Neutral Citation Number: **[2023] EWHC 3097 (Fam)**

Case No: PR22C50265

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Sitting in Lancaster Family Court

Date: 01/12/2023

Before:

MR JUSTICE HAYDEN

- -

Between:

LANCASHIRE COUNTY COUNCIL	**Applicant**
- and -	
M	**1ST Respondent**
- and -	
F	
- and -	**2nd Respondent**
A and J (By their Children's Guardian)	**3rd Respondent**

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Ms Samantha Bowcock KC and Mr Paul Hart (instructed by **Stephensons Solicitors as agents for Lancashire County Council**) for the **Applicant Local Authority**
Mr Michael Jones KC and Mr Patrick Gilmore (instructed by **BSG Solicitors**) for the **1st Respondent**
Miss Gill Irving KC and Miss Kathryn Korol (instructed by **Holdens Solicitors**) for the **2nd Respondent**
Miss Sarah Probert (instructed by **Vanguards Solicitors**) for the **3rd Respondent**

Hearing dates: 30th October – 1st November 2023

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN

The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

MR JUSTICE HAYDEN:

1. I am concerned with two children, A, age 5 years and J, age 3 years. The Local Authority was first involved in A's life in 2019, when care proceedings were commenced, arising from her exposure to parental domestic abuse. There is no dispute in this case that the father (F) has consistently behaved in a violent and controlling manner towards the mother (M). He admits that when intoxicated by alcohol, he behaves violently and aggressively. His verbal abuse of M is particularly vituperative, calculated to belittle and demean her. F was convicted of an offence of battery of M in May 2021. This involved an incident of strangulation; it was met by a custodial sentence, which was suspended. Only a few months later, July 2021, there were further serious incidents between the couple. At the conclusion of the care proceedings, a Supervision Order was made, predicated on the assumption that the parents had separated. They had not.

2. During the course of the proceedings and at the time that the Supervision Order was made, M repeatedly reassured the social workers and health visitors that she and F were no longer living together. F recounted the same false story to his probation officer. In fact, throughout the entire period, M and F were together as a couple with F staying in the same house. It would appear that the professionals were entirely credulous and made no robust attempt to test the truth of the accounts they were given, for example by way of spot checks and unannounced visits. The paternal grandparents had been charged with the responsibility for supervising F's contact. Whether checks were made in relation to that, I am unclear. M and F's relationship has, self-evidently, been an enduring one.

3. In August 2021, the Local Authority was notified of M's pregnancy with a third child. F was the father. The baby (R) was born in March 2022. The records reveal a healthy little boy whose progress was entirely developmentally normal. It is significant that on the 19th April 2022, the health visitor carried out the new birth visit, at home, where amongst other matters she conducted, as she is required to with every new-born, a safer sleep assessment. In the questionnaire completed with M, M stated that she never took R into her bed with her. She also claimed, falsely as it transpired, that she did not share her bed with anybody else. She denied, again dishonestly, that she did not abuse alcohol or take drugs. A standard booklet was left with her from the Lullaby Trust. In clear and accessible terms, that handbook emphasises babies should always be placed on their back for sleep and given a clear, flat, separate sleep space in

the same room as the parents. Firm guidelines are identified, specifically "no pods, nests or sleep positioners".

4. The safer sleep assessment was reviewed on the 5th May 2022 on a further home visit. M, again, told the health visitor that she was living on her own with the children, with their father seeing them at their paternal grandfather's home. She also stated that R slept in his Moses basket. This too, she later accepted as entirely untrue.

5. The dishonesty of these accounts was tragically revealed on a disastrous weekend in late May 2022. M and F attended the wedding of F's sister. M had taken A and J in advance of F and R, to take part in wedding hair and beauty preparations. M began drinking in the afternoon. She continued to drink heavily throughout the day. Shortly before midnight, M and F went to a room that they had booked on the ground floor of the hotel, to put J and R to bed. A had gone to bed earlier in a room occupied by an aunt. At some point in the evening, the paternal grandfather advised the couple to "slow down" because they were plainly drinking too much and certainly, far too much to be responsible for such a young baby. A night porter in the hotel had seen the couple on the dance floor and had commented that they were 'steaming' drunk.

6. It is now clear, as the mother has stated, that R (aged 2 months) was placed in the double bed. He was not changed but remained in the clothes that he had worn for the wedding. M and J also got into the bed. M too went to bed fully clothed. F left the room and returned to the hotel bar where he had more to drink with his family. Eventually, he returned to the room to roll a joint of cannabis, which he went to smoke, outside, before finally going to bed. When he returned and started to undress, he noticed that R's entire body had been covered by the duvet. He pulled it back immediately and discovered R lying with his face towards his mother's, lifeless and floppy. F ran from the room, plainly and understandably greatly distressed, carrying R in his arms. He made his way to reception to seek assistance from the hotel staff.

7. Very shortly before 3am, a member of the hotel staff dialled 999. The police were at the scene within 7 minutes and the first two paramedics within 8 minutes. R was in cardiac arrest and received CPR. A total of 4 paramedics worked with R until they were able to restore his heartbeat and transfer him to hospital, shortly before 4am. Later that day, R was transferred to a children's hospital specialising in intensive care. Tragically, his condition became moribund and the parents, sadly but properly, upon receiving medical advice, agreed that he should be taken off life support. Death is recorded as having occurred at 14:50 on that day.

8. The Local Authority applied for Care Orders in respect of A and J in June 2022. Both girls have been cared for by their paternal grandparents since the 30th May 2022 i.e., from the day R died. Assessments of their capacity to care for the children have been positive. It is agreed that the quality of care they provided to their son (F) had also been of good quality. In this respect, it differed greatly from M's own childhood, which was traumatic.

9. In June 2022, M applied for a Non-Molestation Order against F. Her statement in support of that application has been the subject of scrutiny in these proceedings. This statement permits of no ambiguity. M is alleging that F has been controlling of her freedom, denigrating of her, violent and has caused significant damage to the property. This is stated in express terms to be "following" R's birth on 11th March 2022. M does not resile from the allegations but now suggests that these incidents "might have" occurred before R's birth. Given that they were all included in a statement supporting an application for an injunction, made on 22nd June 2022, I consider M's professed confusion to be disingenuous. The passage below could not be clearer. Moreover, it was drafted with the assistance of experienced lawyers.

> *"We notified the local authority, and we underwent a child and family assessment in March 2021. Both [F] and I were working with the Local Authority at that time and had safeguarding plan in place and strategies to manage potential or any conflict. Subsequent to this, [R] was born on 11th March 2022.*
>
> *Following this time, [F]'s behaviour continued to deteriorate."*

10. There is no doubt that both parents have been deeply and profoundly shocked by the circumstances of R's death. The removal of A and J from the house further compounds their sadness. Their grief and guilt is, perhaps inevitably, a heavy burden for them. They have sought solace and support in each other.

