Neutral Citation Number: [2020] EWFC [57]

Case No: WV19C00177

IN THE FAMILY COURT

Royal Courts of Justice

Date: 17/08/2020

Before :

MR JUSTICE KEEHAN
Re ABC (Children: Overlaying Child)

- -

Between :

The Local Authority	**Applicant**
- and -	
The Mother	**1st Respondent**
-and-	
The Father	**2nd Respondent**
-and-	
A, B and C	**3rd – 5th**
(Children by their Children's Guardian, Pat Foster)	**Respondents**

- -
- -

Mr L Messling (instructed by **Legal Services**) for the **Applicant**
Ms E McGrath QC & Mr R Plunkett (instructed by **Clark Brookes Turner Cary**) for the **1st Respondent**
Miss K Brown (instructed by **HRS Family Law Solicitors Limited**) for the **2nd Respondent**
Mr C Watson (instructed by **Pickerings Solicitors**) for the **3rd - 5th Respondents**

Hearing dates: 10th - 21st July

- -

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.

.....
MR JUSTICE KEEHAN

This judgment was delivered in private. 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.

The Hon Mr Justice Keehan :

Introduction

1. I am concerned with three children, A, who was born on 2nd October 2009 and is 10 years of age, B, who was born on 24th August 2011 and is 8 years of age, and C, who was born on 3rd November 2017 and is 2 years of age. They had a brother, D, who was born on 19th January 2019. Tragically during the night of 12th and the early hours of 13th March 2019, he died.

2. The parents of all four children are the mother and the father. The children have an older half sibling, E. He is the mother's son from a previous relationship.

3. These public law proceedings were issued by the local authority, on 8th April 2019. The mother and father gave consent for the children to be accommodated pursuant to s.20 of the Children Act 1989 on 14 March and 13 March respectively. A and B were placed with their paternal grandmother and C was placed with his maternal grandmother. They remain living with their respective grandmothers.

4. This fact-finding hearing is to establish the cause of D's death and the circumstances in which he sustained multiple rib fractures.

5. The case had originally been listed for a combined fact-finding and welfare hearing in March of this year. This hearing, with the consent of all parties, had to be adjourned. At the experts' meeting held on 12th March 2020, convened shortly before this hearing was to have commenced, the experts were agreed that it was necessary for further forensic investigations to be undertaken by Professor Al-Sarraj. There was an issue as to whether some of the findings in respect of D's thoracic paraspinal nerve roots bleeding/injury were sustained traumatically or not.

6. This hearing is a fact-finding hearing. The welfare hearing is listed in August of this year.

The Law – Fact Finding

7. The burden of proof lies with the local authority. It is the local authority that brings these proceedings and identifies the findings they invite the court to make. Therefore, the burden of proving the allegations rests with them.

8. In family proceedings there is only one standard of proof, namely the balance of probabilities. This was described by Denning J in *Miller v Ministry of Pensions* [1947] 2 All ER 372: "If the evidence is such that the tribunal can say: "We think it more probable than not", the burden is discharged but, if the probabilities are equal, it is not.

9. In *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35, [2008] 2 FLR 141, Baroness Hale, while approving the general principles adumbrated by Lord Nicholls in *Re H and Others*, expressly disapproved the formula subsequently adopted by courts to the effect that 'the more serious the allegation, the more cogent the evidence needed to be to prove it'. Baroness Hale stated:

> "[70] My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts

> necessary to establish the threshold under s 31(2) or the welfare considerations in s 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies.
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> [71] As to the seriousness of the consequences, they are serious either way. A child may find her relationship with her family seriously disrupted; or she may find herself still at risk of suffering serious harm. A parent may find his relationship with his child seriously disrupted; or he may find himself still at liberty to maltreat this or other children in the future."

10. The inherent probability of an event remains a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred: common sense, not law, requires that in deciding this question regard should be had, to whatever extent appropriate, to inherent probabilities – per Lord Hoffman in *Re B* at paragraph 15.

11. The burden of disproving a reasonable explanation put forward by the parents falls on the local authority (see paragraph 10 *Re S (Children)* [2014] EWCA Civ 1447).

12. The inability of a parent or carer to explain an event cannot be relied upon to find an event proved, see *Re M (A Child)* [2012] EWCA Civ 1580 at paragraph 16 – the view taken by the Judge was:

> "that absent a parental explanation, there was no satisfactory benign explanation, ergo there must be a malevolent explanation. And it is that leap which troubles me. It does not seem to me that the conclusion necessarily follows unless, wrongly, the burden of proof has been reversed, and the parents are being required to satisfy the court that this is not a non-accidental injury"

13. Findings of fact in these cases must be based on evidence. As Munby LJ, as he then was, observed in *Re A (A Child) (Fact-finding hearing: Speculation)* [2011] EWCA Civ 1:

> "[26] It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation."

14. Peter Jackson J, as he then was, in *Re BR (Proof of Facts)* [2015] EWFC 41 said, at paragraph 15-17:

> "[15] It would of course be wrong to apply a hard and fast rule that the carer of a young child who suffers an injury must invariably be able to explain when and how it happened if they

> are not to be found responsible for it. This would indeed be to reverse the burden of proof. However, if the judge's observations are understood to mean that account should not be taken, to whatever extent is appropriate in the individual case, of the lack of a history of injury from the carer of a young child, then I respectfully consider that they go too far.
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> [16] Doctors, social workers and courts are in my view fully entitled to take into account the nature of the history given by a carer. The absence of any history of a memorable event where such a history might be expected in the individual case may be very significant. Perpetrators of child abuse often seek to cover up what they have done. The reason why paediatricians may refer to the lack of a history is because individual and collective clinical experience teaches them that it is one of a number of indicators of how the injury may have occurred. Medical and other professionals are entitled to rely upon such knowledge and experience in forming an opinion about the likely response of the individual child to the particular injury, and the court should not deter them from doing so. The weight that is then given to any such opinion is of course a matter for the judge.
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> [17] In the present case, an adult was undoubtedly in the closest proximity to the baby whenever the injuries occurred and the absence of any account of a pain reaction on the baby's part on any such occasion was therefore one of the matters requiring careful assessment"

15. In *Re BR*, Peter Jackson J, as he then was, sets out a list of risk factors and protective factors that might assist the court in assessing the evidence it hears in cases of alleged inflicted injury. At paragraph 18 he said:

> "In itself, the presence or absence of a particular factor proves nothing. Children can of course be well cared for in disadvantaged homes and abused in otherwise fortunate ones. As emphasized above, each case turns on its facts. The above analysis may nonetheless provide a helpful framework within which the evidence can be assessed and the facts established".

16. The judge must decide if the facts in issue have happened or not. There is no room for finding that it might have happened. The law operates a binary system in which the only values are 0 and 1, per Lord Hoffman in *Re B* at paragraph 2. This applies to the conclusion as to the fact in issue (e.g. did it happen; yes or no?) not the value of individual pieces of evidence (which fall to be assessed in combination with each other).

17. When carrying out the assessment of evidence regard must be had to the observations of Butler-Sloss P, as she then was, in *Re T* [2004] EWCA (Civ) 558:

> "[33] Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and

> to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the Local Authority has been made out to the appropriate standard of proof."

18. When considering the 'wide canvas' of evidence the following section of the speech of Lord Nicholls in *Re H and R (Child Sexual Abuse: Standard of Proof)* [1996] 1 FLR 80 remains relevant:

> "[101B] I must now put this into perspective by noting, and emphasising, the width of the range of facts which may be relevant when the court is considering the threshold conditions. The range of facts which may properly be taken into account is infinite. Facts including the history of members of the family, the state of relationships within a family, proposed changes within the membership family, parental attitudes, and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats, and abnormal behaviour by a child, and unsatisfactory parental responses to complaints or allegations. And facts, which are minor or even trivial if considered in isolation, taken together may suffice to satisfy the court of the likelihood of future harm. The court will attach to all the relevant facts the appropriate weight when coming to an overall conclusion on the crucial issue."

