



Neutral Citation Number: [2024] EWHC 618 (Fam)

Case No: OX23C50033

IN THE HIGH COURT OF JUSTICE

Reading District Registry

Before :

HHJ MORADIFAR

(SITTING AS A JUDGE OF THE HIGH COURT)

In the matter of;

Re Z (Infant fatality)

Mr Andrew Bagchi KC and Mr Tom Wilson (instructed by A Local Authority Legal Services) on behalf of the local authority applicant.

Mr Simon Miller and Mr Alex Perry (instructed by Jackson West) on behalf of the mother.

Mr Mark Twomey KC and Mr Jonathan Adler (instructed by Brethertons) on behalf of D.
Mr Michael Trueman and Lorraine King (of Trueman's Solicitors) for the child through his guardian, Simon Smith and subsequently Helen McMullen

Hearing dates: 8, 10, 15, 16, 17, 22, 23, 24, 26 January and 6 And 18 March 2024

Judgment

HHJ MORADIFAR:

1. At 15.58 hours on 11 May 2022 A was pronounced dead at his local Accident and Emergency Department. A was three years and eight and a half months old. The events leading to his death took place at his home address whilst he was in the care of his stepfather (“D”) who drove A to the hospital after finding him unresponsive.
2. There are ongoing police investigations concerning the circumstances of A’s death. The local authority applies for public law orders in respect of Z who is A’s maternal half sibling born in June 2023; Z is the mother’s fourth child and D’s first child. The application is made against a background of concerns around neglect of A and his older siblings, B and C, who now live with their father (“F”). The matter comes before me to determine the local authority’s allegations against the mother and D.
3. Broadly, the local authority asserts that;
 - a. On 11 May 2022, the mother and D left A home alone for a significant period.
 - b. Later, during the same day, A died whilst in the care of D due to lack of adequate supervision or, in the alternative, the court is invited to find that D has failed to give an honest or full account of the circumstances of A’s death and that he continues to mislead the court.
 - c. D was cruel and abusive towards A, B, and C.
 - d. The mother has failed to protect A, B and C.
 - e. Both the mother and D have been unwilling to work openly with professionals, and
 - f. D and the mother intended to flee the jurisdiction of this court before Z was born.
4. In summary, the mother accepts leaving A alone at home but asserts that this was for a short time and that he would be safe in D’s care. She denies being uncooperative with professionals or intending to flee the jurisdiction. She awaits the outcome of the court’s determination in respect of the circumstances of A’s death. The mother accepts that D may have inappropriately chastised the oldest children but asserts that she put a stop to this and she denies failing to protect any of the children.
5. D accepts that A was left alone at home and that this was inappropriate. He also accepts that D died whilst in his care but denies any intentional action that may have contributed to this. More recently, he has accepted that, on one occasion, he put B

and C in a ‘stress position’ and he covered A’s mouth to stop him crying. He denies the remaining allegations.

The law

6. In this context the law has been long settled. It is a simple and general proposition of the law that the party seeking to rely on a disputed fact must prove that fact. In civil and family proceedings such facts must be proven on a balance of probabilities. The guiding principles were most helpfully summarised by Baker J (as he then was) in *Re JS* [2012] EWHC 1370 (Fam). Following this decision, Jackson J (as he then was) in *Lancashire County Council v C, M and F (Children: Fact finding Hearing)* [2014] EWFC 3 added a further item to this invaluable list of important considerations. Furthermore, I have considered and applied the observations of the former President of the Family Division in *Re A (A child)* [2016] 1 FLR 1. I am not bound by the local authority’s schedule of findings and can make such findings as are relevant and supported by evidence.
7. More recently, in *Re A, B and C (Children)* [2021] EWCA Civ 45, Lady Justice Macur has provided a most helpful guidance on the treatment of lies and dishonesty. These may be summarised as follows:
 - a. A ‘Lucas’ direction which is formulaic in nature must not be included in a judgment as a ‘tick box exercise.’
 - b. Such a direction is not called for in every family case.
 - c. Such a self-direction may be called for if there is “*an established propensity to dishonesty as determinative of guilt ... Conversely, an established propensity to honesty will not always equate with the witness’s reliability of recall on a particular issue*”.
 - d. If such a self-direction is called for, it is good practice “*to seek Counsel’s submissions to identify: (i) the deliberate lie(s) upon which they seek to rely; (ii) the significant issue to which it/they relate(s), and (iii) on what basis it can be determined that the only explanation for the lie(s) is guilt.*”

