Neutral Citation Number: [2018] EWFC 102

Case No: MA17C00972

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/10/2018

Before :

THE HONOURABLE MR JUSTICE HAYDEN

Between :

ROCHDALE BOROUGH COUNCIL	**Applicant**
- and -	
M	**1st Respondent**
(acting through the Official Solicitor)	
- and -	
F	**2nd Respondent**
- and –	
Z, B AND J	
(children acting through their Children's Guardian)	**3rd – 5th Respondent**

- -

Mr P Rothery & MS L Milburn (instructed by **Rochdale Borough Council**) for the Appellant
Ms J Delahunty QC & Ms N Ismail (instructed by **Temperley Taylor** solicitors) for the Respondent
Ms E Isaacs QC and Mr D Mackley (instructed by **Molesworths** solicitors) for the Respondent

Mr S Spencer on behalf of the Children's Guardian (instructed by **WTB** solicitors)
Hearing dates: 9 October 2018 to 22 October 2018

- -

Approved Judgment

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

.....

THE HONOURABLE MR JUSTICE HAYDEN

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

The Honourable Mr Justice Hayden :

1. I am concerned here with three children who are subject to Interim Care Orders in favour of Rochdale MBC. The case is listed both as a fact-finding hearing and for consideration of the welfare decisions that require to be made in respect of the children's future. Both parents are 41 years of age. They are cousins. The father (F) has resided in the United Kingdom (UK) since September 1984, when his parents immigrated. The parents married in Kashmir in 1997. The mother (M) joined her husband in the UK in 2001. The following year, in 2002 Z was born. B was born in 2003 and J in 2005.

2. M has been assessed within these proceedings as having extremely low cognitive ability. Her non-verbal reasoning is at the 0.2th percentile, and her 'processing speed' places her at the 0.1th percentile. M displays little ability to understand or communicate in English. Her native language is Murpuri. Though her language difficulties impede a clear assessment of her verbal reasoning, it is plain that she faces real challenges in this sphere. She has been assessed as having a learning disability. Throughout the proceedings she has also been assessed by two psychologists and a psychiatrist as lacking the capacity to instruct her solicitors.

3. Accordingly, M is a 'protected party' at this hearing, as defined in rule 2.3 of the Family Procedure Rules 2010. As such, she acts by her litigation friend, the Official Solicitor. M has had the benefit of Leading and Junior Counsel and has been assisted throughout the hearing by a skilled intermediary.

4. B, aged 15 years, has been diagnosed with Autistic Spectrum Disorder. B also has a significant learning disability and limited communication skills. All agree that he is a child who will need considerable input by skilled and supportive carers if he is to achieve his own potential. I have heard, during evidence, that he is an engaging and handsome young man.

5. Z, aged 16 years, is achieving extremely well in her academic studies. Her brother J, aged 13 years, also has real academic potential, although he is as not industrious as his sister. F comes from a family of high achievers and attended University, where he obtained a Diploma. He takes a great part in the life of his local community, where he perceives himself to be admired and respected.

6. The family first became known to the Children's Services Department in May 2005. The main concern of the Local Authority centred upon poor and neglectful home conditions and real concerns arising from the difficulties in meeting B's care needs, particularly his health and nutrition.

7. In January 2016, A was born. His weight was on the 16th centile at birth, fractionally over 3kg. During the course of his short life, which was to be only 17 months, the parents received significant support in relation to his feeding and weight gain. A's progress was faltering with periods of marked weight loss. He was admitted to hospital twice in 2016 for observations. On both occasions he gained weight but lost it again on his return home. No organic cause for the weight loss was identified. A's weight fell below the 0.4th centile, notwithstanding advice to the parents from dieticians. In the context of my analysis later in this judgment, it requires to be noted that a Health Visitor and three other professionals observed M force feeding A in

November 2016. She was seen to be squeezing A's cheeks to spoon food into his mouth. As I will relate below, she gave evidence at this hearing, but I note at this point, merely that in response to Mr Spencer's question, on behalf of the children that she identified A's reluctance to feed as a situation which made her very sad.