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

20. The process by which the facts are judicially determined is further complicated for the potent reason Leggatt J, as he then was, set out in *Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor* [2013] EWHC 3560 (Comm) (15 November 2013), [paragraphs 15-21] in relation to testimony based on memory:

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

> in their recollection, the more likely their recollection is to be accurate."

21. Leggat LJ additionally made the following observations as to demeanour in *R (on the application of SS) (Sri Lanka) v The Secretary of State for the Home Department* [2018] EWCA Civ 1391:

> "36. Generally speaking, it is no longer considered that inability to assess the demeanour of witnesses puts appellate judges "in a permanent position of disadvantage as against the trial judge".

22. That is because it has increasingly been recognised that it is usually unreliable and often dangerous to draw a conclusion from a witness's demeanour as to the likelihood that the witness is telling the truth. The reasons for this were explained by MacKenna J in words which Lord Devlin later adopted in their entirety and Lord Bingham quoted with approval:

> "I question whether the respect given to our findings of fact based on the demeanour of the witnesses is always deserved. I doubt my own ability, and sometimes that of other judges, to discern from a witness's demeanour, or the tone of his voice, whether he is telling the truth. He speaks hesitantly. Is that the mark of a cautious man, whose statements are for that reason to be respected, or is he taking time to fabricate? Is the emphatic witness putting on an act to deceive me, or is he speaking from the fullness of his heart, knowing that he is right? Is he likely to be more truthful if he looks me straight in the face than if he casts his eyes on the ground perhaps from shyness or a natural timidity? For my part I rely on these considerations as little as I can help.
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> 40. This is not to say that judges (or jurors) lack the ability to tell whether witnesses are lying. Still less does it follow that there is no value in oral evidence. But research confirms that people do not in fact generally rely on demeanour to detect deception but on the fact that liars are more likely to tell stories that are illogical, implausible, internally inconsistent and contain fewer details than persons telling the truth: see Minzner, "Detecting Lies Using Demeanor, Bias and Context" (2008) 29 Cardozo LR 2557. One of the main potential benefits of cross-examination is that skillful questioning can expose inconsistencies in false stories."

23. The findings made by the judge must be based on all the available material, not just the scientific or medical evidence; and all that evidence must be considered in the wider social and emotional context*: A County Council v X, Y and Z (by their Guardian)* [2005] 2 FLR 129. This was expressed as the expert advises and the judge decides in *Re Be (Care: Expert Witnesses)* [1996] 1 FLR 667 .

24. In *A Local Authority v K, D and L* [2005] EWHC 144 (Fam), [2005] 1 FLR 851 Charles J referred to the important distinction between the role of the Judge and the role of the expert (see paragraph 39), saying:

> "(a) that the roles of the court and the expert are distinct, and
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> (b) that it is the court that is in the position to weigh the expert evidence against its findings on the other evidence, and thus for example descriptions of the presentation of a child in the hours or days leading up to his or her collapse, and accounts of events given by carers."

25. These comments were developed by Charles J. in a lengthy section in the judgment in *Re K, D and L* by a review of the relevant case law in the area:

> "[44] …in cases concerning alleged non- accidental injury to children properly reasoned expert medical evidence carries considerable weight, but in assessing and applying it the judge must always remember that he or she is the person who makes the final decision;
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> [49] …In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non- accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof;"

26. The conclusion reached by Charles J (following his judicial summation of the relevant case-law in this area) is to be found at paragraph 63, where he said:

> "I am therefore able to reach a conclusion as to cause of death and injury that is different to, or does not accord with, the conclusion reached by the medical experts as to what they consider is more likely than not to be the cause having regard to the existence of an alternative or alternatives which they regard as reasonable (as opposed to fanciful or simply theoretical) possibilities. In doing so I do not have to reject the reasoning of the medical experts, rather I can accept it but on the basis of the totality of the evidence, my findings thereon and reasoning reach a different overall conclusion."

27. In assessing the expert evidence, the court must bear in mind that in cases involving a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bring their own expertise to bear on the problem, and the court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others (see observations of King J, as she then was, in *Re S* [2009] EWHC 2115 Fam).

28. The court is not precluded from making a finding that the cause of harm...is unknown. The judgment of Hedley J in the case of *Re R (Care Proceedings: Causation)* [2011] EWHC 1715 (Fam) sets this out:

> "[10]...there has to be factored into every case which concerns a disputed etiology giving rise to significant harm, a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."

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

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

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

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

> "40. As to the second, if the judge cannot identify a perpetrator or perpetrators, it is still important to identify the pool of possible perpetrators. Sometimes this will be necessary in order to fulfil the "attributability" criterion. If the harm has been caused by someone outside the home or family, for example at school or in hospital or by a stranger, then it is not attributable to the parental care unless it would have been reasonable to expect a parent to have prevented it. Sometimes it will desirable for the same reasons as those given above. It will help to identify the real risks to the child and the steps needed to protect him. It will help the professionals in working with the family. And it will be of value to the child in the long run.
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> 41. In North Yorkshire County Council v SA [2003] EWCA Civ 839, [2003] 2 FLR 849, the child had suffered non-accidental injury on two occasions. Four people had looked after the child during the relevant time for the more recent injury and a large number of people might have been responsible for the older injury. The Court of Appeal held that the judge had been wrong to apply a "no possibility" test when identifying the pool of possible perpetrators. This was far too wide. Dame Elizabeth Butler-Sloss P, at para 26, preferred a test of a "likelihood or real possibility".
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> 42. Miss Susan Grocott QC, for the local authority, has suggested that this is where confusion has crept in, because in Re H this test was adopted in relation to the prediction of the likelihood of future harm for the purpose of the threshold criteria. It was not intended as a test for identification of possible perpetrators.
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> 43. That may be so, but there are real advantages in adopting this approach. The cases are littered with references to a "finding of exculpation" or to "ruling out" a particular person as responsible for the harm suffered. This is, as the President indicated, to set the bar far too high. It suggests that parents and other carers are expected to prove their innocence beyond reasonable doubt. If the evidence is not such as to establish responsibility on the balance of probabilities it should nevertheless be such as to establish whether there is a real possibility that a particular person was involved. When looking at how best to protect the child and provide for his future, the judge will have to consider the strength of that possibility as part of the overall circumstances of the case."

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

> "46. Drawing matters together, it can be seen that the concept of a pool of perpetrators seeks to strike a fair balance between the rights of the individual, including those of the child, and the

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

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

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

49. To guard against that risk, I would suggest that a change of language may be helpful. The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: Re D (Children) [2009] EWCA Civ 472 at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is

> there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'.
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> 50. Likewise, it can be seen that the concept of a pool of perpetrators as a permissible means of satisfying the threshold was forged in cases concerning individuals who were 'carers'. In Lancashire, the condition was interpreted to include non-parent carers. It was somewhat widened in North Yorkshire at [26] to include 'people with access to the child' who might have caused injury. If that was an extension, it was a principled one. But at all events, the extension does not stretch to "anyone who had even a fleeting contact with the child in circumstances where there was the opportunity to cause injuries": North Yorkshire at [25]. Nor does it extend to harm caused by someone outside the home or family unless it would have been reasonable to expect a parent to have prevented it: S-B at [40].
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> 51. It should also be noted that in the leading cases there were two, three or four known individuals from whom any risk to the child must have come. The position of each individual was then investigated and compared. That is as it should be. To assess the likelihood of harm having been caused by A or B or C, one needs as much information as possible about each of them in order to make the decision about which if any of them should be placed in the pool. So, where there is an imbalance of information about some individuals in comparison to others, particular care may need to be taken to ensure that the imbalance does not distort the assessment of the possibilities. The same may be said where the list of individuals has been whittled down to a pool of one named individual alongside others who are not similarly identified. This may be unlikely, but the present case shows that it is not impossible. Here it must be shown that there genuinely is a pool of perpetrators and not just a pool of one by default."

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

> "37 The first basis of the cross-appeal is the father's responsibility for the October event. Is it likely, asks Miss Hodgson on behalf of the mother, that, within the space of less than seven weeks, the partial suffocation of a baby is caused by one parent and yet injuries to his body are, or even just may be, perpetrated by the other? It is certainly not unknown for judges to give a negative answer to that type of question and, by reference to it, to proceed to identify the perpetrator of a second

> non-accidental injury. When they do so, their reasoning is – in my view – in principle valid . . ."