11. Ms Bowcock KC, counsel for the local authority, acknowledges that the couple has been, during the assessments following R's death, *"relatively open and honest about their substance abuse"*. This candour extends not only to the period prior to R's death but in the months that followed. The local authority accepts that the information emerging from hair strand blood and alcohol testing reports reveals that F has addressed a longstanding and heavy use of cannabis. It is also the case that his consumption of alcohol has decreased significantly. Notwithstanding this, however, he is revealed to take cocaine recreationally and continues to drink alcohol. The most up to date tests were only a few weeks ago, revealing that F had used cocaine between early and late September 2023. He had also either consumed cannabis in late August/early September or had passive exposure to it during that period. There was no evidence of excess alcohol use detected. This is a very significant change in F's behaviour and requires to be identified as such.

12. However, the period leading up to R's death shows a different picture. F accepts this, at least to some degree. The following results were obtained from the Forensic Testing Service:

> *"In our opinion, the findings from the investigation and testing of [F]'s samples are more likely than not to represent the following:*

> ***Cocaine;*** *use of cocaine from around April to early July 2022.*
> ***Cannabis;*** *use of cannabis from around April to early July 2022.*
> ***Codeine & Dihydrocodeine;*** *use of codeine and dihydrocodeine during at least a proportion of the period from around April to May/June 2022.*
> ***Zopiclone;*** *use of zopiclone during the period from around early June to early July 2022.*
> ***Diazepam;*** *use of diazepam during the period from around May to early July 2022.*
> ***Ketamine & MDMA (Ecstasy);*** *passive exposure to ketamine and MDMA during around April/May 2022.*
> ***Alcohol;*** *borderline-excessive alcohol consumption during the majority of the period from around April to early July 2022."*

13. Ms Bowcock highlighted that F's use of alcohol was *"borderline excessive"* in the period leading up to R's death. On 26th March 2022, F broke his wrist playing football on a Saturday morning. F has an enthusiastic interest in football. He trains on Wednesday evenings and plays most Saturdays. This is usually followed by going to the pub and watching the league games on the television. As Dr Kate Hellin, the Consultant Psychologist, who assessed M and F, has identified that football is integral to F's general mental wellbeing. F also recognises this. From this point, F's wrist was in a plaster cast. He was unable to work or play football. It was necessary for him to remain at home for several weeks. His employment is as a roofer. I accept that he went back to work, probably sooner than he should have, with his wrist in a cast, to undertake administrative and supervisory tasks. The above test results show positives for codeine and dihydrocodeine. F states that these were prescribed to treat the pain of the fracture. I have no reason to think that is inaccurate. However, it must be confronted that in this period the tests show positives for cannabis, likely to have been on a daily basis having regard to F's own account, cocaine, the prescription painkillers I have mentioned and also for zopiclone (not to be used with alcohol). M's statement supporting her application for a Non-Molestation Order, regarding F's behaviour also cover this period. Even on F's account, there were certainly heated arguments between the couple in this period. M was also drinking excessively and periodically using cocaine. The pathology, discussed below, illustrates why this period is particularly significant.

14. Before I turn to the post-mortem findings, it is important that I consider the parental dynamic. What is striking is the high level of agreement which exists between the couple as to their respective functions in the home. This I find to be secure evidence upon which I can confidently place weight. In her evidence, M was manifestly keen to minimise F's violent behaviour in the early weeks of R's life. She struck me as keen to portray him in a favourable light. Interestingly, however, she gave a description of F's role in the family that, objectively, most people would, these days, consider to be critical. M's account was entirely free from criticism. It was a non-judgmental

description of family life as she experienced it with F. Strikingly, F agreed with the description entirely, also without any apparent sense of the unfavourable light in which it inevitably cast him. Ms Irving KC, on behalf of F, enquired whether F was *"a hands-on dad"*. M said no, he wasn't. She described him as *"more of a hands-off dad"*. She told me F left the house early in the morning, worked all day as a roofer and dedicated most, frequently all of, Saturdays to football and his teammates. He took no part at all in caring for the children, feeding them, entertaining them or helping in any way with their general welfare. M told me, I am bound to say, somewhat unconvincingly, that F had occasionally changed R's nappy. Though M was looking after the house, preparing the meals and caring for three children under 5, it never seemed to occur to either of them that F might help out domestically in some way. M accepted, without criticism, that feeding R in the night and attending to him was entirely her responsibility. There was not even a whiff of resentment towards the father in the description of this routine. This was simply a description of her normal everyday life which she accepted.

15. F agreed with all the above. He told me, with no sense of irony, that he had initially tried helping with A but it was obvious to him that M was much better at it and thereafter he left it to her. Though in the tragic circumstances of this case, I place no emphasis upon it, I nonetheless record that at no point did the character and personality of any of these children find its way into the evidence. Neither party suggested that the introduction of a third child into the house had added to M's burden. F, who has been critical of the mother's drinking, has never suggested, at any stage, that her care of the children or her attention to domestic routine was in any way deficient. I had a strong sense that this was important to him. I also consider that he would not have held back had he considered M to be falling short in either respect. The arguments between this couple, always fuelled by drink, focused on their jealousy of each other's independence. M complains of F inveigling his way into each corner of her life, repeatedly checking up on her with his embarrassingly frequent telephone calls. F accepts this. However, M also resents F's time away from her with his teammates on Saturdays. It is also important to note that M was not unsupported in her care of the children but was able to call upon significant help from her mother and sister. The care proceedings relating to A were properly predicated on the children's exposure to parental domestic violence. Neither parent strikes me as having shown any real insight into the emotional impact of such exposure. There is, however, no suggestion that there was physical harm to or neglect of A. Nor is there any suggestion that home conditions were poor.

<u>The post-mortem findings</u>

16. The post-mortem took place on the 1st June 2022. It was conducted by Dr Armour, Home Office Pathologist and Dr Annavarapu, Consultant Histopathologist. Properly and pursuant to the order of HHJ Bancroft, Dr Fonfé, Consultant Paediatrician, prepared an independent report. Dr Armour and Dr Annavarapu gave evidence before me (by video link). Though Dr Fonfé was scheduled to give evidence, she was, ultimately, not called.

