on the right side of his neck and bruising to the skin of his neck and within his neck muscles were attributable to *"applying pressure in the neck like hitting by a solid object or applying significant pressure against a solid object or falling on a solid object*" (Dr Magid) or "*must raise concerns of pressure on the neck*" (Dr Jeffery).

    (iii) The tear to the base of his tongue in the area of the frenulum was attributable to "*forcibly feeding the child*" (Dr Magid) or "*difficult to reconcile with him putting his own fingers or hands into his own mouth…there is a case report in the literature which demonstrates very similar injuries to the lingual frenulum in which a parent admitted to having thrust their fingers into a child's mouth in a desperate attempt to quieten them*" (Dr Jeffery).

    (iv) "*We would not typically expect bruising of the nature seen to be the result of resuscitation (CPR), even inexperienced attempts*" (Dr Jeffery).

67. The evidence strongly suggests, and I conclude on a balance of probabilities, that these are non-accidental injuries. Again, I have in mind in the latter context the comments of Ryder LJ in *Re S* [2014] EWCA Civ 25. I cannot on the evidence say that the mechanism for the infliction of the injury was in the nature of a deliberate attempt to injure the child, but I can say on a balance of probabilities that there was more than one incident, and that the incidents were executed in a way which was well outside normal handling of a small child and which were conducted in a way in which the perpetrator was reckless as to the consequences for Child Y. I find it hard to conceive of how these injuries could have been caused in their totality in any lesser

way. In particular, having heard the mother's account of the resuscitation efforts, I reject her assertion that these injuries were caused by such efforts. I agree with the expert evidence that this was most unlikely to be the case.

68. In terms of timing of the asserted injuries, the following conclusions are tolerably clear from the medical evidence:-

    (i) All the injuries pre-date Child Y's death;

    (ii) The external bruises were "*in keeping with recent injury, within a couple of days or so prior to death…possibly sustained shortly before death*" (Dr Jeffery).

    (iii) The bruising within the neck muscles "*couldn't have happened on the day…it must have occurred 2 or 3 days before death*" (Dr Jeffery, oral evidence) but would not have been visible externally.

    (iv) The frenulum injury: "*the presence of healing debris gives this injury an approximate age of 24 to 48 hours (before death)"* (Dr Magid).

69. Further, in terms of timing, I note that the father's evidence (which I accept, and in this regard does not differ from that of the mother) that when he left for work on the afternoon Child Y died, having spent a few hours with Child Y up to that moment: "*I did not see any bruises on Child Y save for a small bruise above his eyebrow…mother told me he had bumped his head on a cot*".

70. In considering therefore who is the perpetrator I shall start by first considering *"whether there is a 'list' of people who had the opportunity to cause the injury*". For these injuries, occurring actually on the day Child Y died and/or probably no more than 2/3 days before that, it seems to me that both the mother and the father (and nobody else) are on the list of people who had the opportunity to cause the injuries.

71. Having reached this conclusion, am I able (without straining) to identify a perpetrator or is there a 'real possibility' that either of them was the perpetrator? In answering this question I have in particular listened carefully to the account by both parents as to what happened in the 2 or 3 days leading up to Child Y's death, including overnight on the day before and into and through the day Child Y died. I have found myself believing the father's account of what happened and disbelieving the mother's account. I have reached the clear conclusion on a balance of probabilities that the mother was the perpetrator and not the father. Many of the factors which I have already discussed above in the context of the skull fracture also influence me here. The mother's overall dishonesty in dealing with these matters, her general attitude towards Child Y, her cannabis consumption and her propensity towards aggression and (sometimes) violence. Also, in this context, I have found it unlikely that the father had the opportunity to cause all those injuries to Child Y without the mother observing what he was doing or seeing any of the consequences of it. It seems to me

not at all likely that all the bruises were inflicted prior to father leaving for work on the day Child Y died, but none of the bruising was visible at all until the mother began her CPR attempt at 6.40 p.m. on that day. It seems highly improbable that the father could have caused those number of injuries, either on the morning of the day Child Y died or earlier, without the mother observing something of what was happening or at very least some symptoms.

72. In summary I conclude on a balance of probabilities that:-

    (i) On the day Child Y died, or within 2 or 3 days before that, Child Y sustained:-

        (a) Three bruises to the right side of the forehead.

        (b) Three bruises to the left side of the forehead.

        (c) A widespread area of petechial bruising on the anterior area of the right shoulder.

        (d) An area of petechial bruising on the right side of his neck.

        (e) Bruising to the skin of his neck and within his neck muscles.

        (f) A tear to the base of his tongue in the area of the frenulum.

    (ii) The perpetrator was the mother.

    (iii) There was more than one incident, and the incidents were executed in a way which was well outside normal handling of a small child and which were conducted in a way in which the perpetrator was reckless as to the consequences for Child Y.

    (iv) The injuries were not caused by resuscitation efforts.

73. For the same reasons expressed above in relation to the skull fracture, I decline to make any specific failure to protect findings against the father.

**What has been established in relation to the allegations that the parents failed to ensure that Child Y received appropriate medical attention?**

74. The local authority invite me to conclude that the parents neglected Child Y's medical care by reason of the following :-

    (i) failing to obtain any medical advice and/or attention in respect of the 'patio door' injury which occurred in early June 2018; and

(ii) failing to ensure that Child Y was taken to follow up neonatal appointments in 2017 and 2018.

75. The parents both accepted that they had deliberately failed to seek medical attention after the injury in early June 2018 because they feared that the reaction from the authorities would have been similar to the reaction in late 2017 and they did not want to take that risk. Both have accepted that this was an inappropriate and irresponsible decision for them to take and I find that this is the case and accept the local authority's case in this regard. A reasonable carer would have sought medical attention at that time. In this respect the evidence suggests that the father took a leading role in making this decision.

76. There is no dispute that Child Y did miss the scheduled medical appointments referred to above. Again, this was irresponsible and inappropriate and, given Child Y's medical needs, potentially dangerous. On this issue I blame both parents and accept the local authority's case in this regard. It was their mutual responsibility to ensure that these things were done and, even if the mother, as the non-working parent, was more likely to have been the one making the practical arrangements, it was in my view incumbent upon the father to interest himself in the subject sufficiently to ensure that Child Y was receiving proper care. The parents' mutual suspicion for the authorities after the events of late 2017 do not provide an adequate excuse for this failure.

**What has been established in relation to the allegation that the parents' relationship contained domestic violence and/or abuse?**

77. The local authority invite me to conclude that the parents' relationship contained domestic violence and/or abuse, in particular that:-

(i) In early 2018 the mother assaulted the father and broke his nose; and

(ii) the relationship was volatile with numerous arguments.

78. The parents have not really challenged these allegations and, in so far as they have, I have little hesitation in finding these allegations as having been established. I have already commented on the violent incident which occurred in early 2018, when the mother deliberately hit the father on the nose, breaking it and leaving him covered in blood. The father told me he might have retaliated if Child X had not walked in at that moment, which shows that not only was this a toxic relationship, but also that the children had witnessed things, or were likely to witness things, which were potentially harmful. I have no doubt also that the children were exposed to volatile arguments. One that I heard about was the one on mid June 2018; but the tone of the text messages tells me that things were very often very bad indeed between the parties. It was incumbent on both parties to make sure that the children were not exposed to this toxic situation. Even if the mother was often the main aggressor (which I think was

likely on most occasions) I am satisfied that the father contributed to this and could and should have distanced himself from the mother long before he did. His lack of insight can be shown by the fact that he continued to reside with the mother until another argument broke out in mid July 2019. As the father himself accepted, he will have to establish over time that he has now realised the toxicity of the relationship with the mother. His conduct through the proceedings, right up to mid July 2019, has not inspired confidence in this regard.