34. The evidential basis for making a finding of a failure to protect was considered by the Court of Appeal in the case of L-W Children [2019] EWCA Civ 159. At paragraph 40, King LJ emphasised that it is for the local authority to prove the necessary link between its case on the facts and its threshold allegations. At paragraph 62, King LJ said:

> "62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.
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> 63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries.
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> 64. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm."

35. The rule of *R v Lucas* [1981] QB 720 was adopted in the family courts in *A County Council v K, D and L*. The principle is that if the court concludes that a witness has lied about one matter it does not follow that he has lied about everything. A witness may lie for many reasons, for example out of shame, humiliation, misplaced loyalty, panic, fear, distress, confusion and emotional pressure.

36. In the criminal courts a lie can only be used to bolster evidence against a defendant if the fact-finder is satisfied that the lie is deliberate, relates to a material issue and there is no innocent explanation for the lie.

37. The court has considered the case of *Re: H-C (Children*) [2016] EWCA Civ 136, in particular paragraphs 98 to 100 of the decision of Lord Justice McFarlane, as he then was, where he said:

> "98. The decision in R v Lucas has been the subject of a number of further decisions of the Court of Appeal Criminal Division over the years, however the core conditions set out by Lord Lane remain authoritative. The approach in R v Lucas is not confined, as it was on the facts of Lucas itself, to a statement made out of court and can apply to a "lie" made in the course of the court proceedings and the approach is not limited solely to evidence concerning accomplices.
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> 99. In the Family Court in an appropriate case a judge will not infrequently directly refer to the authority of R v Lucas in giving a judicial self-direction as to the approach to be taken to an apparent lie. Where the "lie" has a prominent or central relevance to the case such a self-direction is plainly sensible and good practice.
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> 100. One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of R v Middleton [2001] Crim.L.R. 251.
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> In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt".

The Background

38. On 30th April 2016, the mother gave birth to a daughter, F. She was born extremely premature at 24 weeks. Very sadly, but not unexpectedly, she died on 5th May 2016 as a result of her extreme prematurity and associated medical conditions.

39. In consequence of the death of F, the mother took an overdose of paracetamol and she left a suicide note. The mother survived, she was referred by her general practitioner ('GP') to mental health services and was advised to reduce her intake of alcohol.

40. After the birth of C on 3rd November 2017, a health visitor, G, visited the mother. She discussed safe sleeping arrangements with her and the mother was encouraged:

    i) not to share a bed with C; and

    ii) not to sleep on the sofa whilst holding the baby.

41. On 3rd January 2018 the health visitor visited the mother and, once again, reinforced the advice on safe sleeping practice. The mother declined the health visitor's request to view the sleeping arrangements: she said this was because her son was asleep.

42. On 27th February 2018 the children's school made a referral to children's services in respect of the care and appearance of A and B. An assessment was undertaken by the local authority which concluded that the threshold for intervention by children's services was not met and the case was closed. The school reported that the referral had led to an improvement in the case and appearance of the children. It led, however, to the mother, but not the father, not engaging with the school.

43. On 8th September 2018 the children's older half sibling, E, was stabbed. E's stabbing led to a further assessment of the children by the local authority. No concerns were raised in respect of A, B and C: the concerns had related to E's alleged gang affiliations and the potential for reprisal attacks or the targeting of the family by rival gang members.

44. A Child Protection Conference held on 16th October 2018 concluded that the threshold for child protection plans was not met but that E needed to be supported as a child in need.

45. On 15th January 2019 the case was closed on the basis that the objectives of the child in need plan had been achieved and that the parents were managing to keep E safe.

46. On 19th January 2019, D was born at 31 weeks gestation. He was admitted to the Neonatal Ward of the Birmingham Children's Hospital ('BCH') three days later. On 22nd February 2019, he was discharged home to the care of his parents. Thereafter, it is agreed he was always in the care of his mother and/or father.

47. On 12th March 2019 a health visitor, H, visited the family home. The parents, B and D were present. D was reported to be developing well and had gained weight. The health visitor discussed safe sleeping arrangements with the mother and with the father. They were advised against having D in bed with them even with the use of a "sleepy head". The family home was reported to be cluttered but not unclean.

48. Later on that day of 12th March 2019, it is agreed that:

    i) other family members came to the parents' home to watch the horse races at the Cheltenham Festival;

    ii) the parents and family members consumed alcohol through the afternoon;

    iii) once challenged with a toxicology report, the father accepted having taken some cocaine at 2pm in the afternoon;

iv) at around 3pm the father collected A and B from school;

v) the mother cooked the evening meal;

vi) there was further alcohol consumed in the evening; and

vii) the parents, B, C and D all slept in the same bed.

49. In the early hours of 13th March 2019, the father woke up to feed C. He checked on D, he said, and found he was not breathing. He woke the mother. The father carried D downstairs and called 999. He then passed D to the mother who attempted to perform cardiopulmonary resuscitation ('CPR').

50. The paramedics arrived at the family home just after 3am. They continued to perform CPR on D.

51. The paramedics arrived with D at BCH at 3:37am on 13th March 2019. He remained in asystolic cardiac arrest. Resuscitation attempts continued until 3:47am. At 3:58am D was declared dead.

52. Later that day the parents were each interviewed by the police.

53. Subsequent toxicology analysis concluded that on 12/13th March the parents had consumed and were under the influence of drugs and/or alcohol.

54. The mother was further interviewed by the police on 14th June 2019 and the father was the subject of a further interview on 20th June 2019.

55. On 25th June 2019 the father was sentenced to a sentence of 12 months imprisonment for an offence of conspiracy to commit fraud by false misrepresentation. He was released on home detention curfew on 25th September and was subject to licence conditions until 24th June 2020. Thereafter, post sentence supervision commenced and is due to expire on 24 December 2020.

56. The father was again interviewed by the police on 15th October and the mother was again interviewed on 18th October 2019.

57. The court had ordered the parents to undergo repeated drug testing. The mother complied with the same. The father had inconclusive or no test results because he had insufficient lengths of facial or body hair which would be susceptible to any meaningful testing. It would appear that despite being aware of his agreement to and need to undergo periodic court ordered drug testing, the father had maintained his habit of regularly shaving his head and body hair. Was this an innocent continuation of a regular practice or a deliberate attempt to prevent any effective analysis of the father's immediate past drug and/or alcohol consumption?

58. This is a matter to which I will need to give careful consideration and, in particular, to the extent to which I should draw any adverse inference against the father in respect of his recent failure to provide any hair samples which could yield any effective results from testing, whether positive or negative.

Expert Medical Evidence

59. Four medical experts were instructed in these proceedings:

i) Dr Lockyer, a consultant forensic pathologist;

ii) Professor Al-Sarraj, a consultant neuropathologist;

iii) Professor Mangham, a consultant histopathologist; and

iv) Dr Zeitlin, a consultant paediatrician.

All, save for Dr Zeitlin, had undertaken or were associated with the post-mortem examination and investigations into D's death.

60. Further, I have the benefit of reports from:

i) Dr Marton, a consultant perinatal pathologist who performed the post-mortem examination with Dr Lockyer; and

ii) Professor Williams, an expert in the interpretation of micro CT scans.

61. In his report of 11th November 2019 Dr Lockyer concluded that D's cause of death was unascertained. His opinion was:

> "Baby D was a 6-week-old male infant who was pronounced deceased following the circumstances described herein. It is alleged that baby D was placed in bed with his intoxicated mother along with father and two siblings.
>
> Post-mortem examination showed no evidence of definite deep or superficial bruising. There were a number of rib fractures identified (a total of 24) which involved both the front and back (anterior and posterior) aspects of the ribcage. Professor MANGHAM confirmed that these fractures showed a myriad of changes indicating that they were inflicted at different times with the oldest being those within the posterior shafts of the ribs (left 7th rib, in particular). The timeframe proposed by Professor MANGHAM for the rib fractures ranges from near to or after death for the most recent to between 35 hours and 3 days for the oldest. I note that no callous formation was described and no injury of the right distal femur was seen.
>
> There was no evidence of neck injury or injuries to the scalp or skull. No intracranial haemorrhage was described and neuropathological examination of the brain showed no evidence of traumatic brain injury but some mild, non-specific changes related to localised old ischaemia was described.
>
> Paediatric pathological examination of the tissues and organs revealed no significant natural anatomical disease to account for

sudden death. Non-specific petechial haemorrhages of the lung, thymus gland and heart were described.