Background

8. The parents were born in China and are Chinese nationals. The mother came to the UK in 2011 to attend university in the north of England where she met F. They married in the same year. B was born in 2013 and C in 2016. On both occasions, the

children were placed on Child In Need ('CIN') Plans due to concerns about neglect and poor home conditions.

9. D came to the UK in 2017 and enrolled at the same university. A was born in 2018. During 2018 and 2019, the mother and D became friends. The mother and F separated and by the June or July 2019, the mother and D formed a relationship and began living together in September of the same year, shortly after A was born. At this time, A remained in the care of the mother, with B and C living with F.
10. Children's services remained involved and continued to be concerned for the children with escalating concerns about neglect and poor home conditions. In February 2020, all three children were made the subject of Child Protection Plans ('CPP'). Later, in September 2020, D secured a position at a different university and moved with the mother and A to a different part of England. B and C joined them in October of the same year. Following a transfer to the relevant local authority, the children were placed on CIN plans. Having observed improvements in the children's circumstances, the local authority's involvement ended in January 2021.
11. In September 2021, D, the mother and three children moved to live in the Midlands. However, the demands of looking after the three children on a limited budget was such that in early 2022, B and C returned to F's care, where they continue to live. A remained living with the mother and D.
12. On the morning of 11 May 2022, D went to the gym, leaving A at home with his mother. The mother was due to start her shift at a local restaurant at 12.00 noon. D arrived back at the property at 11.51 am and at 11.54 the mother and D left A alone at home whilst the mother was driven to work. D returned to the address and after a short break attended a remote meeting with colleague. A played by himself in his bedroom until later, when D found him inside a bedside cabinet. He was unresponsive and D drove him to the hospital where attempts at resuscitating him were unsuccessful and he was pronounced dead. Police conveyed the mother to the hospital where she was reunited with A after being informed of the terrible events of that day.
13. As part of the continuing police investigations, D and the mother were interviewed under caution. During the investigations, B and C were interviewed and raised allegations of abuse against D and further alleged that the mother was aware of D's treatment of the children. On or about September 2022, the mother fell pregnant with Z and in October of the same year D and the mother moved to their current address. Before his birth, in November 2022, Z was made the subject of a multiagency CPP.

On 23 June 2023, the local authority applied for public law orders in respect of Z, who was subsequently placed in the interim care of the local authority and removed to foster care, where he continues to reside. The matter has since progressed to this hearing before me where I am tasked with determining the local authority's allegations against D and the mother.

Analysis and evidence

14. The evidential canvas is rich, and I have had the benefit of considering a significant amount of evidence, much of which has been gathered during the police investigation. I am extremely grateful to West Midlands Police and its officers for their exemplary, professional, and cooperative way in which they have interacted with these proceedings. For entirely proper reasons, much of the evidence has not been challenged.
15. It is important to note that, although the mother and D appear to have a good command of English, this is not their first language and their interactions with the professionals over the years must be considered with this in mind. All members of this family, including the extended family members, have suffered a significant loss that has, and will continue to have a profound effect on them. It is inevitable that this will impact on their approach, their interactions, and memories of key events. There is no uniformity of expected behaviour in individuals who face the reality of such loss and different individuals may react differently in the face of such tragedy. The subject matter on which the mother and D gave their evidence is highly distressing. These are significant factors that must guide any assessment of the evidence.
16. By the time that the mother and D formed a friendship, she had long been established in the UK. D is significantly younger than her, and at the time of the commencement of their relationship, he was in his early twenties. As confirmed by him, he had nominal experience of caring for children. Until more recently, he had not informed his family of his relationship with the mother. By the time D was involved in caring for all three older children, the world was in the grips of a global pandemic necessitating spending greater time at home with the children.
17. The issue of neglect concerning the three older children has been a long-standing concern, involving different local authorities. A great deal of these concerns predates D's involvement with the family. Following the separation of the mother and F, there appeared the green shoots of improvements in the mother's care of the children. D was involved with A from an early age and both mother and D described a close bond