**What has been established about the cause of Child Y's death?**

79. I note at the outset that the local authority, having analysed all the documentary material, reached the conclusion that "*the cause of Child Y's death cannot be conclusively determined or ascertained*". This remains the local authority's view at the end of the evidence, despite the guardian's decision to plough a slightly different furrow. In his closing submissions Mr Morgan has said:-

*"The LA would ask the Court to consider the composite threshold document and the LA do not resile from the findings invited in that document. There is no invitation for the Court to make threshold findings over the cause of Child Y's death – this has always been the LA's declared case…No issue is taken with the guardian putting a case to the Mother over the cause of Child Y's death and her culpability in it. If the Court is able to make findings over that issue at the request of the guardian's team then so be it."*

80. In reaching this conclusion the local authority in particular relied upon the evidence of Dr Jeffery (the Forensic Pathologist), but also that of Dr Magid (the Paediatrician). The shared view of these experts was that there are a number of possible causes of Child Y's death:-

    (i) Overheating.

    (ii) Sudden Unexpected Death in Infants (SUDI).

    (iii) Non-accidental injury, the mechanism for which might be smothering or drowning.

81. The local authority's conclusions in this respect most obviously derive from the evidence of Dr Jeffery, as follows:-

    (i) In her report she said: "*Regardless of the causation of (the skull fracture) there were no residual changes associated with it that could account for a sudden unexpected death…there is no direct link that can be established between that injury and the death"*.

    (ii) In her report she said: "*the distribution and number of bruises present on Child Y is worrying for non-accidental injury including potential pressure*

*on the neck…but there are no pathognomic features that provide of non-accidental injury"*.

(iii) In her report she said: "*There appears to have been no objective evidence of significant dehydration or raised temperature to support an environmental cause for his death…the petechial haemorrhages present are non-specific and so they cannot be considered diagnostic of overheating …the cause of death remains unascertained…the pathological features do not allow for the favouring of any one particular cause even on the balance of probabilities*".

(iv) In the experts' meeting she said: "*I give the cause of death as unascertained and that's because we don't have a single pathology that is an obvious cause of death in this case…we're into the realm of guessing, really, causes of death that might occur, that might not leave obvious pathological findings…There are some findings, such as breakdown of muscle and the like, which we can see in severe cases of raised temperature, but not in all cases and we haven't seen those findings in Child Y's case…we can't exclude it from the pathology but we do not have sufficient evidence to suggest it…he was in the age whereby we do see SUDI where there is no obvious explanation for the death…we have potential for a non-accidental injury that has not caused any specific pathological findings to indicate such…for example smothering…drowning…we don't have any pathological features that put more weight on any one of those possibilities than the others…the death should be considered unascertained. I don't think we have enough evidence to say the one thing over another*"..

(v) She was asked questions about this in cross-examination before me, but did not depart from the above opinions in any way which was significant. My note of her evidence was to the effect that: "*we can't establish the cause of death. It is frustrating but that is it…I really don't think there is sufficient evidence of any particular factor that enables me to say on a balance of probabilities what it was. It remains unascertained…I have not found anything to support a virus…if he did have a virus it wouldn't have caused his death…there were no significant signs of dehydration…sudden unexpected death leaves no pathological features…when there is smothering by a pillow there are no post-mortem findings whatsoever"*.

82. Dr Magid has (on one interpretation) gone somewhat further in speculating how some of the other features in the case might have contributed to the sequence of events leading to the death of Child Y, and in this respect his report requires some analysis and gave rise to some investigation in cross-examination. In this paragraph he said:-

*"In my opinion the likely incident that happened is that Child Y had unwitnessed respiratory arrest due to all the factors mentioned above, the head injury, the viral illness, the lack of energy, all those factors contributed to the possible respiratory arrest, and the absence of an adult to rescue him was in my opinion an important factor in his death".*

83. I have found myself troubled by the robustness of this paragraph, or even its real meaning, in the context of the important question (the one clearly and directly answered by Dr Jeffery) as to whether the evidence permits us to favour any one of the possible causes of death on a balance of probabilities.

84. Dr Magid was in my view properly criticised by Mr Norton when he said in his closing submissions:-

*"In his paediatric opinion, Dr Magid, with little apparent evidential foundation referred to a likely viral infection [none having been detected pathologically by inflammation or biologically by culture]. Dr Magid also opined about concussion from a fall [noting that a child would not refer to concussion but that Child Y may have been unwell following a fall ["may have contributed to him being unwell"] although there was no traumatic pathology to the brain. Dr Magid also did not take account of the father's evidence of Child Y having taken a feed at 4 or 5 that morning."*

85. Dr Magid has speculated that the absence of an adult present on the scene can be regarded as a contributory cause of death. I agree with the local authority's general proposition that leaving a child unattended makes the child in the vulnerable position of having no responsible person available to deal with any primary care or medical needs, and is an irresponsible act in itself, but to elevate this to a cause of death on the facts of this case to my mind involves clear elements of speculation rather than evidence. As Dr Jeffery has said, it is difficult to make such an assertion without knowing what was the actual cause of death. I find myself further troubled by the robustness of a further paragraph of Dr Magid's when he said: "*Well, even in the presence of an adult, he could have died, but there is a chance, I can't quantify it, that if he had respiratory arrest and there was an adult the chance will not be zero. I would not be 100% that he was going to die. There is a chance of saving him. How much of that, I can't tell exactly*." It is difficult to argue that this paragraph supports the proposition that "*the absence of an adult to rescue him was in my opinion an important factor in his death"*.

86. Taking Dr Magid's evidence as a whole, however, I did not interpret him as saying that the court could make safe findings about the cause of death or that he fundamentally disagreed with Dr Jeffery in this respect. If he did, he certainly did not say so clearly or directly or expressly. Given opportunities to disagree with Dr Jeffery at the experts' meeting he did not take them, indeed he answered at one point "*No. I don't disagree with her"*. Accordingly, to put forward a case (as Mr Momtaz does, when he says in his closing submissions: "*We submit that it is extremely unlikely that Child Y died as a result of SUDI (SIDS). Given the evidence that the court has heard the other two possibilities are much more plausible and likely. We submit that the court's determination of whether Child Y died as a result of overheating/dehydration or non-accidental injury is finely balanced. However, if the court finds that the mother inflicted multiple non-accidental injuries on Child Y and that some of those*

*were inflicted either on the day he died, or very close to it, this must increase the likelihood that his death was also caused non-accidentally most likely through strangulation and/or smothering")* that I can safely rule out Sudden Unexpected Death in Infants (SUDI) as a cause of death, and so reach a finding on one or the other of the two remaining possibilities, both of which place greater culpability on the mother's shoulders, has to proceed without clear expert support and without local authority support.

87. I have read Mr Momtaz's careful and intelligent arguments about this aspect of the case and I understand why he has advanced these propositions. I do not criticise him or the guardian for raising these matters and I recognise the guardian's anxiousness about Dr Jeffery's conclusions in this respect (given the specific findings I have made against the mother in relation to her treatment of Child Y, how likely is it really that a wholly different event, SUDI, also intervened?). I also recognise that it is ultimately for the court to reach a conclusion as to what happened, not for the experts. On the totality of the evidence, however, I find myself unable to follow the path to the conclusion recommended by Mr Momtaz. The strong and clear expert evidence of Dr Jeffery, who was undoubtedly a competent, compelling, experienced and knowledgeable witness, really stands too powerfully in the way of that path for me safely to reach the conclusions about the cause of death urged on me by Mr Momtaz.

88. I have to note, also, that an important pillar of Mr Momtaz's argument in this respect was in relation to the relative rarity of SUDI as a cause of death. He made this point: *"The NHS website says that in the UK more than 200 babies die suddenly and unexpectedly every year. Although this figure may sound alarming SIDS is rare and the risk is low. It is more common in the first 6 months of a baby's life and infants born prematurely are at greater risk. SUDI (SIDS) tends to be slightly more common in baby boys."* Although these points were explored a little with Dr Magid in cross-examination, they did not form part of the cross-examination of Dr Jeffery and it would not, I think, be safe for me to attach too much significance to generalised comments about NHS website statistics without having any context for them from the pathologist employed in the case.

89. Having considered all of these matters, I propose not to make any findings about the cause of death other than that it is at present unascertained and the usual forensic binary principle consequences flow from this. In view of this conclusion it is not necessary for me to deal in detail with Ms Hunter's comments about procedural fairness in this respect, save to comment that in general terms Mr Momtaz correctly asserts that he gave the mother advance warning that he would be pursuing the line of argument which he did, so it could not be argued that the mother was taken by surprise.