Toxicology analyses showed no evidence of drugs or alcohol at the time of death.

Extensive post-mortem examination with specialist opinion has confirmed a significant number of fractures involving both the front and the back of the rib shafts with 24 fractures being identified in total. Such injuries are caused by front to back or side-to-side forceful compression of the chest which can have both inflicted and accidental causes:

a. Inflicted causes include gripping the chest forcefully with both hands and squeezing such as in an attempt to stop a baby from crying. I am not aware such actions were performed in this case and indeed, no discoid or fingertip bruising was seen to either the skin overlying the chest and back or within the subcutaneous tissues.

b. Accidental causes include overlaying whereby an adult inadvertently rolls onto baby whilst sleeping. There were unsafe sleeping practices employed here including baby D being in bed with mum who had been drinking significant alcohol (described as being one bottle of wine).

Dr MARTON has described further risk factors including parental smoking, prematurity and environmental factors, the latter which are related to the unsafe sleeping practices.

It is for the reasons described above that this death must be regarded as unascertained. It would not be appropriate in this case to attribute death to Sudden Infant Death Syndrome (SIDS) given the presence of several risk factors."

62. Dr Marton set out the following in his report of 12th September 2019:

"The following risk factors of cot death were identified:

Intrinsic to the baby: Premature birth, young infant.

Parenting: Maternal alcohol consumption (mother is heavily intoxicated.

Environment: Co-sleeping (5 individuals involved), parental smoking, infant was under duvet, in the crook of arm of mother facing mother.

> The listed risk factors put this baby high risk for cot death and it is not appropriate to classify the death as Sudden Infant Death Syndrome.
>
> Interpretation of the rib fractures of different age is a matter for the Home Office Pathologist and Specialist Pathologist.
>
> I did not find any medical cause of death."

He was of the same opinion as Dr Lockyer that the cause of D's death was unascertained.

63. In his report of 17th April 2019 Professor Williams recorded the following findings and conclusions:

> "The femur displays a fine layer of lower mineralised bone tissue on the posterior surface.
>
> No damage was identified on the sternum.
>
> The ribcage displayed numerous injuries.
>
> There is a total of 13 incomplete fractures on the anterior aspects of the ribs near the sternal ends. These are only visible on the internal surfaces and have the appearance of vertical creases within the cortical bone.
>
> In addition, there are 17 possible posterior rib fractures through the deep corner of the rib heads. They are very subtle.
>
> The majority of the anterior fractures identified on the post-mortem radiology have been confirmed on the micro-CT images.
>
> The anomaly on the distal right femur appears like new bone formation on the micro CT-images.
>
> In addition to these features there were subtle possible fractures on the posterior rib aspects, their nature should be verified by histology.
>
> No fracture age can be provided from the scan images alone, this again is best done by histology."

64. Professor Al-Sarraj offered an initial opinion in his report of 18th June 2019:

> "The deceased was a 3 month old child who was found unresponsive in bed and not breathing. It was reported he slept in the bed with mother and two other siblings and that he was born prematurely and diagnosed with health conditions prior to death (not revealed at time of this report).

> The brain examination shows a few non-specific changes. For instance, there is a small and microscopic focus of old ischaemia and infarct in the white matter of the right parietal lobe associated with mild increase in number of activated microglia cells and mild macrophage infiltration in the meninges. These appearances indicate old reactive changes to a previous localised ischaemia in the brain most likely related to premature birth and other health conditions. The changes in the brain are mild and focal and unlikely to have contributed to death.
>
> There are occasional accumulations of βAPP indicating mild and focal axonal disruption in the brainstem which could be due to final events of ischaemia in the brain although this is not certain. There is no evidence, however, of established ischaemia in other parts of the brain or βAPP deposition.
>
> The brain shows no evidence of natural disease which could have caused or contributed to death. There is, for instance, no evidence of inflammation (encephalitis or meningitis) or malformation subarachnoid haemorrhage or internal bleeding.
>
> The pathological changes in the brain are required to be considered closely with autopsy examination, toxicology and other investigations before final conclusion.
>
> Conclusion
>
> Mild non-specific changes consistent with localised old ischaemia. No evidence of traumatic brain injury."

65. In his report of 12th September 2019 Professor Mangham summarised his histopathological findings and opinions in the following terms:

> "There is a total of 24 anterior and posterior rib fractures. All of the fractures are small, partial and subtle. They show a variety of histological appearances that indicate that they most likely occurred at at least two different time points. Most of the anterior rib fractures show appearances that indicate that they occurred several hours before death and some fractures show features that indicate that they could have occurred either a few hours prior to death, at the time of death or, even after death due to attempted CPR (generally the amount of haemorrhage is small). Many of the posterior rib fractures show features that indicate that they occurred significantly earlier than the anterior rib fractures. Some of these fractures show an established tissue reaction that indicates that they occurred between 36hrs and 3 days prior to death. The posterior rib fracture with the most clear cut features indicating that it occurred within this time frame is the left 7th posterior rib fracture (block 54).

> These rib fractures would have been caused by significant (i.e. significantly more force than might be imparted by "rough play") chest compression. The anterior rib fractures would have been caused by either anterior to posterior (front to back compression and/or lateral to lateral (side to side) compressive force. These posterior rib fractures implicate an element of lateral to lateral (side to side) compressive force.
>
> A factor that needs to be considered in this case is whether the bones were weakened by birth prematurity – i.e. "osteopaenia of prematurity". There is no particular histological evidence that this was the case because widespread microfractures of different ages are not present in this extensively sampled case.
>
> There is fresh perineural haemorrhage involving the two thoracic nerve roots. Haemorrhage into nerve roots is evidence for extensions/flexion trauma of the spine.
>
> There are no fractures in the right distal femur (including no classic metaphyseal fracture).
>
> The high number, differing ages and distribution of the fractures and the presence of thoracic nerve root haemorrhage, in the absence of an alternative explanation, are typical of non-accidental injury."

66. In her paediatric overview report of 16th February 2020 Dr Zeitlin concluded as follows:

> "D was a premature but otherwise healthy baby at the time of his death. He was found to have died in the parents' bed in which both parents and two other siblings were also sleeping. His parents had both been drinking alcohol and his father had also taken cocaine on the previous day.
>
> The skeletal survey and the post mortem findings identified a number of fractures to D's ribs that had occurred up to 3 days before his death.
>
> These ante-mortem fractures would have been painful and distressing both at the time they were caused but also when the baby was subsequently changed and handled.
>
> The mechanism, by which the posterior fractures were caused i.e. side-to-side compression, was different from the mechanism likely to have caused at least some of the anterior rib fractures. At least some of the anterior fractures could have been caused during attempts to resuscitate the baby."

67. Professor Mangham's findings of fresh perineural haemorrhage involving the two thoracic nerve roots was the subject of supplemental written questions. The questions and his answers were:

> "What are the possible/probable causes of this haemorrhage? Extension/flexion trauma to the spine.
>
> When is this haemorrhage likely to have occurred (in terms of a date/time and in relation to the death)? There is no tissue response to the haemorrhage and this indicates that the haemorrhage would have occurred at any time point within a few days prior to death including immediately prior to death. More precise dating than this may be possible by an expert neuropathologist."

68. Dr Lockyer was asked in a supplemental written question to comment on Professor Mangham's answers and he responded:

> "I have reviewed Prof Mangham's responses and I am concerned regarding his interpretation of the spinal nerve root haemorrhage:
>
> > When is this haemorrhage likely to have occurred (in terms of a date/time and in relation to the death)? There is no tissue response to the haemorrhage and this indicates that the haemorrhage would have occurred at any time point within a few days prior to death including immediately prior to death. More precise dating than this may be possible by an expert neuropathologist.
>
> With this [in] mind and considering his later opinion that this bleeding cannot be explained by overlay, I feel it is essential that this matter is addressed by an expert neuropathologist and that they should examine the material reviewed by Professor Mangham, specifically to address dating of the bleeding/injury of the thoracic paraspinal nerve roots as this could have significant implications regarding causation."