17. Dr Armour considered that the likely cause of R's death, though it could not be ascertained pathologically, was as a result of overlaying. At the pre-hearing review before me, M conceded that overlaying was the inevitable finding on the evidence. It is important to say that I consider that concession is not merely a sensible evaluation of the medical evidence but a true recognition, on her part, of what has happened. When I asked Mr Jones KC, on behalf of M, at the PHR, whether the cause of death was actively contested, he was able to take instructions from M very quickly. I am confident that she has recognised how R came to die for some considerable time but had struggled to articulate it in these proceedings. She is suffused with guilt and remorse.

18. Dr Armour sets out, in her report, the fractures to R's anterior left and right ribs. These were sustained in a forensic window between 12 and 24 hours before death. They are consistent with CPR/resuscitation attempts. However, callus formation, which was visible to the naked eye, indicated a fracture to the posterior right fourth rib. This was confirmed histologically as an osteocartilaginous fracture, near to the osteochondral junction. Recent haemorrhage was identified within the fracture, which was consistent with refracturing at around 12-24 hours prior to death. It is important to record the following passages of the report:

> *"The circumstances in this case raise the possibility of overlaying as a cause of death. Deaths due to overlaying occur as a result of an adult or older sibling overlaying the body of the baby which affects the baby's ability to breathe. This gentle occlusive force applied to the body of the baby can occur to the nose and or mouth preventing air entering and leaving the lungs or over the chest/abdominal area affecting respiratory effort or indeed a combination for both. This causes an asphyxial type death – asphyxia meaning deprivation of oxygen. Signs of asphyxia include petechial haemorrhages which for the most part in cases of overlaying are either absent or few. The respiratory obstruction caused by the overlaying process can also produce bleeding from the nose and or mouth and within the lungs.*
>
> *Bleeding within the lungs is also known as intra-alveolar haemorrhage which was present in this case but in my opinion was not present to a significant degree. Therefore, although the circumstances do raise the possibility of overlaying as the cause of death in this case, in my opinion there is insufficient evidence for me to be sure and for this cause of death to be properly established. However, it is well known that intra-alveolar haemorrhage can be absent in cases of overlaying. Deaths due to overlaying have an increased association with alcohol and/or drugs in the adult sharing the bed with the baby. This latter statement is based on my experience. I have*

> *also considered suffocation – either deliberate or accidental as a cause of death in this case. However, no marks or injuries were noted to the baby's face, to the under surface of the skin of the face, to the back of the throat or to the upper airways. Therefore, there is no evidence to support this view but it should be noted that cases of suffocation of a baby as young as this can produce no sign/signs. The autopsy identified the presence of ischaemic hypoxic change within the brain consistent with this baby suffering cardiorespiratory arrest and a downtime of 1 hour 25 minutes before his circulation was re-established.*
>
> *Therefore, the ischaemic hypoxic change within the brain is secondary to the cardiorespiratory arrest that he suffered. There were multiple anterior rib fractures involving right ribs 3, 4 and 5 along with anterior rib fractures to left ribs 2, 3, 4 and 5 in my opinion consistent with attempts to resuscitate this baby. Additionally, a single posterior rib fracture was identified to the right 4th rib with a callous clearly identified to the naked eye at the time of autopsy and identified just lateral to the vertebral column at the costovertebral angle. Histological examination of this fracture did indeed confirm the presence of an old/previous fracture with this aged between 3 – 6 weeks. Therefore, it is my opinion that this fracture would be inconsistent with being caused by birth trauma as baby [R] was 11 weeks of age at the time of his death. Posterior rib fractures require a significant degree of force to inflict and are caused by a forceful side to side chest compression and are associated with forceful gripping/squeezing of the chest. In my opinion this injury would be consistent with a non-accidental injury. As it is however a single posterior rib fracture this clearly did not cause the death of baby [R] nor did it contribute to it. It was inflicted in life and would have caused pain and suffering."*

19. As is clear and consistent with established medical opinion, Dr Armour considers the fracture, given the age of the baby, would have required significant force with side-to-side chest compression. This would also have been associated with squeezing or gripping forcefully. Mr Jones explored the possibility that it might have occurred in an earlier incident of overlaying, given that both parents volunteered that, despite advice, they had regularly co-slept with R. Dr Armour could not regard this as likely. She considered it implausible but did not discount it as impossible. There was ultimately no supportive history to the theory and she was very clear that the side to side and significantly forceful chest compression required was far more strongly indicative of non-accidental injury.

20. In his evidence, Dr Annavarapu confirmed the older posterior right fourth rib refracture. He also confirmed the broader pathological findings, which I need not repeat. He was clear that the posterior rib fracture would be regarded as being consistent with non-accidental injury. Dr Annavarapu emphasised that he had spent significant professional training time with Professor Mangham who has, in other cases, found it *"conceivable that side to side compressive forces might be delivered by severe chest compression due to co-sleeping"*. However, whilst very much respecting Professor Mangham's views, Dr Annavarapu pointed out that those conclusions, in a very limited number of cases, were predicated on a clear factual premise that let in such a possibility. Dr Annavarapu could see no such factual foundation here and remained clear that the most likely cause of the earlier rib fracture was a non-accidental injury sustained by the mechanism set out.

21. A further possible explanation was explored, advanced by M and maternal grandmother, Mrs C. With respect to both of them, I did not find this alternative account entirely clear or coherent. The essence of it was that whilst R was in his baby bouncer, supervised by his grandmother, J fell on top of R, which caused the bouncer to come to the floor, the suggestion being that it generated side to side chest compression. The mother states that she heard a clear cry of pain which was sufficient to indicate to her that something serious had happened. However, both women were clear that R had recovered quickly and showed no evidence of pain, when minutes later, his football shirt was taken off and changed. Quite why it was necessary to change his shirt, neither was clear. The kind of fracture being considered here would have, according to the consensus of the medical evidence, generated considerable pain which was not described. If I may say so, I think this incident was rooted in a real event but, even in the way it was recounted by M and grandmother gave me a strong impression that both of them felt it to be grasping at straws. Dr Fonfé rejects the explanations for the fracture aligning herself with the views of Armour i.e., significant compressive squeezing mechanism with the adults' fingers pressed against the ribs alongside R's spine. Dr Fonfé notes that posterior ribs are more difficult to fracture because they are intrinsically more stable as they are up against the vertebra. She goes on to state that, when lying down, the spine cannot be pushed forwards or the ribs pushed over the transverse spinous processes because the bones are aligned and there is nowhere else for them to go. In explicit terms, she discounts both the fall in the bouncy chair and an injury in the course of overlaying as implausible.

22. As Ms Bowcock and Mr Hart submit in their final submissions, *"the evidence of the three experts in respect of overlay as a cause of the posterior rib fracture was practically identical … they amounted to three slightly different ways of expressing the prudent medical maxim 'never say never'"*. I agree.