## CONCLUSIONS ON THRESHOLD

90. Accordingly, I summarise my threshold findings, on a balance of probabilities, to be

as follows:-

(i) The mother neglected Child Y by leaving him at home without any care or supervision on a number of occasions in June 2018, varying in length from a few minutes to a few hours,. The mother is responsible for all of these events. This left Child Y in the vulnerable position that there was no responsible person available to deal with any primary care or medical needs.

(ii) In relation to the skull fracture:-

(a) Child Y sustained a skull fracture of approximately 15 cm in length passing through the right parietal bone and crossing the lambdoid suture into the right side of the occipital bone and that this was caused by an impact injury to Child Y's head which also caused a degree of traumatic subdural bleeding.

(b) The skull fracture was caused by an event which took place in mid June 2018 (though these dates should represent soft rather than hard edges).

(c) The event must have involved a very significant impact force on Child Y's skull.

(d) There is no explained event which could account for the skull fracture (and whilst Child Y undoubtedly suffered a head injury in early June 2018, it was not this injury which caused his skull fracture).

(e) The perpetrator was the mother.

(f) I cannot on the evidence say whether the mechanism for the infliction of the injury was in the nature of a deliberate or reckless impact (for example a strike with an implement) or a negligent impact (for example being dropped by a carer head first from a height on to a hard surface); but the skull fracture was caused by a very significant force on Child Y's skull and was most unlikely to have been caused by Child Y himself (for example pulling up, losing balance and falling over). The skull fracture was inflicted in an unknown way, but in a way which involves some element of wrong, and in relation to which the mother has decided not to give an explanation.

(iii) In relation to the soft tissue and mouth injuries:-

(a) On the day Child Y died, or within 2 or 3 days before that, Child Y sustained:-

(I) Three bruises to the right side of the forehead.
(II) Three bruises to the left side of the forehead.
(III) A widespread area of petechial bruising on the

anterior area of the right shoulder.

(IV) An area of petechial bruising on the right side of his neck.

(V) Bruising to the skin of his neck and within his neck muscles.

(VI) A tear to the base of his tongue in the area of the frenulum.

(b) The perpetrator was the mother.

(c) There was more than one incident, and the incidents were executed in a way which was well outside normal handling of a small child and which were conducted in a way in which the perpetrator was reckless as to the consequences for Child Y.

(d) The injuries were not caused by resuscitation efforts.

(iv) The parents neglected Child Y's medical care by reason of the following :-

(a) failing to obtain any medical advice and/or attention in respect of the 'patio door' injury which occurred in early June 2018; and

(b) failing to ensure that Child Y was taken to follow up neonatal appointments in 2017 and 2018.

(v) The parents' relationship contained domestic violence and/or abuse, in particular that:-

(a) In early 2018 the mother assaulted the father and broke his nose.

(b) The relationship was volatile with numerous arguments. Things were very often very bad indeed between the parties. It was incumbent on both parties to make sure that the children were not exposed to this toxic situation. Even if the mother was often the main aggressor (which I think was likely on most occasions) I am satisfied that the father contributed to this and could and should have distanced himself from the mother long before he did. His lack of insight can be shown by the fact that he continued to reside with the mother until another argument broke out in mid July 2019.

(vi) The father was well aware that the mother was often caring for the children whilst under the influence of cannabis and he seems to have done not very much about that in terms of identifying the danger and drawing the local authority's attention to it; but I have not been persuaded on the evidence that the father had sufficient warning of the likelihood of the mother inflicting injuries described above to justify a finding of failure to protect in this respect.

91. These facts having been found, plainly the threshold criteria under Children Act 1989, section 31 were passed in relation to Child X as at the date of intervention and I now turn to the question of disposal.

## LAW ON WELFARE DISPOSAL

92. I remind myself in considering the children's welfare I should keep in mind all the factors under Children Act 1989, section 1 and they are as follows.

> *(1) That when a court determines any question with respect to the upbringing of a child the child's welfare shall be the court's paramount consideration*
> *(2) That in any proceedings in which any question arises the court should have regard to the general principle that delay in determining the question is likely to prejudice the welfare of a child*
> *(3) And that in the circumstances the court should have regard in particular to the welfare checklist:*
> *(a) The ascertainable wishes and feelings of the child concerned (Considered in the light of his age and understanding);*
> *(b) His physical, emotional and educational needs;*
> *(c) The likely effect on him of any change in his circumstances;*
> *(d) His age, sex, background and any characteristics of his which the court considers relevant;*
> *(e) Any harm which he has suffered or is at risk of suffering;*
> *(f) How capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;*
> *(g). The range of powers available to the court under the Act in the proceedings in question."*

93. I also need to remind myself of the provisions of Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms:

> ***Article 8 – Right to respect for private and family life***
>
> *1. Everyone has the right to respect for his private and family life, his home and his correspondence.*
>
> *2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others*

94. I also remind myself of a number of matters which are underlined in the then President's judgment in *Re B-S* (Children) [2013] EWCA Civ 1146. These can perhaps be summarised as follows:-

(i) Intervention in the family may be appropriate, but the aim should be to reunite the family when the circumstances enable that, and the effort should be devoted towards that end. Cutting off all contact and the relationship between the child or children and their family is only justified by the overriding necessity of the interests of the child.

(ii) The court's assessment of the parents' ability to discharge their responsibilities towards the child must take into account the assistance and support which the authorities can reasonably be expected to offer.

(iii) It is the obligation of the local authority to make work the order which the court has determined is proportionate. The local authority cannot press for a more drastic form of order, least of all press for adoption, because it is unable or unwilling to support a less interventionist form of order. Judges must be alert to the point and must be rigorous in exploring and probing local authority thinking in cases where there is any reason to suspect that resource issues may be affecting the local authority's thinking.

(iv) In most child care cases a choice will fall to be made between two or more options. The judicial exercise should not be a linear process whereby each option, other than the most draconian, is looked at in isolation and then rejected because of internal deficits that may be identified, with the result that, at the end of the line, the only option left standing is the most draconian and that is therefore chosen without any particular consideration of whether there are internal deficits within that option. The linear approach ... is not apt where the judicial task is to undertake a global, holistic evaluation of each of the options available for the child's future upbringing before deciding which of these options best meets the duty to afford paramount consideration to the child's welfare. The judicial task is to evaluate all the options, undertaking a global, holistic and multifaceted evaluation of the child's welfare which takes into account all the negatives and the positives, all the pros and cons, of each option.

## WELFARE DISPOSAL IN THIS CASE

95. It is a feature of this case that all parties have agreed that the outcome in the best interests of Child X is that she should continue to live with the maternal grandparents and that the permanency of this situation should be recognised by a diminution of contact between Child X and both of her parents. The conclusion of the local authority fostering assessor to the effect that "*Child X presents as happy and settled in*

*the care of (the maternal grandparents)…no indications that Child X has any attachment issues"* has not been challenged by anybody.

96. Equally, the overall conclusions of the local authority parenting assessor, to the effect that a return of Child X either to the care of her mother or to her father would not be in her best interests was not challenged before me. The father told me in a statement : "*I know that…it is going to take further time for me to be able to feel emotionally stable again. I also know that Child X could not be placed with me when there remain concerns that I would prioritise mother over Child X*". The mother's position was made clear in Ms Hunter's closing submissions when she said: "*The mother…does not wish to disrupt the current placement or place maternal grandparents in difficult or conflicted positions in future. As such, does not set herself up in opposition to maternal grandparents on any point relating to the welfare decisions to be made by the court*".

97. I have had no difficulty in agreeing with all the parties that this represents the best solution for Child X. She should continue to have her home with the maternal grandparents.

98. It had been the local authority's care plan in February 2019 that the placement with the maternal grandparents should be under a Special Guardianship Order supported by a Supervision Order.

99. Following the discovery by the local authority of what they considered to be 'unauthorised contact' between Child X and her parents, which appeared to have been approved by the maternal grandparents, the local authority changed their minds about this in June 2019 and the final version of the care plan, recommended that the placement with the maternal grandparents should be under a Full Care Order (the order being to this local authority rather than the local authority where the maternal grandparents currently live). This care plan commits the local authority to "*review the intervention provided to (the maternal grandparents) within six months and revisit their capacity to manage parental responsibility and a potential Special Guardianship Order…if the local authority are not able to recommend a Special Guardianship Order at the six month review, then further reviews will take place every six months to ensure there is no drift for (Child X)"*.