69. The finding of haemorrhage of the thoracic paraspinal nerve roots was the subject of some debate between Dr Lockyer, Professor Mangham and Professor Al-Sarraj at the first experts' meeting which took place on 12th March 2020. The discussion concluded with the experts agreeing that Professor Al-Sarraj should be afforded the opportunity to examine the spinal cord sections reported on by Professor Mangham. Professor Al-Sarraj agreed with Professor Mangham that if there is evidence of a haemorrhage in the thoracic paraspinal nerve roots, he would favour flexion-extension trauma as the cause of the same.

70. Accordingly, on the first day of the first listed hearing on 17th March 2020, I acceded to an application, made by all parties, that I should adjourn the matter to allow Professor Al-Sarraj to examine the spinal cord sections and to report his findings.

71. After examining the spinal cord sections Professor Al-Sarraj reported that he identified the same findings as Professor Mangham and confirmed the presence of haemorrhage in the thoracic paraspinal nerve roots. He preferred a compressive trauma for the cause of the findings rather than resulting from an acceleration/deceleration mechanism in

light of the absence of any other injuries which might be expected from a shaking injury, namely subdural haemorrhages, retinal haemorrhages and/or bruising.

72. These findings and the case more generally were discussed by the four instructed medical experts at a second experts' meeting held on 26th June 2020. They were in broad agreement on all of the medical issues. Of note, Professor Mangham agreed with Professor Al-Sarraj's preferred explanation for the cause of the haemorrhage in the thoracic paraspinal nerve roots.

73. In his evidence Professor Mangham corrected the assertion in his substantive report that D had sustained 24 rib fractures: there were 23. In respect of the right ribs:

    i) there were anterior and posterior fractures of the 3rd, 4th 5th & 6th ribs;

    ii) there was an anterior fracture of the 7th rib; and

    iii) there were posterior fractures of the 8th & 9th ribs.

74. On the left:

    i) there were anterior and posterior fractures of the 4th & 6th rib;

    ii) there were anterior fractures of the 1st, 2nd and 5th ribs and two anterior fractures of the 3rd rib; and

    iii) there were posterior fractures of the 7th, 8th & 10th ribs.

75. In terms of the time frames when the fractures were sustained, Professor Mangham told me that:

    i) the right 3rd posterior fracture was between 2 days to the time of death (including immediately prior to death);

    ii) the left 10th posterior fracture was difficult to date;

    iii) all of the other 9 (R4, R5, R6, R8, R9, L4, L6, L7 & L8) posterior fractures were 72-36 hours of age at the time of D's death; and

    iv) in respect of 2 anterior rib fractures, (R3 & R4), occurred immediately before or after death, (v) 2 (R5 & L2) were in the range of 2-6 hours before death, (vi) 1 (L1) was in the range of 2-12 hours and (vii) 7 (R6, R7, L3 x2, L4, L5 & L6) were in the range of 6-12 hours.

    Thus, the posterior rib fracture of the right 3rd rib and the anterior fractures of the right 3rd and 4th ribs could have been sustained in the course of the administration of CPR after D's collapse, but not those in the range of 2 hours and beyond.

76. The anterior fractures set out at paragraphs (v), (vi) & (vii) above are likely to have been sustained, in one or more events, from the afternoon of 12th March to the very early hours of 13th March. The posterior fractures set out at paragraph (iii) above are likely to have been sustained from the early hours of 10th March to around noon/the early afternoon of 11th March.

77. In the professor's experience there was no evidence that posterior rib fractures resulted from or were caused by the overlaying of a baby.

78. He said that the forces required to cause the posterior rib fractures and the haemorrhage seen at the nerve roots of the spinal cord were considerably in excess of normal handling: notwithstanding that the rib fractures were micro fractures or were mild, subtle and undisplaced. The fact, however, that these fractures had not resulted in the tearing of the nerve ends of the ribs, may have resulted in D not suffering significant pain.

79. Professor Mangham confirmed that there was no evidence that D suffered from any underlying bone fragility, skeletal disease or other abnormality including osteopenia. Indeed, as a very young premature baby his bones would be more pliable and would bend considerably before sustaining a fracture.

80. Whilst favouring a non-accidental explanation for the rib fractures identified in this case, save for those potentially sustained in the course of CPR, Professor Mangham readily conceded that there was conflicting evidence in this case which was difficult to resolve. He was referring to the absence of any subdural or subarachnoid haemorrhages, of any retinal haemorrhages or of any signs of external or internal bruising around the rib cage.

81. Professor Al-Sarraj said that the spinal cord nerve root haemorrhages were less than 48 hours old before death and more likely less than 24 hours given the absence of macrophages or haemosiderin. He said that the healing process of tissue was quite different from that of bone, nonetheless he considered that compressive trauma which had caused the posterior rib fractures had also occasioned the paraspinal nerve root haemorrhage. In the absence of subdural bleeding, retinal haemorrhages and/or external or internal bruising around the rib cage, he favoured a localised compressive trauma rather than an acceleration/deceleration cause (i.e. a shaking event) of these findings.

82. In the experts' meeting of 26th June 2020, Professor Mangham agreed with this analysis and opinion of Professor Al-Sarraj for the reasons he had given.

83. Professor Al-Sarraj was asked that given he had dated the nerve root haemorrhages as more likely to be less than 24 hours and Professor Mangham had dated the posterior rib fractures at between 36 and 72 hours before death, how both sets of injuries could be explained by a single event. He explained that healing rates for tissue and bone were different and the dating of reactive changes in tissue was not a precise and/or accurate exercise. On balance he considered it was more likely that the two sets of injuries were sustained in the same event.

84. The professor had identified a small area of recent ischaemia in the pons. This finding is consistent with but not diagnostic of D dying from asphyxia, resulting from overlaying. No reactive changes were identified and therefore the ischaemia occurred a very short time before death. There was evidence of old reactive changes in the white matter of the right parietal lobe relating to a localised ischaemia which most likely related back to D's birth.

85. Professor Al-Sarraj could not identify any natural disease, process or malfunction in D's brain which could account for D's death. He could not completely exclude the

possibility that D, for whatever reason, simply stopped breathing and died. He struggled to explain D's death and found it difficult to identify the cause of death but in the presence of the rib fractures and evidence of co-sleeping with the parents, he favoured a conclusion that the cause of death was unascertained.

86. He did not favour overheating whilst co-sleeping as the cause of D's death because overheating would not have resulted in the changes he identified in D's brain.

87. Dr. Lockyer explained that he did not classify D's death as sudden death in infancy syndrome because of the presence of two factors in this case:

    i) the extensive rib fractures; and

    ii) the evidence of co-sleeping.

88. He considered this to be a difficult case because it was very unusual to identify ribs at post-mortem in isolation. There was no external or internal bruising noted around the ribcage, no subdural haemorrhages and no retinal haemorrhages.

89. The recent ischaemia identified by Professor Al-Sarraj was consistent with death by asphyxia. When co-sleeping a young baby could die from the parent lying on the child and occluding the airway, or as a result of the baby's face being in a micro climate which was low in oxygen but high in carbon dioxide, or by overheating.

90. Dr. Lockyer said that the rib fractures were far greater in number than would be expected to result from even vigorous CPR. He considered overlaying could be the unifying diagnosis if co-sleeping had occurred on more than one occasion. He noted that:

    i) the pathology of overlaying, particularly with rib fractures, was not well understood but, nevertheless;

    ii) he considered that overlaying was a plausible mechanism for the posterior rib fractures but these were not, on the basis of Professor Mangham's evidence, sustained on the night of 12/13 March.

    There was, he said, little pathological evidence that the rib fractures had resulted from inflicted trauma. When pressed by leading counsel for the mother, Ms McGrath QC, he declined to choose between the two possible causes of the older rib fractures, namely overlay or inflicted trauma.