<u>The psychological reports</u>

23. Although this hearing is concentrated on this single fact-finding issue, it is a combined hearing, in which I am being asked to endorse the care plan. For this reason, it is important that I consider the evidence of Dr Hellin, which provides a characteristically detailed and insightful analysis of the psychological functioning of

each of the parents. I take it into account in my scrutiny of the proposed plan. For the avoidance of doubt, I do not draw upon it to identify any psychological propensity towards violent behaviour. In respect of M, Dr Hellin makes the following observations:

> *"A chronic history of anxiety manifesting from childhood as generalised anxiety and periodic panic attacks.*
>
> *In childhood, [M] was repeatedly exposed to adult conflict and violence.*
>
> *As such, she lived in a state of heightened anxiety through her formative years and this has become a permanent adaptation.*
>
> *[M]'s PAI and her account of her emotional and relationship patterns suggest that she has some traits of borderline or emotionally unstable personality disorder. This is shown by extreme and labile mood with outbursts of emotion; poor emotional and behavioural control as shown by self-harm, both deliberate self-harm but also self-destructive and self-defeating behaviour more generally; intense, ambivalent and unstable intimate relationships; and a lack of sense of self as shown by difficulties in knowing one's aims, preferences, along with chronic feelings of emptiness and a susceptibility to influence.*
>
> *The relationship between [M] and [F] has been volatile, characterised by mutual provocation and his physical violence, intolerable separations and desperate reconciliations."*

24. Dr Hellin concluded the following in relation to F:

> *On the PAI, [F]'s main elevations were in the area of interpersonal conflict, aggression and emotional lability. He described a number of problematic personality traits. Accordingly, I have considered whether he would meet criteria for an antisocial personality disorder with reference to Diagnostic and Statistical Manual, Version 5 (2013). He meets some of its criteria: he has failed to conform to lawful or culturally normative ethical behaviour as shown by his criminal activity and interpersonal violence. He has been dishonest and hostile, sometimes using violence instrumentally to achieve an outcome (to silence [M] or to get her to listen to him, A5.3, A5.17). He is impulsive and prone to self-destructive behaviour including substance use, alcohol*

excesses and gambling. However, I did not find him to be lacking in empathy, unable to form mutual intimate relationships, meal manipulative in the terms of the criteria for antisocial personality disorder or habitually deceitful or callous. Taken together, I do not believe that he meets criteria for an antisocial personality disorder though he has antisocial personality traits.

[F] is likely to become aggressive if he feels thwarted, disregarded, undermined, unheeded. He has used violence to silence people and make listen to him but also to drive them away. As a child, he was aggressive in the absence of substances. In adult hood, his violence has been elicited by a combination of intoxication and provocation. He believes that provocation alone would not be enough to cause him to be violent. His use of alcohol and/or using drugs distort his perspective and make him more interpersonally sensitive, paranoid and inclined to misperceive and overreact to interpersonal situations. [F] risk of violence is increased by drug and alcohol use so his incomplete honesty about his substance abuse and his violence is a risk factor too.

I conclude tentatively that when it matters enough to [F], he can bring his behaviour under control but there have been times that a more prudent person would have done so and he has not. If the court accepts his contention that he has not used any drugs since 24 July 2022 (notwithstanding the hair strand test results which suggest he has used cannabis), and that he has drunk alcohol only in moderation, it appears that he has begun to make some of the necessary changes by which to manage his tendency to aggression and violence.

[F]'s tendency to aggression, drug use and alcohol excesses, his impulsivity and tendency to self-defeating behaviour are not well explained by his formative experiences in childhood which were broadly positive. No one else in his family appears to have similar difficulties or any other problems with substance use, mental health or criminality. In the absence of a clear formulation regarding the origins of [F]'s difficulties, risk management relies on his management of causal and contextual factors; drug abstinence, alcohol abstinence or moderate drinking and the ongoing use of emotional regulation strategies.

He is back at work which gives him structure and purpose and he plays football which greatly helps him as a way of

> *discharging his feelings and being with others in an undemanding way. He is not involved in any formal therapy. I do not suggest that he should have therapy unless he decides that this is something that he wants".*

25. On 20th May 2021, F was convicted of an offence of Battery. He accepted in the witness box that the facts of that offence were primarily based on his 'strangulation' of M. He received a 12-week suspended prison sentence for this offence. F also accepted that the two further allegations of strangulation made by M in the Non-Molestation application are true. Explicitly, therefore, he has accepted three separate incidents of strangulation of M. The Criminal courts have come to understand the significance of this particular type of offending. The Stand Up to Domestic Abuse (SUTDA) survey into the effects of non-fatal strangulation (NFS) made the argument that it should be become a stand-alone offence.

26. Section 70 Domestic Abuse Act 2021 (DA Act 2021) introduced the offences of non-fatal strangulation and non-fatal suffocation. Schedule 2, paragraph 4 DA Act 2021 introduced the offence of racially or religiously aggravated non-fatal strangulation or non-fatal suffocation. The offences came into force on 7th June 2022 and are not retrospective. The summary report on data collected from SUTDA survey emphasised the following:

> *"Intimate Partner Homicide (IPH) has a strong relationship to domestic abuse and coercive control and international research has established that there are certain characteristics of domestic abuse or what are called 'high risk markers' that are especially strongly associated with future homicide and serious harm. Any kind of strangulation is one of the strongest markers. Research has shown that this increases the risk of homicide by eight times. This is not simply because NFS could 'accidentally' end as homicide, but because people who use strangulation are more dangerous."*

27. The impact on victims also needs to be fully understood:

> *"NFS is also associated with severe trauma in its victims and is in fact experienced as a real threat to life. Victims of it report not only that it is incredibly painful, but it is also an experience of potential death. Perpetrators of NFS very often have this as their motivation. It is a particularly traumatic, and because of this an effective, way to exert the ultimate control and leave the victim in no doubt that their life has been threatened. It would be a mistake to think that NFS is a spontaneous and angry assault, it is more likely to be a controlled and determined threat."*

28. These offences are triable either way. A person found guilty is liable on summary conviction to imprisonment for a term not exceeding 12 months, or a fine, or both and on conviction on indictment to imprisonment for a term not exceeding 5 years or to a fine, or both. In ***R. v Cook*** **[2023] EWCA Crim 452; [2023] WLR(D) 376],** the Court of Appeal set out the approach to sentencing in strangulation cases.