100. The reason advanced for this change of plan was explained by Mr Morgan in his closing submissions:-

*"It came to the attention of the LA that MGPs had facilitated direct contact for the parents beyond that which was approved by the LA. Whilst it is not the LA's case that the MGPs intended to be deceitful or place Child X at risk it called into question their judgement and their ability to work openly and honestly with professionals. In light of these events the LA consider the only way that Child X's welfare can be safeguarded is for the making of a Care Order. Having had the benefit of hearing oral evidence*

*from the MGPs, this has further cemented the LA's position…The LA consider that by holding overriding parental responsibility (PR) the LA will be able to act as an effective "buffer" to protect the placement. MGF accepted in his oral evidence that a Care Order may be a "good defence" against occasions where Mother may be manipulative. Decision making would fall to the LA and not the MGP's thus, potentially at least, deflecting the parents' attentions and any pressure from the MGP's and on to the LA….It is clear from listening to the MGPs' oral evidence that they each do not have a full comprehension of the level of risk that Mother may pose to Child X. Indeed, MGF accepted the same. This feature of their understanding will need to be looked at post the judgment being handed down and will also need to be the subject of further work with the MGPs."*

101. This position was supported by the guardian in Mr Momtaz's closing submissions:-

*"The guardian agrees with the amended care plan. She is clear that it is in Child X's best interests to remain the care of the maternal grandparents in the long-term. However, the guardian was also clear in her final analysis and recommendations document and her oral evidence that in light of the recent concerns about the maternal grandparents' ability to protect Child X, the only order that would ensure her best interests are protected is a care order. We submit that the evidence before the Court strongly points in favour of a final care order being made for the following reasons:*

- *The evidence demonstrates that the mother is a highly manipulative individual prepared to lie to the police, her friends, the father, her family and importantly the maternal grandparents to achieve her aims.*
- *Within a short time of the maternal grandparents taking over supervision of the parents' contact in early 2019, they were persuaded by the parents to permit substantial contact beyond what had been agreed with the local authority and with both parents together [see the written agreement in respect of what the arrangements were at this time].*
- *The evidence of both of the grandparents was worrying in that it demonstrated a lack of insight into the risks posed by the parents or indeed any genuine desire at this stage to increase their understanding of the risks;*
- *Neither grandparent seemed to be aware of the significant concerns about the mother's substance misuse despite other maternal family members being well aware*
- *Neither grandparent seemed to fully appreciate the risks to Child X posed by the parents' volatile relationship*
- *Neither grandparent had taken time to read any of the papers which had been disclosed to them; despite the concerns about their awareness in relation to the mother's substance misuse for example having been raised in the special guardianship assessment. Very worringly, despite being present at Court, the maternal grandmother declined to even sit in Court and hear the evidence of her own husband.*
- *The guardian has prepared an additional document following the maternal grandparents' evidence which sets out a plan of work to address the concerns about the grandparents' understanding of risk and to increase their ability to protect Child X. The local authority has agreed with these proposals and they are now set out in the amended care plan"*

102. The maternal grandparents' formal position (with support from the parents) has been that the 'unauthorised contact' was in the nature of a misunderstanding rather than anything more sinister and to wish to go forward with a Special Guardianship Order rather than under a Care Order. In their closing submissions they have said:-

*"We ask that…you are able to find in favour of the SGO to enable us to move forward in providing our granddaughter….the stable, safe and loving future she deserves. We would welcome any supervision/training that accompanies the SGO as you see fit, and will work with the LA to achieve a positive outcome…Had the positive SGO been considered earlier the LA would have still had concerns regarding mother, father and ourselves and that is why we welcome the ongoing support and learning that they are proposing, but do not agree that a full care order in their favour is required to achieve this….After 13 months with (Child X) we feel we need the permanency of the SGO to know she is always safe and happy with us without the fear that she could be removed. She is a remarkable little girl who we love and cherish and would not do anything to cause her harm or distress."*

103. It was, however, very apparent from the oral evidence of both the maternal grandparents that they would be content to work with the local authority whatever the form of the actual Court Order and I was left with the impression that their opposition to the Care Order was not deep seated or such that such an order was unlikely to be workable. In the words of the maternal grandfather: "*We are happy to work with the local authority. We would prefer a Special Guardianship Order and a Supervision Order; but we don't really care*". Overall, my clear impression of the maternal grandparents was that they are respectable and responsible individuals who care deeply for Child X, but have understandably struggled to have a full comprehension of the way their daughter has behaved.

104. Having heard the oral evidence of all those involved I am satisfied that the 'unauthorised contact' resulted from something worse than a misunderstanding; but that the dominating factors in it were not a deliberate exercise of resistance by the material grandparents to the local authority's control, but were rather the mother's tendency towards manipulative behaviour and a combination of the maternal grandparents' reluctance to deal with her in an appropriately robust manner and also the absence of a full understanding of some of the character and behavioural difficulties of their daughter and the dangers this might pose for Child X. In essence, having seen and heard from both maternal grandparents, I share the concerns of the guardian, expressed above in Mr Momtaz's words. The guardian's document headed "Review of the care plan" contains some helpful suggestions as to how to deal with these problems and these have been accepted by the local authority and not opposed by the maternal grandparents. In my view there are good reasons for optimism that this will work and that we could well be moving into Special Guardianship territory before very long.

105. I have considered this dispute against the legal principles discussed above. I agree with the local authority and the guardian that, at this stage, Child X's need for protection against the mother's behaviour requires the greater intervention from the local authority of a Care Order and that moving straight to a Special Guardianship Order at this stage would not adequately protect Child X's safety. I express the hope that we may get to that point and that the maternal grandparents will learn from what has happened, will benefit from the various activities suggested by the guardian, and also from reading the contents of this judgment.

106. The final version of the care plan makes clear that, for the time being, all contact between Child X and her parents will be professionally supervised, so as to ensure that there will not be any 'unauthorised contact'. The initial plan (which would be reviewed) is that such contact will reduce to a monthly basis for three months and then further reduced to six times per year. The care plan has additional, and I think uncontroversial, proposals for wider family contact, including in particular with her paternal grandmother and with other half-siblings. There is a commitment, which I certainly approve, to consider some members of the paternal family, in particular paternal grandmother, for possible supervision of the father's contact (or even to be a back up for the maternal grandparents should something go wrong with the current situation).

107. This plan has not been significantly in dispute, save for this point. The guardian has argued that I should impose a 12 month order requiring the local authority not to waive the requirement of local authority supervision of the parents' contact in this period. As Mr Momtaz has put it in his closing submissions:-

*"The one aspect that remains in issue between the local authority and the guardian is whether the local authority should commit to providing professional supervision of the parents' contact for the next twelve months. The guardian has given careful consideration to this issue but remains of the view that this recommendation is correct….The guardian is clear the evidence is already available to make a decision as to the need for professional supervision for the next twelve months and that that would be the appropriate point to have a review….If the court agrees with the guardian's recommendation that parental contact should be professionally supervised for at least 12 months we would invite the local authority to amend the care plan to reflect this. If the local authority declines to do so we will invite the court to make an order pursuant to Section 34(2) of the Children Act 1989."*

108. The other parties oppose this and the local authority invite me to conclude that the better way forward is for me to allow this issue to be left to the local authority review process. I agree with them. It may be that things will move forward quickly such that 12 months of local authority supervision of contact is unnecessary, most likely in the father's case. If it is not, there is nothing in the local authority's approach to this case which causes me not to trust their bona fides to make a decision on the merits and not to be influenced by considerations such as the financial cost of

supervision. In the circumstances I do not propose to make the section 34 order suggested by the guardian.

109. Accordingly I propose to make welfare orders which reflect all that I have said above. I am satisfied that local authority interventions are proportionate and appropriate in the context of Article 8 ECHR and promote the best interests of Child X.

## CONSEQUENTIAL DISCLOSURE ISSUES

110. I have invited submissions on a number of consequential disclosure issues and have the following comments on the submissions made:-

(i) No party has objected to the local authority having permission to supply a copy of my judgment to the Police. Indeed, this is automatically permitted by FPR 2010, PD12G, paragraph 2.1 so can be done in any event as soon as the local authority are in possession of this judgment.