91. Dr. Lockyer said that one could suffocate a baby without leaving any marks because the act of suffocation need not be forceful. He advised the court to steer away from the explanation that D had simply and spontaneously stopped breathing because of the presence of multiple rib fractures.

92. Dr. Zeitlin explained that premature babies tend not to react to pain in the same manner as full-term babies: their reactions to pain are usually far more subtle than crying.

93. She was of the firm opinion that, on the totality of the medical evidence and the circumstances of this family, overlaying was the most likely cause of D's death. She considered there were four events for the court to consider:

i) the cause of the posterior rib fractures;

ii) the cause of the anterior rib fractures which Professor Mangham dated as being sustained 6-12 hours before death;

iii) the perimortem rib fractures; and

iv) the death of D.

94. Dr. Zeitlin said she could not imagine that ordinary everyday handling of this baby, even taking account of his prematurity, could have caused the multiple rib fractures. Although Dr. Zeitlin, Dr. Lockyer and Professor Mangham accepted that the fresh anterior rib fractures could have been sustained in the course of the administration of CPR.

Lay Evidence

95. I heard brief evidence from the maternal grandmother, J, and from the paternal grandmother, K. They both spoke warmly of the positive qualities of the mother as a parent to her children. Both spoke of the horror and distress of receiving a phone call in the early hours of the morning of 13th March 2019 when the mother telephoned her mother and then K to tell them D had died.

96. The maternal grandmother lived some distance away from the mother's home whereas the paternal grandmother lived just a few minutes' walk away. Accordingly, the paternal grandmother saw D, the parents and the other children on a very regular, if not, daily basis.

97. She was present for a short while in the early evening at the family home on the 12th March when she called in on her way home from work. She said all appeared to be well.

98. She knew and strongly disapproved of her son's (the father) use of cocaine which she understood he indulged in but rarely. She knew too that the mother strongly disapproved of the father's abuse of cocaine.

99. The mother's sister, L, gave evidence but she was, I regret to note, not an impressive witness. She was defensive, truculent and appeared extremely on edge. After the birth of D, when the mother remained in hospital, and then when she was re-admitted in late January 2019 because of medical complications following the delivery of the baby, L spent a great deal of time at the family home looking after the children with the father. She was present at the family gathering on 12th March 2019. After she had left that evening, the father sent her, what on any view, were two particularly fond and loving, if not amorous, text messages. L sought to explain the messages away by saying that:

i) she and the father had a close familial relationship, as did so many members of the maternal family; and

ii) in part the text messages referred to her assistance in designing a website for the father's proposed business.

100. First, I do not begin to understand the latter account. Second, it is of note that despite the alleged quite ordinary and natural reasons for these texts, L:

i) did not reply to either of them; and

ii) she did not tell her sister about either of them.

101. The mother only became aware of these text messages when the police examination of the parents' mobile devices was disclosed into these proceedings. I propose to say no more about this matter because if I did so:

i) I would be speculating; and

ii) it does not assist me in determining the facts surrounding D's death.

102. M is a close friend of the mother. She spoke in very warm terms about the mother's qualities as a mother to her children. She was at the family home on 12th March and was delighted when the mother asked her to be a godmother to D. She described the evening at the family home as relaxed and enjoyable. She left at around 10.30pm when the mother said she was tired and wanted to settle D down to bed.

103. The mother spoke in very warm terms of her great love for her children and of how she put their interests first and foremost. She told me of her very great sadness at the number of miscarriages she had suffered over the years and of the tragic death of F who had died in her arms as a result of her extreme prematurity. Given her very difficult obstetric history, the mother had decided that her pregnancy with D would be her last.

104. The father never lived full time with the mother notwithstanding their relationship over the course of the last 12 years. He maintained his home with his mother. He kept his clothes there and would often sleep in his bedroom at his mother's home, albeit after the birth of D he spent considerably more time with the mother at her home and more regularly stayed the night with her and the children.

105. It was plain from the mother's initial evidence, in chief and when cross-examined by Mr. Messling, on behalf of the local authority, that her relationship with the father was, at best, a difficult one but at times it was toxic. Their relationship was characterised by:

i) domestic abuse, both physical and verbal;

ii) the father's persistent use of cocaine of which the mother strongly disapproved;

iii) his persistent gambling habit;

iv) both of which led to him demanding/borrowing considerable sums of money from the mother – some £25,000 over the course of their relationship; and

v) according to the mother, and accepted by the father, his constant lies and her fears of his unfaithfulness which resulted in her not trusting him.

106. In terms of the domestic abuse, the mother accepted that she could, at times, be as physically and verbally aggressive as the father: some of her texts to him provide some evidence of her verbal aggression and abuse. The mother told me she had been subjected to domestic abuse in her previous relationship with E's father. Nevertheless, she accepted that during the course of an argument with the father in March 2018, she so completely lost her temper and control with the father that she physically assaulted

him not only when some of the children were present but when the father had C in his arms.

107. The mother accepted that she had been repeatedly told by health professionals of the risks and dangers of co-sleeping with babies and young children and of the clear advice not to do so. She accepted that during a visit by the health visitor on 12th March 2019, H had strongly advised against the mother and the father co-sleeping with the children, especially D. However, the mother told me that co-sleeping with her children had worked for her and for the father: they had regularly pursued the practice with all of their children.

108. In respect of D, however, she was adamant that after his discharge from hospital she had always slept downstairs with D: he in his Moses' basket and she on the sofa. Save that on the night of 11th March, for the first time, she and the baby slept in her bedroom with the father, B and C, albeit that D slept in their bed inside his 'sleepyhead' pod. Prior to this night, the mother denied any other occasion when she or the father had co-slept with D whether during the day or the night.

109. The mother identified two periods of time when D was in the sole care of his father, namely:

i) for a period of some three hours on 8th March when the mother was at a local public house with M celebrating the birth of D; and

ii) on the evening of 12th March when she left the family home in the late evening for about an hour to go the home of the paternal grandmother, meet up with M and, after purchasing a bottle of wine from a local shop, to return home with M.

110. The mother denied she or the father had done anything to D which might have resulted in him suffering the multiple rib fractures identified by Professor Mangham.

111. During the course of her cross-examination by counsel for the father, the mother, in my judgment, undermined much of her earlier evidence when she had spoken in clear and vociferous terms about the inexcusable conduct of the father and of her utter lack of trust in him. In this part of her evidence I gained a clear sense of the mother seeking to minimise or excuse the father's behaviour towards her and its adverse impact on the children.

112. The father was a most unsatisfactory and unreliable witness. He started his evidence by assuring me that he had sworn on the Bible to tell the truth and he would do so. In examination in chief he made admissions, from time to time, of lying to the police and to the court about various accounts he had previously given; most notably about his past use and abuse of cocaine.

113. Early in his cross-examination by Mr. Messling, he admitted that he had, in the past, been a serial liar who had lied when and whenever he thought he had the need to do so. In mid-2019 he had stood trial for an offence of fraud by misrepresentation. He had pleaded not guilty and on advice, he said, he had not given evidence at his trial. When asked whether the jury's verdict was correct, he said 100%. When asked why then he had pleaded not guilty, he said his first reaction was always to deny and lie in his best

interests. When asked when he had decided to turn over a new leaf and to tell the truth, he said it was upon his release from his prison sentence in September 2019.

114. The father then said, for the first time, that he had taken cocaine before he looked after the children on 8th March 2019 when the mother was out for the evening with her friend, M. He claimed he had told the mother recently about his use of cocaine on this evening. Upon seeing the mother's tearful reaction to this evidence, he immediately retracted his evidence, said he had made a mistake and that plainly the mother was hearing this account for the first time. He could not explain why seconds earlier he had asserted that he had told the mother about his abuse of cocaine on this evening.

115. It was a most inauspicious start to his evidence and to his asserted claim that he was going to tell the court the truth.