29. This authority is clear that, in light of the conduct inherent in the offence, a custodial sentence will be appropriate, save for in exceptional circumstances. This should ordinarily be one of immediate custody, with a starting point of 18 months imprisonment. The Court identified the following, non-exhaustive, factors which will increase the starting point:

    i. history of previous violence (the significance of the history will be greater when the previous violence has involved strangulation);
    ii. presence of a child or children;
    iii. attack carried out in the victim's home;
    iv. sustained or repeated strangulation;
    v. use of a ligature or equivalent;
    vi. abuse of power;
    vii. offender under influence of drink or drugs;
    viii. offence on licence;
    ix. vulnerable victim;
    x. steps taken to prevent the victim reporting an incident; and
    xi. steps taken to prevent the victim obtaining assistance.

30. I have made reference to these provisions because I consider that they require to be far more widely known and understood by family law practitioners. I am also signalling the extent to which I consider M to be vulnerable in this relationship. I regard her as being in danger.

31. F has certainly curtailed his use of cannabis very drastically and, I accept, now consumes alcohol less frequently. However, he does still occasionally use alcohol to excess. M continues to drink at plainly problematical levels. The dynamic of the couple's relationship, which Dr Hellin has described, when coupled with high alcohol consumption by both, generates what, in my judgement, is a dangerous and volatile situation. Dr Hellin has identified mutual abstinence from drink and drugs as prerequisite to any significant shift in the couple's dysfunctional behaviour. In the witness box, I confronted F with the seriousness with which I regarded the strangulations, in at least one of which M describes a temporary loss of consciousness. In very simple and direct terms, I distilled the research set out above for F to confront. He engaged with the questions directly, accepted the premise of them and acknowledged, with no hesitation, the dangerousness of his behaviour, as well as its potential consequences. It struck me that he had thought about these issues before.

32. Having come to the clear conclusion that the posterior rib fracture was non-accidental; it is necessary to scrutinise the evidence to see whether the likely perpetrator can be identified. The Local Authority and the children's Guardian submit that the evidence does not support a finding to the requisite standard of proof i.e., the balance of probabilities. In her measured presentation of the case, Ms Bowcock put questions to both M and F, advancing those features of the evidence which implicated each of them as the likely perpetrator. In their closing submissions, the Local Authority emphasised that propensity for abusive behaviour in the context of drug and alcohol abuse is not sufficient *"to pick a way through to a finding that [F] was the perpetrator"*.

33. As I have foreshadowed at para. 12 et seq., there are a number of evidential features which point towards F as the likely perpetrator. Most notably, in the forensic window within which the fracture was sustained, there was a significant change in the family's circumstances. For an extended period, F was at home, all day, due to breaking his wrist in a footballing injury. It deprived him of the outlet of work, as a roofer, which is manifestly important to him. It prevented him playing football, training and the associated activities, which Dr Hellin indicates are integral to his sense of general wellbeing. Two key stabilising factors in his life had therefore been lost to him. Furthermore, the day-to-day dynamics of the household had transformed as the couple was effectively thrust together. As I have stated, the test results reveal that F was drinking heavily and smoking an extensive amount of cannabis. He was also taking pain relief and Zopiclone (prescribed for insomnia). M was also drinking heavily and using cocaine. If M's statement in support of her application for a Non-Molestation Order is to be read at face value, there is, at very least, a continuation of controlling and violent behaviour by F in this period. Given the clear interrelationship of drugs and alcohol with F's violent behaviour, identified by Dr Hellin, I consider this likely to be true. In her evidence, whilst M stands by the allegations she makes in the statement dated 22nd June 2022, she contends that she had got the dates wrong and that the behaviour she describes had not continued, following R's birth. The statement does not permit of any ambiguity and with little hesitation I consider it to be reliable. Moreover, I note that M describes F's behaviour as *"deteriorating"*:

> *"We notified the local authority* [i.e., of the birth of R]*, and we underwent a child and family assessment in March 2021. Both [F] and I were working with the Local Authority at that time and had a safeguarding plan in place and strategies to manage potential or any conflict.* ***Subsequent to this, [R] was born on 11th March 2022****.*
>
> ***Following this time, [F]'s behaviour continued to deteriorate. (my emphasis)***
>
> *[F] has controlled me throughout. He is derogatory and will call me names, saying that I am stupid and thick. [F] does not believe that he is a risk to me or to the children. He minimises*

> *all of the concerns that the Local Authority have raised and has previously not engaged in the Building Better Relationships Course. He will say that he is a good dad and sees no reason why we cannot continue to be together."*

34. The degree to which F disengaged entirely from R's care and indeed from the care of the two older children is striking. Perhaps what is most unusual is his obvious inability to see any parental shortcoming in this. He made absolutely no attempt, as some fathers do, to amplify or exaggerate his role, he had plainly decided that practical parenting, of any kind, was not his responsibility. He delegated that, he told me in evidence, to M whom he considered *"was good at it"*. M told me, when asked, that she thought F had *"sometimes changed a nappy"*. I am bound to say that I found even that rather unconvincing. F, in response to Ms Bowcock's questioning, as to how he had adjusted his own life following the birth of R, responded, *"I don't stay at the pub as long"*. He was not, in any way, being flippant or discourteous. In my assessment, he was genuinely trying to answer the question. But the poverty of his response is telling. I am afraid I am also bound to say, again, that in any event, the evidence does not support even this limited assertion. The fact is that F did not change his lifestyle in any way to accommodate a new baby, even though he was at home all day. I recognise that his injury would limit what he could do but it was far from completely disabling. I have noted above, for example, that though he could not actively participate in roofing, he went back to work, in a limited capacity, earlier than he needed to or perhaps ought to have done. M seems to have accepted F's role without rancour or resentment. Certainly, as she recounted F's very limited involvement, she portrayed no hostility towards him. That he was, as Ms Irving put it, *"a hands-off dad"* is entirely uncontentious. I do not doubt that F was delighted to have a son and distraught by his death but there is a vacuum in his insight and emotional responses to the responsibilities and privileges of fatherhood. M's relationship with R was of an altogether richer and more intuitive complexion.

35. Whilst propensity for abusive behaviour, whether identified in psychological assessment, or predicated on previous behaviour, does not permit, without more, a conclusion that F was most likely to have inflicted the injury. Dr Annavarapu emphasised that which each of the experts agrees, namely that a posterior rib fracture requires both forceful and side to side chest compression which would be far in excess of normal handling. What requires to be confronted is whether or to what extent, F's violent behaviour is incorporated into the broader evidential canvas which requires to be considered when identifying a likely perpetrator.