(ii) Apart from the judgment, there are some issues as to what documents should be disclosed to the Police and on what terms, and the mother and the father and the guardian have raised points on this: see, for example, *Re X and Y (Disclosure of Judgment to the Police)* [2014] EWHC 278 (Fam) paragraph 25. I will need to decide this.

(iii) The mother has (alone) objected on legal advice to the local authority having permission to supply a copy of my judgment to the Coroner. I will accordingly need to make a decision on this.

(iv) I need to consider publication of the judgment: *Transparency in the Family Courts, Publication of Judgments, President's Practice Guidance of January 2014*. I will need to decide all these issues and, if there is to be publication, approve a mechanism for anonymisation which satisfactorily protects Child X (and possibly others) from identification.

111. There may also be other matters arising, for example a leave to appeal application or some request for correction or clarification of the detail of the judgment or a detailed drafting issue.

It is clear, therefore that a further hearing will be necessary.

**His Honour Judge Edward Hess**
**Sitting as a Deputy High Court Judge under Senior Courts Act 1981, section 9(1)**
**Swindon Family Court**
**6th August 2019**

APPENDIX

IN THE FAMILY COURT SITTING AT SWINDON

IN THE MATTER OF THE CHILDREN ACT 1989, SECTION 31

AND IN THE MATTER OF CHILD X

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**AGREED NOTE ON THE RELEVANT LAW**

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**Threshold**

1) In **J (A Child) [2015] EWCA Civ 222** Aikens LJ stated that:

*"The formulation of "Threshold" issues and proposed findings of fact must be done with the utmost care and precision. The distinction between a fact and evidence alleged to prove a fact is fundamental and must be recognised. The document must identify the relevant facts which are sought to be proved. It can be cross-referenced to evidence relied on to prove the facts asserted but should not contain mere allegations ("he appears to have lied" etc.)"*

**Definition of a non-accidental injury**

2) In **RE S (SPLIT HEARING) [2014] EWCA Civ 25** Ryder LJ, at paragraph 19 of his judgment, stated:

*"The term 'non-accidental injury' may be a term of art used by clinicians as a shorthand and I*

*make no criticism of its use but it is a 'catch-all' for everything that is not an accident. It is also a tautology: the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from, say, negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of s 31(2) of the CA 1989."*

**Burden of proof**

3) The burden of proof is on the local authority

4) There is no pseudo-burden or obligation cast on the respondents to come up with alternative explanations: **Lancashire County Council v D and E [2010] 2 FLR 196** at paras [36] and [37]; **Re C and D (Photographs of Injuries) [2011] 1 FLR 990**, at para [203]:

*"There is in my judgment an obvious disadvantage to parents in an approach which requires that they provide an explanation for even the smallest bruise failing which there will be an automatic presumption that that bruise must have been an inflicted injury. Such an approach subtly changes the burden of proof and puts the onus on the parents to provide a credible explanation. As a matter of law, it is not for the parents to disprove the suggestion that the general bruising is non-accidental but for the local authority to prove that it is.'*

5) **In Re X (Children) (No 3) [2015] EWHC 3651** Munby P endorses what HHJ Bellamy had said in **Re FM [2015] EWFC B26**, para 122:

"*It is the local authority that seeks a finding that FM's injuries are non-accidental. It is for the local authority to prove its case. It is not for the mother to disprove it. In particular it is not for the mother to disprove it by proving how the injuries were in fact sustained. Neither is it for the court to determine how the injuries were sustained. The court's task is to determine whether the local authority has proved its case on the balance of probability. Where, as here, there is a degree of medical uncertainty and credible evidence of a possible alternative explanation to that contended for by the local authority, the question for the court is not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability'*."

Munby P added: "*the fact, if fact it be, that the respondent (here, the mother) fails to prove on a*

*balance of probabilities an affirmative case that she has chosen to set up by way of defence, does not of itself establish the local authority's case*."

**Findings of fact**

6) Findings of fact must be based on evidence. As Munby LJ, as he then was, observed in **Re A (A Child) (Fact-finding hearing: Speculation) [2011] EWCA Civ 12**:

*"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation."*

7) As Dame Elizabeth Butler-Sloss P observed in **Re T [2004] EWCA Civ 558, [2004] 2 FLR 838** at 33:

*"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."*

8) The court is referred to the guidance of the House of Lords in the case of **Re B [2008] UKHL 35** and the oft-cited dicta of Baroness Hale:

*"70. My Lords, for that reason I would go further and announce ATd and clear that the standard of proof in finding the facts necessary to establish the threshold under section 31(2) or the welfare considerations in section 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies.*

*71. As to the seriousness of the consequences, they are serious either way. A child may find her relationship with her family seriously disrupted; or she may find herself still at risk of suffering serious harm. A parent may find his relationship with his child seriously disrupted; or he may find himself still at liberty to maltreat this or other children in the future.*

*72. As to the seriousness of the allegation, there is no logical or necessary connection between seriousness and probability. Some seriously harmful behaviour, such as murder, is sufficiently rare to be inherently improbable in most circumstances. Even then there are circumstances, such as a body with its throat cut and no weapon to hand, where it is not at all improbable. Other seriously harmful behaviour, such as alcohol or drug abuse, is regrettably all too*

*common and not at all improbable. Nor are serious allegations made in a vacuum. Consider the famous example of the animal seen in Regent's Park. If it is seen outside the zoo on a stretch of greensward regularly used for walking dogs, then of course it is more likely to be a dog than a lion. If it is seen in the zoo next to the lions' enclosure when the door is open, then it may well be more likely to be a lion than a dog.*

*73. In the context of care proceedings, this point applies with particular force to the identification of the perpetrator. It may be unlikely that any person looking after a baby would take him by the wrist and swing him against the wall, causing multiple fractures and other injuries. But once the evidence is clear that that is indeed what has happened to the child, it ceases to be improbable. Some-one looking after the child at the relevant time must have done it. The inherent improbability of the event has no relevance to deciding who that was. The simple balance of probabilities test should be applied."*

9) As to the binary principle:

*"31. … In this country we do not require documentary proof. We rely heavily on oral evidence, especially from those who were present when the alleged events took place. Day after day, up and down the country, on issues large and small, judges are making up their minds whom to believe. They are guided by many things, including the inherent probabilities, any contemporaneous documentation or records, any circumstantial evidence tending to support one account rather than the other, and their overall impression of the characters and motivations of the witnesses. The task is a difficult one. It must be performed without prejudice and preconceived ideas. But it is the task which we are paid to perform to the best of our ability.*

*32. In our legal system, if a judge finds it more likely than not that something did take place, then it is treated as having taken place. If he finds it more likely than not that it did not take place, then it is treated as not having taken place. He is not allowed to sit on the fence. He has to find for one side or the other. Sometimes the burden of proof will come to his rescue: the party with the burden of showing that something took place will not have satisfied him that it did. But generally speaking a judge is able to make up his mind where the truth lies without needing to rely upon the burden of proof."*

10) Peter Jackson J (as he then was) elaborated on the issue of probability in ***Re BR (Proof of facts) [2015] EWFC 41:***

*[7] […] (4) Similarly, the frequency or infrequency with which an event generally occurs cannot divert attention from the question of whether it actually occurred. As Mr Rowley QC*

*and Ms Bannon felicitously observe:*

*"Improbable events occur all the time. Probability itself is a weak prognosticator of occurrence in any given case. Unlikely, even highly unlikely things, do happen. Somebody wins the lottery most weeks; children are struck by lightning. The individual probability of any given person enjoying or suffering either fate is extremely low."*

*I agree. It is exceptionally unusual for a baby to sustain so many fractures, but this baby did. The inherent improbability of a devoted parent inflicting such widespread, serious injuries is high, but then so is the inherent improbability of this being the first example of an as yet undiscovered medical condition. Clearly, in this and every case, the answer is not to be found in the inherent probabilities but in the evidence, and it is when analysing the evidence that the court takes account of the probabilities.*

**Identifying a perpetrator**

11) So far as the identification of perpetrators is concerned, that issue was considered in detail in the Supreme Court case of **Re S-B [2009] UKSC 17**. The standard of proof with respect to any such identification is the balance of probabilities:

*"34. The first question listed in the statement of facts and issues is whether it is now settled law that the test to be applied to the identification of perpetrators is the balance of probabilities. The parties are agreed that it is and they are right. It is correct, as the Court of Appeal observed, that Re B was not directly concerned with the identification of perpetrators but with whether the child had been harmed. However, the observations of Lord Hoffmann and Lady Hale, quoted at paragraph 12 above, make it clear that the same approach is to be applied to the identification of perpetrators as to any other factual issue in the case. This issue shows quite clearly that there is no necessary connection between the seriousness of an allegation and the improbability that it has taken place. The test is the balance of probabilities, nothing more and nothing less.*

*35. Of course, it may be difficult for the judge to decide, even on the balance of probabilities, who has caused the harm to the child. There is no obligation to do so. As we have already seen, unlike a finding of harm, it is not a necessary ingredient of the threshold criteria. As Lord Justice Wall put it in Re D (Care Proceedings: Preliminary Hearings) [2009] EWCA Civ 472, [2009] 2 FLR 668, at para 12, judges should not strain to identify the perpetrator as a result of the decision in Re B:*

*"If an individual perpetrator can be properly identified on the balance of probabilities, then ... it is the judge's duty to identify him or her. But the judge should not start from the premise that it will only be in an exceptional case that it will not be possible to make such an identification."*

12) Where a perpetrator cannot be identified, the Court should seek to identify the pool of possible perpetrators on the basis of the "real possibility" test:

*"40. As to the second, if the judge cannot identify a perpetrator or perpetrators, it is still important to identify the pool of possible perpetrators. Sometimes this will be necessary in order to fulfil the "attributability" criterion. If the harm has been caused by someone outside the home or family, for example at school or in hospital or by a stranger, then it is not attributable to the parental care unless it would have been reasonable to expect a parent to have prevented it. Sometimes it will desirable for the same reasons as those given above. It will help to identify the real risks to the child and the steps needed to protect him. It will help the professionals in working with the family. And it will be of value to the child in the long run.*

*41. In North Yorkshire County Council v SA [2003] EWCA Civ 839, [2003] 2 FLR 849, the child had suffered non-accidental injury on two occasions. Four people had looked after the child during the relevant time for the more recent injury and a large number of people might have been responsible for the older injury. The Court of Appeal held that the judge had been wrong to apply a "no possibility" test when identifying the pool of possible perpetrators. This was far too wide. Dame Elizabeth Butler-Sloss P, at para 26, preferred a test of a "likelihood or real possibility".*

*42. Miss Susan Grocott QC, for the local authority, has suggested that this is where confusion has crept in, because in Re H this test was adopted in relation to the prediction of the likelihood of future harm for the purpose of the threshold criteria. It was not intended as a test for identification of possible perpetrators.*

*43. That may be so, but there are real advantages in adopting this approach. The cases are littered with references to a "finding of exculpation" or to "ruling out" a particular person as responsible for the harm suffered. This is, as the President indicated, to set the bar far too high. It suggests that parents and other carers are expected to prove their innocence beyond reasonable doubt. If the evidence is not such as to establish responsibility on the balance of probabilities it should nevertheless be such as to establish whether there is a real possibility that a particular person was involved. When looking at how best to protect the child and provide for his future, the judge will have to consider the strength of that possibility as part of the overall circumstances of the case."*

13) In **B (Children: Uncertain Perpetrator) [2019] EWCA Civ 575**, Peter Jackson LJ stated:

*46. Drawing matters together, it can be seen that the concept of a pool of perpetrators seeks to strike a fair balance between the rights of the individual, including those of the child, and the importance of child protection. It is a means of satisfying the attributable threshold condition that only arises where the court is satisfied that there has been significant harm arising from (in shorthand) ill-treatment and where the only 'unknown' is which of a number of persons is responsible. So, to state the obvious, the concept of the pool does not arise at all in the normal run of cases where the relevant allegation can be proved to the civil standard against an individual or individuals in the normal way. Nor does it arise where only one person could possibly be responsible. In that event, the allegation is either proved or it is not. There is no room for a finding of fact on the basis of 'real possibility', still less on the basis of suspicion. There is no such thing as a pool of one.*

*47. It should also be emphasised that a decision to place a person within the pool of perpetrators is not a finding of fact in the conventional sense. As is made clear in Lancashire at [19], O and N at [27-28] and S-B at [43], the person is not a proven perpetrator but a possible perpetrator. That conclusion is then carried forward to the welfare stage, when the court will, as was said in S-B, "consider the strength of the possibility" that the person was involved as part of the overall circumstances of the case. At the same time it will, as Lord Nicholls put it in Lancashire, "keep firmly in mind that the parents have not been shown to be responsible for the child's injuries." In saying this, he recognised that a conclusion of this kind presents the court with a particularly difficult problem. Experience bears this out, particularly where a child has suffered very grave harm from someone within a pool of perpetrators.*

*48. The concept of the pool of perpetrators should therefore, as was said in Lancashire, encroach only to the minimum extent necessary upon the general principles underpinning s.31(2). Centrally, it does not alter the general rule on the burden of proof. Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool': see Re S-B at [43]. Approaching matters in that way risks, as Baroness Hale said, reversing the burden of proof.*

*49. To guard against that risk, I would suggest that a change of language may be helpful. The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: Re D (Children) [2009] EWCA Civ 472*

*at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'.*

*50. Likewise, it can be seen that the concept of a pool of perpetrators as a permissible means of satisfying the threshold was forged in cases concerning individuals who were 'carers'. In Lancashire, the condition was interpreted to include non-parent carers. It was somewhat widened in North Yorkshire at [26] to include 'people with access to the child' who might have caused injury. If that was an extension, it was a principled one. But at all events, the extension does not stretch to "anyone who had even a fleeting contact with the child in circumstances where there was the opportunity to cause injuries": North Yorkshire at [25]. Nor does it extend to harm caused by someone outside the home or family unless it would have been reasonable to expect a parent to have prevented it: S-B at [40].*

*51. It should also be noted that in the leading cases there were two, three or four known individuals from whom any risk to the child must have come. The position of each individual was then investigated and compared. That is as it should be. To assess the likelihood of harm having been caused by A or B or C, one needs as much information as possible about each of them in order to make the decision about which if any of them should be placed in the pool. So, where there is an imbalance of information about some individuals in comparison to others, particular care may need to be taken to ensure that the imbalance does not distort the assessment of the possibilities. The same may be said where the list of individuals has been whittled down to a pool of one named individual alongside others who are not similarly identified. This may be unlikely, but the present case shows that it is not impossible. Here it must be shown that there genuinely is a pool of perpetrators and not just a pool of one by default.*

14) Where there are multiple injuries sustained at different times the court must consider separately the question of who is the perpetrator of each injury. If the court is able to identify the perpetrator of one injury, the question would then arise as to the extent to which the court is entitled to rely upon that finding in order to identify the perpetrator of other injuries. That issue was considered by the Court of Appeal in **Re M (A Child) [2010] EWCA Civ 1467**. Wilson LJ (as he then was) said:

*'37 The first basis of the cross-appeal is the father's responsibility for the October event. Is it likely, asks Miss Hodgson on behalf of the mother, that, within the space of less than seven weeks, the partial suffocation of a baby is caused by one parent and yet injuries to his body are,*

*or even just may be, perpetrated by the other? It is certainly not unknown for judges to give a negative answer to that type of question and, by reference to it, to proceed to identify the perpetrator of a second non-accidental injury. When they do so, their reasoning is – in my view – in principle valid . . . '*

**Checklist of applicable principles**

15) The Court may be assisted by the summary of applicable law and principles espoused by Baker J in **Re JS [2012] EWHC 1370**.