and loving relationship between A and D.

18. From October 2020, there was a significant improvement in the children's circumstances after they began living with the mother and D. I also note D's commitment to regularly drive the children great distances to ensure that they could see their father, F. The professional observations and reports on the children spoke to the positive contributions that D was making in supporting the mother and the children. Such was the improvement, that in January 2021, the relevant local authority closed its case. The evidence in this regard is highly informative of the background to this family and must be weighed into the balance when considering the totality of the evidence that is before the court.
19. As attested to by the mother and by D in similar terms, by February 2021, the couple was finding it increasingly difficult to look after all the children, leading to a decision that B and C should return to the care of their father, F. Whilst both mother and D sought to suggest that this was in part in the furtherance of an agreement that the mother and F reached on their separation and the general culture expectation of older boys living with their father, the evidence is clear that the fundamental reasons for the two oldest children's return to their father was mother's and D's inability to cope with all three children, that included financial pressures within the home where the mother was required to work and D was undertaking his self-financed studies.
20. As part of the investigations into A's death, DC McKenna was asked to undertake an interview with B and C. As she explained in her oral testimony, this was part of the background information gathering and it was not intended to be an 'ABE' interview (Achieving Best Evidence Guidelines 2022 updated in 2023). Therefore, she explained that there were some significant departures from this Guide. Within the interviews, the children make a number of allegations of abuse and cruelty against D, relating to the time that they lived with him and their mother.
21. Mr Twomey KC and Mr Adler submit that, notwithstanding the parameters of the interview, the significant failures to comply with the said guidelines bring into serious doubt the reliability and veracity of the children's account. The ABE Guidelines are not an absolute rule that must be followed rigidly, but departure from them can lead to important evidence being contaminated or otherwise deemed unreliable.
22. I will not repeat the comprehensive list of failings that are part of the submissions on behalf of D, but observe, by way of illustration of the point, and agreed to by DC McKenna, that there was no effective preparatory work undertaken with the children

and that by the time of the interview, B and C had lived with their father, F, for a significant period and been exposed to the understandable negative attitudes of the paternal family towards D. There was a significant passage of time before the children were interviewed. There was no ‘truth or lies’ exercise undertaken with the children nor was there any attempt at establishing the children’s understanding of timing and duration. Finally, DC McKenna was given little background information about the family to provide her with important context to better assess and engage with the children. Whilst I do not accept that these failures are catastrophic, in the absence of corroborating evidence, extreme caution needs to be exercised before placing any reliance on the evidence of the two children.

23. Until he filed his final statement during this hearing, D had consistently denied B and C’s allegations. In his recent statement, he admits that, on one occasion, he placed B and C in the ‘stress position’ by making them face the wall and hold their arms up. He stated that this was in the context of ongoing concerns about B’s dental issues and his desire to consume chocolate whenever possible. I did not gain much assistance from his evidence in this regard or the reasons for not accepting B and C’s version earlier, insofar as he has now admitted to the same. His evidence in this regard lacked credibility. He also admits to covering A’s mouth to quieten him. Whilst this part of his evidence was more consistent, I found him to provide the minimum detail in his answers and evaded engaging with what was, by his own admission, an entirely inappropriate means by which to quieten a young child.
24. I found the evidence of the mother in respect of these allegations to be unreliable. She too was highly evasive in her answers and this was sadly a theme that emerged when answering questions about the allegations that were put to her. She resisted engaging with the questions and gave answers that were not on point. In her response document she accepts that D made the children face the wall as a form of punishment and this was “*sometimes for up to 15 minutes*”, thus suggesting that there were multiple examples of this form of punishment that she was aware of and contradicting her assertion that she only saw this once and was able to put a stop to it. Her attempts at distancing herself from her response were, in my judgment, guided by self-preservation and lacked any credibility. I have no doubt that this form of punishment was used on multiple occasions and the mother was unable to address it or to put a stop to it.
25. This brings into sharper focus the independent evidence that is capable of