116. At the family gathering on 12th March for the Cheltenham Races, the father gambled by placing bets on the races at a bookmakers and by using his 'betting app'. He said that in contrast to his normal form, when he would win thousands of pounds, on this day he lost at least three hundred pounds. Earlier in his evidence he had described the 12th March as a happy day, that he was feeling good and was enjoying himself. Later in his evidence, as his betting losses mounted, he said he was 'desperate', 'it was a crap day', 'the betting was not going good' and he felt so desperate that he needed some cocaine. Around 4pm he contacted his dealer, collected the cocaine about 5pm and took it at his mother's house before returning to the mother and the children.

117. Later that day, as his mobile telephone records established, he again contacted his drugs dealer and collected further cocaine around 9pm. In evidence the father claimed that after collecting the drugs he had a change of heart, did not want to ruin the 'happy' day and left the cocaine at his mother's house. I do not believe him. He has been a cocaine addict, albeit he denied being an addict, for twenty plus years, he had had a frustratingly bad day betting on the Cheltenham races and he had already consumed a quantity of cocaine in the late afternoon. I cannot accept that in these circumstances that he did not take this cocaine on the late evening of 12th March at his mother's home before, once more, returning to the mother and the children.

118. The father, like the mother, was first interviewed by the police on the day of D's death. During the course of his evidence when discrepancies in his oral evidence compared with what he told the police in this first interview were put to the father, he complained that:

i) he was not in a good place on that day;

ii) he did not listen properly to the police officer's questions; and

iii) he ought not to have been interviewed.

I have some sympathy with his complaint, but the nature and number of the discrepancies cannot all be explained away by this explanation.

119. He was asked in his police interview about the sleeping arrangements for D on the nights of 10th, 11th and 12th March and conveyed the impression that B, C and D had all slept in the parents' bed with them. Whereas, he maintained in his evidence that D and

the mother had only slept in the parents' bed on the nights of 11th and 12th March and not on the night of the 10th March. He told the police that 'normally' the mother and D slept on the right hand side of the bed and he and C slept on the left hand side of the bed, with B sleeping at the bottom of the bed. Whereas, when he went up to bed on the night of 12th March D was sleeping on the far left hand side of the bed, the mother lay next to him, lying on her right side facing D, with C sleeping towards the right hand side of the bed. The father lay down next to C. In his evidence he disputed this account and said that when he used the term 'normally' in the police interview he was speaking about the usual sleeping arrangements for C and not for D. I regret I do not believe him.

120. In his police interview he said that after C had awoken for the third time that night for a bottle of milk, he had become concerned that D had not woken for his night-time feed. He went to check on him but 'found him difficult to find'. When asked about this, he said in his evidence that D had been hard to find because it was dark. It was put to him that he had told a member of the nursing staff on the day of D's death that 'when he found D the duvet was up over him'. He accepted that he may have said this but that it was not true. At first he said it was difficult to say where the duvet was and then said it was 'half way up us'. His account to the nurse would explain why he had difficulty finding D in the bed. His account in evidence would not explain why he had difficulty finding D.

121. The father said in his evidence that he was aware that the mother had turned over during the night to sleep on her left side and as she did so she moved further away from D and closer to C and the father.

122. When the father eventually found D, he was convinced the baby was dead. He shook the mother awake and told her that D had 'passed away'.

123. The father denied doing anything to deliberately or intentionally harm D or to cause him any injury.

124. The father accepted that he had been present with the mother when the health visitor visited them earlier this day and gave the clearest possible advice against co-sleeping with D.

125. At paragraphs 57 and 58 above I referred to the father's repeated cutting of his hair which prevented effective drug testing being undertaken. Having listened to his evidence I am satisfied he deliberately continued to cut his hair to prevent effective drug testing being performed. He knew any drug test would demonstrate that he had continued to use cocaine. Ultimately, in May 2020 he did undergo a drugs test and it was positive for the use of cocaine. He told me that since May 2020 he has not taken any cocaine. I hope this is true. I am satisfied the father wanted to hide his continued use of cocaine and nothing more sinister was intended. Accordingly, I do not draw any adverse inference against him.

Analysis

126. I have no hesitation in accepting the expert medical opinion which is unanimous in all material respects. Dr. Lockyer and Professor Al-Sarraj were both careful to restrict their opinions to their respective observations and examinations at the post-mortem and on the examination of the brain and of the spinal cord. Dr. Zeitlin, in providing the

paediatric overview, felt able to offer a firmer overall opinion. I am immensely grateful to all of the expert medical witnesses for their reports and for their clear and helpful oral evidence. It was plain that in this complex case they had each given it earnest consideration and had reached measured and compelling conclusions.

127. I must now consider this expert medical evidence together with the totality of the evidence I have read and heard to determine the findings of fact I am satisfied, on the balance of probabilities, that I can properly make.

128. D was a premature baby and was therefore a vulnerable child but Dr. Zeitlin told me that he had been progressing very well and putting on weight. The prospect that he simply stopped breathing and died with 20 rib fractures (I discount the 3 rib fractures that may have been sustained during CPR) of different ages is so unlikely as to be a remote possibility.

129. The mother and the father accepted the expert evidence that D had sustained 23 rib fractures and that there was no medical or organic cause of the same. During at least two events these fractures were sustained. The parents could not give me any explanation for the cause of any of them.

130. It is in this context that I consider the cause of death. The parents admitted co-sleeping with D on the nights of 11th March and 12th March. I consider it is more likely than not that he slept in his parents' bed with his parents and his brothers, on more occasions than just those two nights for the following reasons:

a. the mother told me that co-sleeping had worked for her and the father with D as it had with their other children;

b. in the father's first interview with the police he spoke of the 'normal' sleeping arrangements which included D, B and C sleeping in their parents' bed with them; and

c. at the hospital on the day of D's death the mother told a member of the nursing staff that she feared she had rolled over onto D. This was said at a time when it was unknown that D had sustained rib fractures.

131. For the reasons set out in the preceding two paragraphs, I am satisfied that the parents have not told me the truth about the events in the family home over the period of Friday 8th March to the early hours of Wednesday 13th March.

132. On the basis of the expert medical evidence I am satisfied that D died in the very late evening of 12th March or the very early hours of 13th March from asphyxia which was caused either by:

i) one of his parents over laying him so as to occlude his airway; or

ii) D being in a micro climate in his parents' bed which was low in oxygen and high in carbon dioxide.

I do not accept he died as a result of overheating because Professor Al-Sarraj was of the opinion that this mechanism of death would not result in the changes in the baby's brain identified by him.

133. How were his rib fractures sustained? On the basis of the expert evidence, there are just two possibilities either:

i) the rib fractures were sustained in two or more episodes of overlaying by one or other of his parents; or

ii) they were inflicted in two or more events by one or other of his parents compressing his chest sufficiently forcibly as to cause fracture of D's ribs.

134. Given that I have found that the parents have not given me a truthful account of the events in their home over the relevant period, should or must I leave open the possibility that the rib fractures resulting from inflicted injury?

135. In seeking to answer this question I have considered the following factors:

i) the parents had a volatile relationship which, from time to time, resulted in physical and verbal abuse;

ii) save for the mother's assault on the father in March 2018, none of the physical abuse appears to have taken place in the presence of the children or in recent times;

iii) the verbal abuse appears to have been mainly restricted to exchanges via text messages;

iv) the father was a long-term drug addict and, from time to time, indulged in binges of drug and alcohol abuse which, most notably, prevented him from collecting the mother and C from hospital after his birth;

v) the father's conduct towards the mother has, at times, been shameful and he has put his drug and gambling habits ahead of the needs of the mother and the children. This has resulted in him 'borrowing' £25,000 from the mother over the course of their relationship;

vi) the mother and the father do have many fine qualities as parents. The parenting assessment undertaken by the local authority, albeit completed before the disclosure of the parents' mobile telephone records revealed the truth of their volatile relationship, is very positive about their abilities as parents to A, B and C;

vii) I have no doubt the children are delightful but all three presented challenges to the parents:

a) A with the need to control her diabetes;

b) B as a child with autism;

c) C as a child who woke very regularly throughout the night; and

d) in addition, the mother had to contend with the challenging behaviours and misdemeanours of her son, E;

viii) the children's schools and health professionals are all entirely positive about each of the three children and the care that they had received from the parents;

ix) it would appear that the difficulties in the parents' relationship had not had an adverse impact on the development of these three children;

x) apart from occasional hand slapping, which I do not condone, there is no evidence of the mother or the father being physically aggressive to or of assaulting any of the three children – the evidence is all the other way;

xi) the mother and father very clearly love A, B and C and very much loved D;

xii) the mother had had a very difficult obstetric history. She had suffered a number of miscarriages. The parents then suffered the tragic loss of F who died, as a result of her extreme prematurity, in her mother's arms; and

xiii) in light of this difficult obstetric history, the parents had agreed that D would be their last child.