*"36. In determining the issues at this fact finding hearing I apply the following principles. First, the burden of proof lies with the local authority. It is the local authority that brings these proceedings and identifies the findings they invite the court to make. Therefore the burden of proving the allegations rests with them.*

*37. Secondly, the standard of proof is the balance of probabilities (**Re B [2008] UKHL 35**). If the local authority proves on the balance of probabilities that J has sustained non-accidental injuries inflicted by one of his parents, this court will treat that fact as established and all future decisions concerning his future will be based on that finding. Equally, if the local authority fails to prove that J was injured by one of his parents, the court will disregard the allegation completely. As Lord Hoffmann observed in Re B:*

*"If a legal rule requires the facts to be proved (a 'fact in issue') a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1."*

*38. Third, findings of fact in these cases must be based on evidence. As Munby LJ, as he then was, observed in **Re A (A Child) (Fact-finding hearing: Speculation) [2011] EWCA Civ 12**:*

*"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation."*

*39. Fourthly, when considering cases of suspected child abuse the court must take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss P observed in Re T [2004] EWCA Civ 558, [2004] 2 FLR 838 at 33:*

*"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate*

*standard of proof."*

*40. Fifthly, amongst the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental head injury, is expert medical evidence from a variety of specialists. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. The roles of the court and the expert are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence (see* ***A County Council & K, D, & L [2005] EWHC 144 (Fam)****; [2005] 1 FLR 851 per Charles J). Thus there may be cases, if the medical opinion evidence is that there is nothing diagnostic of non-accidental injury, where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts.*

*41. Sixth, in assessing the expert evidence I bear in mind that cases involving an allegation of shaking involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others (see observations of King J in* ***Re S [2009] EWHC 2115 Fam****).*

*42. Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them (see Re W and another (Non-accidental injury) [2003] FCR 346).*

*43. Eighth, it is common for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (see R v Lucas [1981] QB 720).*

*44. Ninth, as observed by Hedley J in* ***Re R (Care Proceedings: Causation) [2011] EWHC 1715 Fam****:*

*"There has to be factored into every case which concerns a disputed aetiology giving rise to significant harm a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on*

*the balance of probabilities."*

*The court must resist the temptation identified by the Court of Appeal in R v Henderson and Others [2010] EWCA Crim 1219 to believe that it is always possible to identify the cause of injury to the child.*

*45. Finally, when seeking to identify the perpetrators of non-accidental injuries the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator (see North Yorkshire County Council v SA [2003] 2 FLR 849. In order to make a finding that a particular person was the perpetrator of non-accidental injury the court must be satisfied on a balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interest of the child, although where it is impossible for a judge to find on the balance of probabilities, for example that Parent A rather than Parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to do so (see Re D (Children) [2009] 2 FLR 668, Re SB (Children) [2010] 1 FLR 1161)."*

**Procedural fairness / notice of findings to be sought**

16) **Re W [2016] EWCA Civ 1140,** per McFarlane LJ:

*93. It can properly be said that by keeping these matters to himself during the four week hearing, and failing to arrange for the witnesses to have any opportunity to know of the critical points and to offer any answer to them, the judge was conducting a process that was intrinsically unfair. […]*

*95. Where, during the course of a hearing, it becomes clear to the parties and/or the judge that adverse findings of significance outside the known parameters of the case may be made against a party or a witness consideration should be given to the following:*

*a) Ensuring that the case in support of such adverse findings is adequately 'put' to the relevant witness(es), if necessary by recalling them to give further evidence;*

*b) Prior to the case being put in cross examination, providing disclosure of relevant court documents or other material to the witness and allowing sufficient time for the witness to reflect on the material;*

*c) Investigating the need for, and if there is a need the provision of, adequate legal advice, support in court and/or representation for the witness.*

*96. In the present case, once the judge came to form the view that significant adverse findings*

*may well be made and that these were outside the case as it had been put to the witnesses, he should have alerted the parties to the situation and canvassed submissions on the appropriate way to proceed. One option at that stage, of course, is for the judge to draw back from making the extraneous findings. But if, after due consideration, it remains a real possibility that adverse findings may be made, then the judge should have established a process that met the requirements listed in paragraph 95 above.*

**Failure to protect**

17) In **Re L-W (Children) [2019] EWCA Civ 159** King LJ stated the following:

*"62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.*

*63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries.*

*64. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm."*

18) In **G-L-T (Children) [2019] EWCA Civ 717** King LJ repeated what she had said in Re L-W and further stated that:

*"72. I repeat my exhortation for courts and Local Authorities to approach allegations of 'failure to protect' with assiduous care and to keep to the forefront of their collective minds that this is a threshold finding that may have important consequences for subsequent assessments and decisions.*

*73. Unhappily, the courts will inevitably have before them numerous cases where there has undoubtedly been a failure to protect and there will be, as a consequence, complex welfare issues to consider. There is, however, a danger that significant welfare issues, which need to be teased out and analysed by assessment, are inappropriately elevated to findings of failure to protect capable of satisfying the section 31 criteria.*

*74. It should not be thought that that the absence of a finding of failure to protect against a non-perpetrating parent creates some sort of a presumption or starting point that the child/children in question can or should be returned to the care of the non-perpetrating parent. At the welfare stage, the court's absolute focus (subject to the Convention rights of the parents) is in relation to the welfare interests of the child or children."*

**Medical evidence and controversy**

19) In addition to the principles referred to in the Baker J in **Re JS [2012] EWHC 1370** the following points are also of relevance:

20) When considering the evidence provided by an expert the Court is respectfully reminded that the evidence of an expert is not in any special position and there is no presumption of belief in an expert no matter how distinguished he or she may be.

21) If the Court disagrees with an expert's conclusions or recommendations an explanation is required see **Re B (Care: Expert Witnesses) [1996] 1 FLR 667** and **Re D (A Child) [2010] EWCA 1000.**

22) In ***Re B (Care: Expert Witnesses)*** **[1996] 1 FLR 667** Ward LJ gave the following guidance as regards the evidence of expert witnesses:

"*The expert advises but the Judge decides. The Judge decides on the evidence. If there is nothing before the court, no facts or no circumstances shown to the court which throw doubt on the expert evidence, then, if that is all with which the court is left, the court must accept it. There is, however, no rule that the Judge suspends judicial belief simply because the evidence is given by an expert*."

Butler-Sloss LJ continued:

"*An expert is not in any special position and there is no presumption of belief in a doctor however distinguished he or she may be. It is, however, necessary for the Judge to give reasons for disagreeing with experts' conclusions or recommendations. That, this Judge did. A Judge cannot substitute his own views for the views of the experts without some evidence to support what he concludes.*"

23) In **A County Council v K,D and L [2005] EWHC 144** Charles J indicated that (a) it was the role of the Court to take into account and weigh the expertise and speciality of expert witnesses; (b) in a case where the medical evidence was that the likely cause of an injury was non-accidental the Court was entitled to find that the injury had a natural cause or was accidental or that the Local Authority had not established the threshold criteria to the required standard; (c) in a case where the medical evidence was that there was nothing diagnostic of a non-accidental injury, the Court could nonetheless reach a finding on the totality of the evidence that there had been a non-accidental injury and the threshold was satisfied; and (d) it was open to the Court, on the basis of the totality of the evidence, to reach a conclusion as to the cause of the injury that was different to, and did not accord with, the conclusion reached by the medical experts.

24) There are numerous cases where the courts have had to consider the question of how to approach medical evidence, a number of which are cited above by Baker J. Two of the most notable are the cases of **Re U (Serious Injury: Standard of Proof); Re B [2004] EWCA Civ 567, [2004] 2 FLR 263**, and **Re R (Care Proceedings: Causation) [2011] EWHC 1715 Fam.**

25) In **Re U (Serious Injury: Standard of Proof); Re B;** Butler Sloss P stated in the Court of Appeal at paragraph [23]

- the cause of an injury or an episode that cannot be explained scientifically remains equivocal
- recurrence is not in itself probative
- particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause
- the court must always be on guard against the over-dogmatic expert, the expert whose reputation or amour proper is at stake, or the expert who has developed a scientific prejudice
- the judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark.