36. Though she has had responsibility for the practical parenting of three children, there has been no suggestion, by anybody, that M has lost patience with or handled any of her children roughly. F has described M as a loving, attentive, caring parent. The elder child is five, the younger is three. There has been no allegation that M has hurt either of them or has failed in any aspect of their practical care. M also has backup and support from her own mother. There is no report of M having been violent to F or indeed to anybody else. Perhaps inevitably, in the light of what I have said above, any

insight into the children's lives comes from M's evidence. It is pertinent to note that M spoke movingly and spontaneously about R's temperament and nature. She told me he was *"always such a good baby"*. She found him easy to care for. She was very much aware that he was *"very mummy"*, as she described in her statement. She talked about how R would follow her with his eyes. She said he could sometimes be "quite clingy" with her. Dr Hellin, in her report, considers that M is very resistant to any compliment, indeed, she recoils from them. Nonetheless, it is important that she hears that I consider that the evidence amply establishes that she had an instinctive and intuitive understanding of both R's physical and emotional needs. There was manifestly a healthy bond between mother and child.

The Legal Framework

37. For many years, the judgment of Wall J (as he then was) in ***CB and JB (Care Proceedings: Guidelines)*** **[1998] EWHC Fam 2000**: **[1999] 1 WLR 238**, has stood as a citadel, guiding the approach to the admission of evidence, likely to be relevant in establishing contested identified facts (i.e., 'fact finding hearings'). Some of that judgment's footings have crumbled, a little, over the years. The *"ex hypothesi"* assumption that *"capacity to parent children"* can only commence after a clear factual substratum has been identified in a 'split hearing', no longer carries with quite the same emphasis. Wall J also identified, as part of the *"lessons to be learned"*, how the Court should approach evidence of 'propensity'. He stated:

> *"(v)* ***Evidence of propensity or a psychiatric or psychological assessment of one of the parties is unlikely to be of any assistance in resolving a purely factual issue*** (my emphasis). *There will in any event be before the court evidence from the local authority and the parents relating to the history of the case and the backgrounds of each of the parents. A psychologist or psychiatrist instructed to undertake an assessment of a parent for the first stage of a split hearing is unlikely to have a complete knowledge of the facts.*

38. Wall J went on to say:

> *(vi) Furthermore, such a witness may, as here, express opinions as to propensity or as to responsibility for a child's injuries which are both prejudicial and wrong. The assessment of adult credibility as to the responsibility for a child's injuries (often the critical factual issue) remains the function of the judge. In my judgment, therefore, a psychiatric or psychological assessment of the parties should not be permitted at the first stage of a split trial unless the particular facts of the case demonstrate that such evidence is or is likely to be directly relevant to the factual issue to be tried.*

39. It is important to emphasise that Wall J went no further than saying that propensity evidence was *"unlikely"* to be of any assistance in resolving a purely factual issue, he did not exclude it. Too frequently, the dicta in Re CB and JB (supra) have been interpreted as a complete prohibition on reliance on propensity evidence in fact-finding hearings. This is a misconstruction. Propensity evidence has a long-established place in the criminal law of England and Wales. Indeed, the criminal law has moved towards greater admissibility of propensity evidence in the years following Wall J's judgment. In ***R. v Hanson*** **[2005] EWCA Crim 824: [2005] WLR 3169,** the Vice President, Rose LJ observed:

> *[7] Where propensity to commit the offence is relied upon there are thus essentially three questions to be considered:*
>
> 1. *Does the history of conviction(s) establish a propensity to commit offences of the kind charged?*
>
> 2. *Does that propensity make it more likely that the defendant committed the offence charged?*
>
> 3. *Is it unjust to rely on the conviction(s) of the same description or category; and, in any event, will the proceedings be unfair if they are admitted?*

40. Rose LJ went on to analyse the scope of admissibility:

> *[8] In referring to offences of the same description or category, section 103(2) is not exhaustive of the types of conviction which might be relied upon to show evidence of propensity to commit offences of the kind charged. Nor, however, is it necessarily sufficient, in order to show such propensity, that a conviction should be of the same description or category as that charged.*
>
> *[9] There is no minimum number of events necessary to demonstrate such a propensity. The fewer the number of convictions the weaker is likely to be the evidence of propensity. A single previous conviction for an offence of the same description or category will often not show propensity. But it may do so where, for example, it shows a tendency to unusual behaviour or where its circumstances demonstrate probative force in relation to the offence charged (compare DPP v P [1991] 2 AC 447 at 460E to 461A). Child sexual abuse or fire setting are comparatively clear examples of such unusual behaviour but we attempt no exhaustive list. Circumstances demonstrating probative force are not confined to those sharing striking similarity. So, a single conviction for*

> *shoplifting, will not, without more, be admissible to show propensity to steal. But if the modus operandi has significant features shared by the offence charged it may show propensity.*

41. The Supreme Court considered the circumstances in which propensity evidence might be established in ***R v Mitchell*** **[2016] UKSC 55; [2017] AC 571.** Lord Kerr addressed the issue thus:

> *"Propensity - the correct question/what requires to be proved?*
> *39. A distinction must be recognised between, on the one hand, proof of a propensity and, on the other, the individual underlying facts said to establish that a propensity exists. In a case where there are several incidents which are relied on by the prosecution to show a propensity on the part of the defendant, is it necessary to prove beyond reasonable doubt that each incident happened in precisely the way that it is alleged to have occurred? Must the facts of each individual incident be considered by the jury in isolation from each other? In my view, the answer to both these questions is "No".*
>
> *43. The proper issue for the jury on the question of propensity… is whether they are sure that the propensity has been proved. ... That does not mean that in cases where there are several instances of misconduct, all tending to show a propensity, the jury has to be convinced of the truth and accuracy of all aspects of each of those. The jury is entitled to - and should - consider the evidence about propensity in the round. There are two interrelated reasons for this. First the improbability of a number of similar incidents alleged against a defendant being false is a consideration which should naturally inform a jury's deliberations on whether propensity has been proved. Secondly, obvious similarities in various incidents may constitute mutual corroboration of those incidents. Each incident may thus inform another. The question ... is whether, overall, propensity has been proved.*
>
> *44. ... the jury should be directed that, if they are to take propensity into account, they should be sure that it has been proved. This does not require that each individual item of evidence said to show propensity must be proved beyond reasonable doubt. It means that all the material touching on the issue should be considered with a view to reaching a conclusion as to whether they are sure that the existence of a propensity has been established."*

42. I refer to the judgments above not to suggest that the approach set out in the criminal jurisdiction is to be imported, in an identical manner, into the fact-finding process in family proceedings in precisely the same way (plainly, they cannot be), but merely to demonstrate that which I consider to be an essentially self-obvious proposition i.e., that if propensity evidence is potentially admissible in criminal law proceedings, it would be entirely illogical to exclude it from consideration in investigative proceedings in the family court. Moreover, and with the greatest diffidence and respect for Wall J, the starting point for consideration of the relevance of such evidence should not be hampered or distorted by a presumption that such evidence is *"unlikely"* to be of assistance. It will depend on the facts of the individual case.