corroborating or disproving the allegations. It is clear that at school, B stated that he was made to stand in the stress position on one occasion. There is also evidence that B can lie and maintain the lies in the face of challenge. C is also said to be prone to exaggeration. It is also important to note that the allegations about mistreatment of A on the stairs are not supported by any independent evidence.

26. Turning to the events of 11 May 2022, the mother and D accept that they left A alone at their property whilst D drove the mother to work. They both expressed their remorse and acknowledgement that it was entirely inappropriate. Despite their earlier assertions, during cross-examination, they each accepted the CCTV footage as accurate which showed D leaving at 09.54 and returning at 11.50:57 and the couple leaving without A at 11.55:48 with D returning to park his car at 12.03.58. They each stated that the decision to leave A was made under some pressure as the mother was running late for work, A was playing on the iPad, which caused D to become angry, this having previously been an issue. D then told the mother in words to the effect that ‘either leave A at home or be late for work.’
27. It is entirely understandable that their recollection of the detail will be impacted by the circumstances of the day, what followed and the passage of time. However, I found their respective accounts about the decision to leave A alone lacking in any meaningful consideration or credibility. Both asserted that this was the only time that A had been left unattended. Despite this, neither was able to explain why there were no arrangements nor any expectation that D would call the mother as soon as he returned home to ensure that A was well. The mother’s explanation that D would call if ‘something happened’ showed no concern for A whatsoever. More puzzling still, was her unsuccessful attempts at calling D later to ask for help with a delivery at the restaurant without having A in mind. After starting her shift, the next occasion that she spoke to D was in hospital after A was pronounced dead. Tragically, the last time she saw her son alive was when she left him, alone, at home.
28. Both the mother and D were taken through a series of photographs and questions about A’s safety during the period that he was left unattended. The mother was clear that she was asleep when D left for the gym in the morning, but D was less than clear about this. However, his lack of knowledge about the mother’s availability to look after A in his absence demonstrated no regard for A’s wellbeing or safety. His answers about the number of dangerous implements that A could have accessed was fast becoming a familiar theme that spoke to D’s concerning lack of knowledge or

care about A's safety. Despite his attempts at trying to explain why certain knives or meat cleavers were left on the kitchen side, he displayed a manifest lack of understanding of the danger that A was in.

29. From the point of his return to the property, at just after midday, until A's admission to hospital later in the afternoon, D was the only person who had care of A. By his and the mother's account, this was the first time that A had been left unattended and yet there is a staggering paucity of detail in his knowledge about where A was in the property or what he was doing when he returned to the property. Before attending his prearranged video meeting that commenced at 12.43, D prepared a snack and rested. He clarified his evidence during his oral testimony that in material parts contradicted his earlier statements, he checked on A about twenty or thirty minutes after the meeting started. He was unable to give any meaningful detail about A on this first check, save that he was sitting in the cabinet playing with his Lego. D further stated that, on the second occasion he looked into the room on the way back from the bathroom, but he didn't see A. D accepted that this was not an adequate check. The meeting then ended at 14.06. As D explained in his oral testimony, at this point he went to the kitchen to prepare lunch without first checking on A. D then entered the room to check on A to find the cabinet face down and, as he lifted and turned the cabinet, he discovered A inside. He pulled him out and attempted to resuscitate him. He demonstrated his actions using the same cabinet, as produced by West Midlands Police, during his oral testimony.
30. As is submitted by Mr Bagchi KC and Mr Wilson, by D's own evidence, A was left unattended for a continuous period of fifty-five to sixty-five minutes. Between 14.06 and 14.16, D's attempts at resuscitating D were unsuccessful and he decided to drive D to the nearest accident and Emergency Department. He is seen carrying A to the car at 14.16:50 hours and driving out of the parking area at 14.19.24 hours. D explained that the time he spent sitting in his car was used to look up the nearest hospital having already decided that it would be quicker to drive A than to wait for an ambulance, though he later called for an ambulance whilst driving to the hospital.
31. I found D's account of the events of the 11 May 2022 to lack credibility and in material respects lacking in detail. There are significant inconsistencies in his account of what A was doing when he first checked on him and an inherent improbability in the accounts insofar as he asserts that A was sitting in the cabinet playing with Lego in circumstances where the cabinet would have offered A very limited space in which