26) In **R v Henderson [22] EWCA Crim. 126** , Moses LJ:

*"There are few types of case which arouse greater anxiety and controversy than those in which it is alleged that a baby has died as a result of being shaken. It is of note that when the Attorney General undertook a review of 297 cases over a 10 year period following the case of R v Cannings [2004] 2 Criminal Appeal Reports 63, 97 were cases of what is known as "shaken baby syndrome". The controversy to which such cases gives rise should come as no surprise. A young baby dies whilst under the sole care of a parent or child-minder. That child can give no clue to clinicians as to what has happened. Experts, prosecuting authorities and juries must reconstruct, as best they can, what has happened. There remains a temptation to believe that it is always possible to identify the cause of injury to a child. Where the prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative cause, it is tempting to conclude that the prosecution has proved its case. Such a temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude beyond reasonable doubt an unknown cause. As Cannings (177) teaches, even where, on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown".*

27) A member of the Court of Appeal in that case was Hedley J who imported the reasoning of Moses LJ in the Court of Appeal in **Henderson** into family law in **Re R (Care proceedings: Causation) [2011] EWHC 1715 (Fam)** in which Hedley J explained that it does not represent forensic failure for a judge to reach a conclusion that the cause is unknown. He explained the reasoning behind unknown cause:

*"There has to be factored into every case which concerns a disputed aetiology giving rise to significant harm a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities…. In my judgment, a conclusion of unknown etiology in respect of an infant represents neither professional nor forensic failure. It simply recognises that we still have much to learn and it also recognises that it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism. Maybe it simply represents a general acknowledgement that we are fearfully and wonderfully made."*

**Lies**

28) Given that the truthfulness or otherwise of the witnesses in this case may be an issue, the Court may be assisted by the following excerpt from **Re M (Children) [2013]**

**EWCA Civ 388**, in which the applicability of the Lucas direction to family proceedings was highlighted by Ryder LJ:

*"7…. A Lucas direction is a criminal direction derived originally from a case on corroboration, R v Lucas [1981] QB 720. It is used to alert a fact-finding tribunal, that is a jury in a criminal trial, to the fact that a lie told by a defendant does not of itself necessarily indicate guilt because the defendant may have some other reason for lying; that is, he may lie for innocent reasons. A witness may lie because she lacks credibility, or because she has an innocent motive for lying. If she lies about the key fact in issue, that is one thing; if she lies about collateral facts, that may be quite another. A judge of fact may not be able to separate out every fine distinction, but may nevertheless conclude that an allegation is proved, despite the fact that the witness has lied about other matters.*

*8. This is often simplified in the circumstances of emotionally-charged allegations remembered through the fog of distress and relationship breakdown as a core of truth surrounded by sometimes exaggerated and sometimes badly recollected or hazy memory. There may also be an overlay of deliberate untruth arising out of the anger and distress of the breakdown and/or the nature of the application before the court, and I remind myself this was a strongly disputed application. It is also too frequently the case that a Family Judge is faced with internally inconsistent or even untruthful witnesses who are locked in a battle in which their energies and antagonism have sadly come to be focused on who should look after the children or have contact with them."*

29) Further, Munby LJ observed in **Re A (A Child) (Fact-finding hearing: Speculation) [2011] EWCA Civ 12** at paragraph 104

*"Any judge who has had to conduct a fact-finding hearing such as this is likely to have had experience of a witness – as here a woman deposing to serious domestic violence and grave sexual abuse – whose evidence, although shot through with unreliability as to details, with gross exaggeration and even with lies, is nonetheless compelling and convincing as to the central core. It is trite that there are all kinds of reasons why witnesses lie, but where the issues relate, as here, to failed marital relationships and the strong emotions and passions that the court process itself releases and brings into prominence in such a case, the reasons why someone in the mother's position may lie, even lie repeatedly, are more than usually difficult to decipher. Yet through all the lies, as experience teaches, one may nonetheless be left with a powerful conviction that on the essentials the witness is telling the truth, perhaps because of the way in which she gives her evidence, perhaps because of a number of small points which, although trivial in themselves, nonetheless suddenly illuminate the underlying realities."*

30) In **Hertfordshire CC v Ms T and Mr J [2018] EWHC 2796** Keehan J stated at paragraphs 9 and 10 of his judgment:

*When considering the evidence, particularly the evidence of the mother, I give myself a revised Lucas direction, namely, I should only take account of any lies found to have been told if there is no good reason or other established reason for the person to have lied. I also take into account the decision of the Court of Appeal in Re H-C [2016] EWCA civ 136 where McFarlane LJ (as he then was) said at para.100:*

*"One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the 'lie' is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is 'capable of amounting to a corroboration.' In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of R v Middleton [2001] Crim.L.R. 251. 'In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should, therefore, take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt'."*

*I entirely accept that the mere fact of a lie being told does not prove the primary case against the party or the witness should they have been found to have lied to the court. I also bear in mind that there is no obligation on a party to prove the truth of an alternative case put forward by way of defence and the failure by the party to establish the alternative case on the balance of probabilities does not of itself prove the other party's case, Re X (No 3) [2013] EWHC 3651 Fam and Re Y (No 3) [2016] EWHC 503 Fam.*

**Factors relevant to factual framework**

31) In **BR (Proof of Facts), Re [2015] EWFC 41** Peter Jackson J (as he then was), whilst acknowledging that each case turns on its own facts, endorsed an analysis of relevant factors to be considered by the court which had been prepared by counsel for the Children's Guardian from material produced by the NSPCC, the Common Assessment Framework and the Patient UK Guidance for Health Professionals.

The risk factors were:

a) Physical or mental disability in children that may increase caregiver burden
b) Social isolation of families

c) Parents' lack of understanding of children's needs and child development
d) Parents' history of domestic abuse
e) History of physical or sexual abuse (as a child)
f) Past physical or sexual abuse of a child
g) Poverty and other socioeconomic disadvantage
h) Family disorganization, dissolution, and violence, including intimate partner violence
i) Lack of family cohesion
j) Substance abuse in family
k) Parental immaturity
l) Single or non-biological parents
m) Poor parent-child relationships and negative interactions
n) Parental thoughts and emotions supporting maltreatment behaviours
o) Parental stress and distress, including depression or other mental health conditions
p) Community violence

The protective factors were:

q) Supportive family environment
r) Nurturing parenting skills
s) Stable family relationships
t) Household rules and monitoring of the child
u) Adequate parental finances
v) Adequate housing
w) Access to health care and social services
x) Caring adults who can serve as role models or mentors
y) Community support

**Memory and reliability of eye witness testimony**

32) In **Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor [2013] EWHC 3560 (Comm)** Leggatt J, at paragraphs 15 – 21 of his judgment, stated:

*An obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory.*

*While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people's memories are unreliable and believe our memories to be more faithful than they are. Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.*

*Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flashbulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event. (The very description 'flashbulb' memory is in fact misleading, reflecting as it does the misconception that memory operates like a camera or other device that makes a fixed record of an experience.) External information can intrude into a witness's memory, as can his or her own thoughts and beliefs, and both can cause dramatic changes in recollection. Events can come to be recalled as memories which did not happen at all or which happened to someone else (referred to in the literature as a failure of source memory).*

*Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances where his or her memory of it is already weak due to the passage of time.*

*The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty (such as an employment relationship) to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give evidence for one side in the dispute. A desire to assist, or at least not to prejudice, the party who has called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces.*

*Considerable interference with memory is also introduced in civil litigation by the procedure of*

*preparing for trial. A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer who is inevitably conscious of the significance for the issues in the case of what the witness does nor does not say. The statement is made after the witness's memory has been "refreshed" by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to recall. The statement may go through several iterations before it is finalised. Then, usually months later, the witness will be asked to re-read his or her statement and review documents again before giving evidence in court. The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events.*

*It is not uncommon (and the present case was no exception) for witnesses to be asked in cross-examination if they understand the difference between recollection and reconstruction or whether their evidence is a genuine recollection or a reconstruction of events. Such questions are misguided in at least two ways. First, they erroneously presuppose that there is a clear distinction between recollection and reconstruction, when all remembering of distant events involves reconstructive processes. Second, such questions disregard the fact that such processes are largely unconscious and that the strength, vividness and apparent authenticity of memories is not a reliable measure of their truth.*

**Repeated accounts and possible reported discrepancies**

33) Peter Jackson J (as he then was) in the case of **Lancashire County Council v The Children [2014] EWHC 3 (Fam)**, at paragraph 9 stated:

*"… where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record-keeping or recollection of the person hearing and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be*

*unnatural – a process that might inelegantly be described as 'storycreep' – may occur without any necessary inference of bad faith."*