43. Propensity evidence is, primarily but not exclusively, a criminal law construct which, in simple terms, adopts the reasonable proposition that where an individual has been proved to have behaved in a particular way in the past, it is more likely that they might behave in that same way again. The evidential framework, governing admissibility of propensity evidence, in a criminal trial, predicated on the criminal standard of proof, is very different from that in an essentially investigative process in family proceedings. In the Family Court, the Judge will, invariably, be scrutinising a broad evidential landscape. Where the lodestar for the Court's approach is the paramountcy of the child's welfare, a very wide category of evidence will fall for consideration. This will include hearsay evidence, be it first or second hand, in documentary format or in oral evidence. It will also include expert opinion evidence. The standard of proof is, of course, the civil standard, requiring facts to be proved on the balance of probabilities. As Lord Brandon of Oakbrook said in ***The Popi M, Rhesa Shipping Co SA v Edmunds, Rhesa Shipping Co SA v Fenton Insurance Co Ltd*** **[1985] 1 WLFR 948; 956,** this is a test to *"be applied with common sense"*. Lady Hale makes the same point in ***Re B (Children) (Care Proceedings: Standard of Proof) (CAFCASS intervening)*** **[2008] UKHL 35; [2009] 1 AC 11**:

> *"[31] My Lords, if the judiciary in this country regularly found themselves in this state of mind, our civil and family justice systems would rapidly grind to a halt. 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."*

44. All of this applies with equal rigour to the obligation upon the Judge to identify not only harm that may have been sustained by a child but the likely perpetrator of that harm. The exercise is a parallel one and, for the reasons that Lady Hale has identified in the passage above, the obligation on the Judge every bit as exacting. There will, inevitably, be cases where the identity of the perpetrator will be uncertain. Paradigmatically, injuries to a child occur in the hands of a parent or carer. Section 31(2) of the Children Act 1989 requires the court to focus not only on the significant harm sustained by the child but on its attributability. Inevitably, within the home environment, there are unlikely to be witnesses. The investigative process must track down ascertainable facts from the broadest canvas available and, where possible, draw such inferences as those facts will support. It is frequently a difficult task, but it is not one that can be shirked. The danger in failing to confront it is that an innocent individual may be tainted by a finding that has a direct impact, both on her and on the child. A finding which leaves a parent in a pool of potential perpetrators is likely to adversely influence the nature and extent of the contact arrangements or indeed, on where and with whom the child will live in the future. Of course, the imperative of child protection must not generate a reason to burden unsatisfactory evidence with a greater weight than it can legitimately support. That would create injustice to all, not least the subject children, but neither does it absolve the Judge of the responsibility to confront the findings that the evidence properly establishes. The same obligation for forensic rigour applies to the lawyers.

45. The above principle is established with absolute clarity in ***Re SB (Children) (Standard of Proof)*** **[2009] UKSC 17** at para 34, per Lady Hale:

> *"[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."*

46. As Lady Hale makes clear, Section 31(2) mandates attributability in careful terms:

> *"(2)A court may only make a care order or 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—*
>
> *(i)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; or*
> *(ii)the child's being beyond parental control."*

47. As Lady Hale notes, there is no requirement imposed on the Judge to identify a perpetrator nor should the 'paramountcy principle' mesmerise the Judge into straining to identify a perpetrator where the evidence does not permit of it:

> *"[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."*

48. The benefits in making a finding are also analysed:

> *[36] There are particular benefits in making such a finding in this context, especially where there is a split hearing. Miss Frances Judd QC, on behalf of the children's guardian in this case, has stressed that the guardian would rather have a finding on the balance of probabilities than no finding at all. There are many reasons for this. The main reason is that it will*

> *promote clarity in identifying the future risks to the child and the strategies necessary to protect him from them. For example, a different care plan may be indicated if there is a risk that the parent in question will ill-treat or abuse the child from the plan that may be indicated if there is a risk that she will be vulnerable to relationships with men who may ill-treat or abuse the child.*
>
> *[37] Another important reason is that it will enable the professionals to work with the parent and other members of the family on the basis of the judge's findings. As the Court of Appeal said in Re K (Non-Accidental Injuries: Perpetrator: New Evidence) [2004] EWCA Civ 1181, [2005] 1 FLR 285, at para 55: "It is paradigmatic of such cases that the perpetrator denies responsibility and that those close to or emotionally engaged with the perpetrator likewise deny any knowledge of how the injuries occurred. Any process, which encourages or facilitates frankness, is, accordingly, in our view, to be welcomed in principle." Often, it is not only the parents, but the grandparents and other members of the family, who may be the best resource to protect the child in the future but who are understandably reluctant to accept that someone close to them could be responsible for injuring a child. Once that fact is brought home to them by a clear finding based upon the evidence, they may be able to work with the professionals to keep the child within the family."*

49. The Supreme Court also noted, without any additional comment, the observations of Wall LJ in ***Re K (Non-Accidental Injuries: Perpetrator: New Evidence*) [2004] EWCA Civ 1181, [2005] 1 FLR 285:**

> *"[56] As a second background proposition, we are also of the view that it is in the public interest that children have the right, as they grow into adulthood, to know the truth about who injured them when they were children, and why. Children who are removed from their parents as a result of non-accidental injuries have in due course to come to terms with the fact that one or both of their parents injured them. This is a heavy burden for any child to bear. In principle, children need to know the truth if the truth can be ascertained."*

50. Although described by Wall LJ as a "background proposition" in terms of the reasoning within the judgment, it, to my mind, focuses on a fundamental facet of the rights of the child.

51. In ***CB and JB***, Wall J was considering one facet of propensity evidence, namely, an identified predisposition to behave in a particular way, predicated on psychiatric or psychological assessment, as opposed to ascertainable facts or reasonable inferences. The danger inherent in such evidence is now entirely recognised. As Wall J made clear, this opinion evidence, might easily be both prejudicial and wrong. Moreover, it trespasses on the function of the Judge in the assessment of adult credibility as to the responsibility for a child's injuries. This is, of course, entirely different from evaluating propensity generated by evidence of established behaviour.

Identification of the perpetrator

52. Ms Bowcock and Mr Hart submit that F's *"propensity for abusive, violent, controlling behaviour, in the context of drug and alcohol abuse is, however, not sufficient to pick a way through to a finding that he was the perpetrator"*. Ms Probert, acting on behalf of the children, arrives at the same conclusion. I have given their submissions great thought. Neither parent has been able to accept the medical evidence in relation to the likely cause of the posterior right rib fracture. Neither has stated that if the fracture was not accidental, it must have been the other parent who caused it. It had been asserted that F would not have been able to cause the injury because his wrist and hand was in a plaster cast. That was not, ultimately, pursued, nor could it sensibly have been for the reasons discussed below. Ms Irving and Mr Jones, in their closing submissions, have remained, appropriately, true to their clear instructions.