to sit in and highly unlikely that he would have been able to play, given the dimensions of the cabinet. D was unable to give any detail of how he was sitting or playing. The mother's account that she was not aware of A's propensity to go into the cabinet or to fit in the cabinet sheds further doubt upon D's account.

32. Both D and the mother in their evidence demonstrate a most concerning lack of regard for A where he appears to have roamed the house without much supervision and, at times, completely alone. In my judgment, this brings into serious question the mother's assertions of a close and loving relationship between D and A. I have no doubt that D was very much a dominant figure in his household and he sees this as being culturally acceptable when the adult male, or the father figure, gets the 'final word.' The evidence of both adults was, in my judgment, sadly evasive and opaque on the relevant issues.
33. On 13 May 2022, A was the subject of a postmortem examination and the findings are set out in the reports of Dr A Kolar (Home Office-Registered Forensic pathologist), Dr RDG Malcolmson (Consultant Paediatric and perinatal Pathologist) and Professor Al-Surraj (Consultant Neuropathologist). There are no areas of contradiction or disagreement between the three experts and their collective findings may be summarised as follows:
 - a. There were no signs of subarachnoid haemorrhage, contusions, lacerations, or internal bleeding on the brain.
 - b. A's measurements in a foetal position are broadly compatible with being trapped in the bedside cabinet.
 - c. There was no evidence of a physical assault, but this does not exclude the possibility of A being placed in the cabinet by a third party.
 - d. A had abrasions to his forehead and back that appear to have been sustained around the time of his death.
 - e. The pattern of injuries was compatible with forceful movements against the inside of the bedside cabinet but does not exclude other explanations such as a third party attempting to extricate him, attempts to extricate himself or terminal seizure activity when in a morbid state.
 - f. There were no toxicological contributors to A's death.
 - g. The medical cause of death is positional asphyxiation consequent on A's entrapment in the bedside cabinet.
34. Dr Shields, who is a Consultant Paediatrician, was the lead clinician in the Sudden

Unexpected Death investigations concerning A. He noted a number of injuries to A's body, which were mostly consistent with everyday toddler activities and a small minority that were less so where he expected a greater explanation from the mother about these. He also visited the property and confirmed that the cabinet was in the place as seen in the photographs with its back to the wall and its left side flush to the bed. He examined the cabinet and could not comment about how A might have got in the cabinet but having taken measurements of the cabinet, he observed that this would have been a "tight fit" for A and would have required his head to be bent forward which would have affected his capacity to open his airways. The space was limited, offering A little room to move around. The cabinet had a low centre of gravity and, in his opinion, he had some difficulty with understanding how A might have caused the cabinet to fall forward but he could not say that this was impossible.