136. I have very well in mind the revised *Lucas* direction and the words of the now President in *Re H-C*, at paragraphs 35-37 above. In my judgment the parents have not told me the truth, not for any sinister reason but, it is far more likely, they have not done so because of the guilt, shame and remorse they both now feel as a result of their roles in the death of D.

137. I also take account of Dr. Lockyer's opinion that this was an unusual case because it was rare to find rib fractures at post-mortem in isolation. There were no subdural haemorrhages, no subarachnoid haemorrhages and no retinal haemorrhages which are often, but not always, found in cases of inflicted non-accidental injury.

138. In all of these circumstances, whilst it is a possibility that one or other of them inflicted the rib fractures which D sustained on two or more occasions, I am satisfied that it is, on the balance of probabilities, far more likely that they were sustained in, at least, two episodes of overlaying D when he was co-sleeping with his parents.

Findings of Fact

139. I do not consider it necessary or appropriate to make each and every finding of fact sought by the local authority.

140. My principal findings of fact, made on the balance of probabilities, are as follows:

i) D died in the late hours of 12th March or the early hours of 13th March;

ii) he died as a result of asphyxia by:

a) overlaying by his mother or by his father; or

b) by being confined in a micro-climate where the atmosphere was low in oxygen but high in carbon dioxide;

iii) in recent times but, most importantly, on the morning of 12th March the parents had been strongly advised by the health visitor not to engage in co-sleeping with any of the children but, most especially D – given his vulnerable and premature condition – and not to use the sleepyhead pod. This advice had been given in clear and unequivocal terms;

iv) in the premises, his tragic death was entirely preventable either by:

a) his mother not having passed out (as a result of tiredness and/or the consumption of alcohol) with D on her chest when she went upstairs to settle him down for the night; and/or

b) the father removing D to a place of safety, that is to his attached cot, when he went to bed late in the evening of 12th March and/or when he woke up in the very early hours of 13th March to attend to and to feed C, who was also in bed with the parents and B;

c) at the time of these events the mother was extremely tired and under the influence of alcohol consumed during the course of the day and the father was under the influence of cocaine taken during the course of the day, most particularly in the late evening of 12th March, and exacerbated by the consumption of alcohol taken throughout the day;

v) the three recent anterior fractures may have been sustained during the course of CPR administered by the mother or, more likely, by the paramedics who attended to D on 13th March;

vi) the other anterior rib fractures and the posterior fractures set out in paragraphs 73 & 74 above were sustained either by one or other of the parents overlaying D on, at least two separate occasions, namely some time on the 10/11th March 2019 or 12/13th March;

vii) during the latter event the spinal nerve root haemorrhage identified by Professor Mangham and Professor Al-Sarraj is most likely to have been sustained by the compressive pressure resulting from the overlaying;

viii) the parents have both denied having overlaid D at any material time in the period 8th March to the late hours of 12th March 2019; and

ix) in the premises, the parents have not given me an honest account of the events that befell D between 8th March and the early hours of 13th March.

Conclusions

141. This is a tragic case in which D, a small premature baby, died in circumstances which were wholly preventable. I propose to say no more about the culpability of the parents because these loving parents of a much-cherished child will have to live with the fatal consequences of their actions in March 2019.

142. At the welfare hearing in August I will determine the future care arrangements for A, B and C in the light of the findings of fact I have made.

Postscript

143. A draft of this fact-finding judgment was sent to counsel on 23rd July 2020 for proposed editorial and typographical corrections. I gave permission for a copy of this draft judgment to be provided to the parents.

144. Subsequently, both the mother and the father filed and served witness statements in which they:

    i) accepted all of the findings of fact I had made; and

    ii) apologised, in terms, for not having been entirely frank with the court in their written and oral evidence about the events of 8th to 13th March 2019.

    Most importantly, they accepted that co-sleeping with D had occurred on nights in addition to the admitted events of 11th and 12th March.

145. In consequence, prior to the commencement of the welfare hearing, the local authority proposed that A, B and C should be rehabilitated to the care of the mother, supported by the father, with the benefit of a Child in Need Plan for all three children. The children's guardian supported the proposed rehabilitation subject to some amendments to the Child in Need Plans.

146. On the first day of the final welfare hearing I was told by counsel for the local authority that all parties were in agreement with the rehabilitation plan and that it was proposed, subject to the court's approval, that the children should return to the care of the mother, supported by the father, later in the evening of that day.

147. I unhesitatingly approved the rehabilitation plan as being manifestly in the welfare best interests of A, B and C.

148. Given that this case arose from the death of a much loved baby, D, whilst in the care of the mother and the father, I am bound to explain my reasons for coming to this conclusion and approving the return of the three children to the care of the parents.

149. There is no doubt that the parents deeply love each of the children and the children deeply love their parents. The accounts of observed contact between the children and the parents are uniformly positive.

150. The parents' relationship is somewhat unconventional and has, from time to time, been characterised by very aggressive and emotive mobile telephone messages exchanged between them. It has very occasionally included physical confrontations.

151. The father's conduct in securing or taking monies from the mother to fund his gambling or drug habits is appalling. His long-standing addiction to cocaine cannot and is not condoned. I accept the mother never approved of his drug use and I accept that he almost invariably took cocaine at his mother's home and not in the presence of the children. During the course of his evidence at the fact-finding hearing the father asserted that since May of this year he had stopped taking cocaine.

152. Save for E during his teenage years, the family were unknown to children's services prior to the death of D. Since the inception of these proceedings the parents have fully co-operated with the local authority. They have each agreed to do so in the future and I do not doubt the sincerity of their agreement.

153. The parents were fully engaged with the children's schools. A and B attended school regularly and the parents always attended and engaged in parents' evenings.

154. All three children were achieving the best of their potential in the care of the parents. A's diabetes was very well managed. The parents, but most especially the father, were particularly adept at dealing with the challenges presented by B as a result of his diagnosis of ADHD.

155. Save for their practice of co-sleeping with all of their children, they were co-operative with health professionals. Whilst this practice may 'have worked for them in the past', it tragically did 'not work' for D.

156. The death of D was entirely preventable and resulted from the parents' very ill-advised practice of co-sleeping. I accept that the parents are stricken with guilt and regret that their actions resulted in the death of their baby. I do not doubt they will each endure this guilt and regret for the rest of their lives.

157. D's death did not result from any intentional act to harm him. It resulted from a very young baby being placed in a potentially life-threatening situation caused by co-sleeping and D being incapable of extricating himself from it. I am satisfied that A, B and C are not at any such risk of physical harm given their respective ages and degree of physical maturity.

158. The risk of any of them suffering any significant harm in the care of their parents is non-existent or, at worst, is extremely low, whereas the risk of them suffering significant emotional and psychological harm from the continued separation from their parents is very real.

159. I wish to pay tribute to the paternal and maternal grandmothers who stepped in and who have afforded excellent care to their grandchildren during these proceedings.

160. I am entirely satisfied that it is in the welfare best interests of each of the children to return to the full time care of the mother, supported by the father and supported by the local authority as outlined in the Child in Need Plans.

161. I am pleased to note that no party sought any public law order to underpin the rehabilitation of the children to the mother supported by the father. A care order would have been an unnecessary, disproportionate and inappropriate interference in the private lives of the parents and of the children. A supervision order would have added nothing of value to the agreement of the parents to work co-operatively with the local authority under the terms of the Child in Need Plans: see s.1(5) of the 1989 Act.

162. All parties were agreed that an anonymised version of the fact-finding judgment and this revised judgment should be published. I hope the publication of these judgments will highlight and underscore the dangers inherent in co-sleeping with babies and young children.