53. The unusual feature of this case is that the cause of R's death is not in dispute. The acceptance of this, and their responsibility for it, has enabled both parents to grieve to a degree which continuing involvement in contested proceedings sometimes inhibits. The grief of both is visceral and raw. I have no doubt that they loved R greatly. The intensity of their sadness has been almost palpable during this hearing. It has been navigated by the experienced advocates with sensitivity and skill. However, the force of it causes me to draw back from any evaluation of their demeanour. In their heightened emotional state, it would be forensically dangerous and, ultimately, unfair to them to seek to draw any inferences from the manner of their responses or general presentation.

54. I have set out the law in such detail above because, ultimately, I do not agree that this is a case where the evidence does not support a finding as to likely perpetrator. My conclusions have, to some degree, been foreshadowed. However, they require to be repeated in the context of the applicable law.

55. The fracture to the fourth posterior rib was an isolated injury. There are no other unexplained injuries and most particularly, none of the 'harbinger' injuries that indicate a carer who was failing to cope more generally. There is, for example, no evidence of a torn frenulum, no account of any earlier bruising, no other identified fractures.

56. All agree that R was a placid baby. Both parents said that he was easy to care for. On this point, I can say that their descriptions were spontaneous, guileless, and consistent with wider family and professional observations. Given that M undertook nearly the entirety of R's care, R was, unsurprisingly, observed to be most comfortable with his mother. It was she to whom he turned for comfort. There is no suggestion, within the evidence, that M was under stress in her day-to-day care of R. Despite her longstanding challenges with alcohol dependency, M has been functional. All this evidence points to M having the same strong and instinctive bond with R that she has with the older children. Whilst a strong bond by no means excludes the possibility of causing a non-accidental injury, it is a recognised contraindicator.

57. The single fracture to the fourth posterior rib is manifestly, as the medical evidence indicates, an isolated incident. It signifies a loss of control where an obviously excessive degree of force was used. It required a forceful side-to-side chest compression *"far in excess of normal handling"*, as was the consensus of medical opinion. Dr Fonfé, Paediatric Consultant, considered:

> *"The mechanism is forceful squeezing with the thumbs on the front of the chest and the fingers pressed against the ribs along the spine."*

58. It is beyond dispute that in the period identified as a window for causation of this earlier fracture, F was, atypically, at home during the day. Though, as mentioned above, it was insinuated that he could not have caused the injuries because he was wearing a plaster cast covering his hand and wrist at the time, this had, in fact, been replaced, after a few days, by a modest splint which, as he agreed in evidence, permitted him to use his fingers freely to the extent that he drove a car and undertook some light duties at work. I noted when this was put to him in cross examination, he yielded to it without any prevarication.

59. F enjoys his work, as a roofer, and works hard. It is equally clear that he enjoys his football, both playing and following his team. Both these provide his life with ballast. In the period in which R's fracture was sustained, this ballast was no longer available to him. There was a very significant change in the family's routine. It is a fact that F smoked a lot of cannabis in this period and drank excessively. It is also the case that he used other drugs e.g., cocaine. In her application for a non-Molestation injunction, M stated that he was violent and aggressive towards her at this time. She resiles from that to a limited degree, in that she now says that she cannot remember whether F was violent after the birth of R. I do not accept the change in her evidence as reliable. I find it far more likely that the detail of her statement, filed in support of the injunction, is accurate and, given this couple's history, the drinking and drug misuse in this period was likely to have generated the dynamic that led to F becoming violent and aggressive in the way that M described. This was an established pattern.

60. There is long history of F losing his temper. In his evidence F accepted this with some candour. It is also the case that frequently, when he loses his temper, he is not only

violent but out of control. On three occasions, at least, as I have mentioned above, he has strangled M with his bare hands. On at least one occasion, M lost consciousness. In her statement for the injunction, M described F as punching his fists into walls and through cupboard doors.

61. Paradigmatically, a squeezing injury to a baby's chest is an expression of parental frustration and loss of control. There is here an established pattern of F becoming violent and losing control. This is exacerbated with drug and alcohol consumption, which, as I have stated, the evidence establishes as being used in excess at the relevant time. Also, M and F were living in much more confined circumstances, arising from F's injury. Both, I note, had identified their respective needs for privacy and space. The changed situation compromised this. I have concluded that F was behaving, as M asserted in her application, violently and personally out of control. I emphasise that all these are ascertainable facts from which reasonable inferences can be drawn. They also establish a propensity for F to lose control, in an extreme way, and to become violent. By contrast, there is no such evidence relating to M's behaviour. Cumulatively, for the reasons that I have identified throughout this judgment, I consider the evidence points markedly towards F as most likely to have caused R's fractured fourth posterior rib. On the balance of probabilities, I find that he did.

62. The old nostrum that inherently improbable allegations require a more cogent standard of proof has now been consigned to history. The inherent improbability of a parent seriously injuring a child must be factored into the evidence. Where the facts indicate that a parent has been behaving violently and out of control, injury to a baby becomes inherently less improbable.

63. It also requires to be stressed, in my judgement, that identifying a perpetrator, on the 'balance of probabilities', is a duty imposed upon a Judge, where the facts permit. Built into the civil standard of proof is an inevitable risk of error, with which conscientious practitioners, litigating very serious injury to a child are sometimes uncomfortable. The civil standard of proof applies in Children Act proceedings because it gives effect to the central objective of the Act itself, namely, to promote the welfare of the child. Any application of an elevated standard of proof runs the risk of leaving an unnecessary pall of suspicion over a non-perpetrating parent which may hinder the construction of clear and effective strategies, designed both to protect the child and promote the full range of opportunities for her relationship with either or both parents. Indeed, the impact of an 'uncertain perpetrator' finding is more likely to limit the options for a child than to expand them. For this reason, it is to be avoided if possible. Declining to identify a perpetrator, where the evidence establishes it, is not merely erring on the side of caution, it is a failure to exercise the duty imposed by law. The test is simply whether an identified individual is more likely than not to have caused the injuries, *"nothing more, nothing less"*.

64. Finally, it is important to clarify that the posterior rib injury, whilst serious, was not, in any way, related to R's death. Both parents have agreed to the plan that the children

be placed with the extended family and the Local Authority is in the process of formulating plans for supervised contact. I am entirely satisfied that this plan is in the children's best interests.