35. Mr Twomey KC and Mr Adler submit by reference to a number of authorities, that the court is not obliged to search for a finding; if the court is left in doubt, then the local authority has failed to prove its case and the less relevant facts are known the more likely it is that the court will conclude that the burden of proof has not been discharged (*Graves v Brouwer* [2015] EWCA Civ 595). They remind me of the inherent risk in "a systematic consideration of possibilities leading to no more than a conclusion regarding the least unlikely cause ..." (*Milton Keynes Borough Council v Nulty & others* [2013] 1 WLR 1183). They further remind me of the helpful warnings by Theis J against 'hindsight bias' and 'outcome bias' (*Re J and E (A Child)* EWHC 2400) quoting from 'Improving the Quality of Serious Case review (June 2013).
36. Furthermore, they point to the 'exculpatory evidence' which includes D's colleague's account whilst in the meeting, D's cooperation with the police investigations, CCTV showing D hurrying to hospital and D's initial account to the police. These are well founded submissions that I agree with and must be actively taken into account when considering the evidential balance. Moreover, I must consider the inherent probability or improbability of D confining A in the bedside cabinet. In my judgment there is no evidence that would support a finding that D confined A in the cabinet and to make such a finding would stretch the permissible evidential boundaries beyond breaking point. However, for reasons that I have set out above, I find that D has not provided a complete or reliable account of the events of this day. I further find that the sad and tragic circumstances leading to A's death was caused by D's gross neglect of A.
37. In their submissions, Mr Bagchi KC and Mr Wilson raise a number of concerns about

the attitude of the mother and D. These include the mother's lack of engagement with D's actions; the conduct and treatment of the three oldest children, including the events leading to A's death; the mother's inability or unwillingness to engage with the allegations that B and C have made; and D's general conduct that includes the inconsistencies in his evidence. They also point to D's inconsistent accounts, honesty, and lack of insight into the scale of his neglectful parenting. In my judgment, these are entirely well founded and justified observations of the conduct and attitude of these two adults.

38. Furthermore, without hesitation, I agree that both the mother and D deliberately omitted to inform the Midwife of the police investigations concerning the circumstances of A's death and provided an untruthful account to the professionals. Whilst I accept that there may be cultural reasons for Z's parents to wish to marry in China and to give birth to Z in China, this assertion was, in my judgment, an attempt to divert attention away from the primary wish and purpose of the arrangements, which was to avoid professional involvement in Z by relocating to China.

Conclusion

39. Having considered all the evidence that is before me together with the concessions that the mother and D have made to the local authority allegations against them, I find that:
- a. Paragraphs 1 – 4 of the local authority's threshold statement is satisfied.
 - b. The facts supporting the threshold finding are:
 - i. A lived in a home where his care was not given adequate priority.
 - ii. On 11 May 2022, the mother and D left A at home alone without any regard for his safety or wellbeing. A was three years and eight and a half months old.
 - iii. Neither the mother nor D have given a consistent or reasonable explanation for leaving A alone.
 - iv. Later, on the same day, in the afternoon of 11 May 2022, when in the notional care of D, A died from positional asphyxia and/or cardiac arrest caused when he became shut or locked inside a bedside cabinet which toppled over.
 - v. A died as a result of the gross neglect of D who was not supervising A properly or at all for significant periods of time that day such that A was able to climb into a bedside cabinet from which he was unable to

escape on his own.

- vi. The marks and injuries found on A's body are consistent with his struggle to free himself from the cabinet.
 - vii. Between October 2020 and February 2022:
 - D was cruel and abusive towards the B and C by making them stand in the corner of the room facing the wall and on at least one occasion placing them in stress positions (arms raised) for long periods of time as a form of punishment, and
 - Behaved entirely inappropriately by covering A's mouth with his hand to stop him crying.
 - viii. The mother was aware of D's conduct towards the three children and failed to protect the children from the abusive behaviour set out in vii., above.
 - ix. The mother does not accept that A died as a result of the gross neglect of D, nor does she accept that D acted in a cruel and abusive manner towards B, C and A.
 - x. The mother and D have not worked with the applicant authority and other professionals in an open and honest way.
 - xi. The mother and A intended to relocate to China prior to Z's birth to avoid the involvement of child protection agencies or these proceedings.
-