8. The initial Child Protection Conference in 2015 resulted in each of the three children being made subject to Child Protection Plans. The professional consensus appears to have been that some progress was made, notwithstanding my observations above concerning the force feeding of A in November 2016. In December 2016, Z and J were removed from the Child Protection Plan but B and A remained subject to its support.

9. Allegations of neglect remained in issue until this hearing. However, the parties were, ultimately, able to agree upon the findings this Court should be invited to make, based on the evidence of neglect within the papers. I endorse the agreement which it is necessary for me to set out:

> Findings about neglect
>
> 1. The children were subject to a child protection plan on the grounds of neglect from 17 June 2015, in the case of Z and J until 14 December 2016, in the case of A until his death and in the case of B until the issue of proceedings;
>
> 2. The parents have not met the children's health needs: they have failed to make or keep necessary medical appointments, for example:
>
> (i) The parents did not make appointments for Z, B or J with a dentist; it was found that Z and J required dental treatment when they were examined;
>
> (ii) The parents did not take Z for a review of her asthma, giving her instead an inhaler used by her brother;
>
> (iii) The parents did not make appointments for Z or J with an optician; both were found to need glasses when their eyes were examined;
>
> (iv) The parents did not keep appointments for B with Speech Therapy and Audiology which were necessary to promote the development of his communication skills;
>
> (v) The parents failed to take B to appointments made with a physiotherapist between 1 June and 4 October 2016;
>
> (vi) The parents did not take A to blood test appointments on some occasions in or around June 2017.
>
> 3. The parents neglected the care of the children by failing to keep the family home sufficiently clean and hygienic. On the day A died the home smelled of stale urine, bedding was left unwashed and was stained, mould was permitted to grow in the household and it was in places dirty. Unsanitary home conditions had been seen by professionals on earlier occasions between April 2016 and 2 July 2017;

4. The parents failed to attend properly to the personal hygiene of A and B, neither of whom had the self-care skills necessary to attend to it themselves:

(i) On post mortem A was found to have dirt in the fingernails, between the toes and in the groins;

(ii) B presented at school with his clothes stained with faeces, dirty and with an odour about him on a weekly basis from 2015 to 2017.

5. The mother and father failed to provide sufficient nutrition to A:

(i) A failed to thrive in their care: at times when A was in nursery or hospital he was able to gain weight, but weight was lost in his parents care;

(ii) The mother was observed on four occasions in November to force feed A using a spoon; she continued to do so having been advised against it.

6. The mother and father were unable to ensure A maintained weight gains he made at times he was at school, during periods of school holiday;

7. The mother has paranoid schizophrenia and learning disabilities which sometimes prevent her from meeting the needs of her children. The father accepts that despite his best intentions he was unable to ensure the children were not exposed to neglect which arose because of the mother's impairments.

Harm

8. By reason of the facts set out above at the time proceedings were brought:

(i) A had suffered neglect and impairment of his development; and

(ii) Z, B and J were at risk of suffering neglect and impairment of their health and development in the care of their parents.

10. On 2nd July 2018, at 7.25pm, F called the ambulance services to the family home. The paramedics arrived within three minutes. A was examined and found to be in cardiac arrest. His extremities were cold to the touch. He was already dead. A was taken to hospital in the ambulance but, despite prolonged resuscitation, circulation was not restored. At 8.30pm A was formally certified as dead. The cause of A's death has been the focus of the fact-finding aspect of this hearing, along with the identification of perpetrator, should the Court find A's death to have been inflicted.

11. It is now clear that prior to his death A sustained six anterior rib fractures:

i) Second right rib with evidence of trauma two to twelve hours prior to death;

ii) Non-displaced incomplete fracture to fifth right rib 17mm from the costochondral junction, two to twelve hours prior to death;

iii) Partial fracture to fourth left rib 22mm from the costochondral junction, two to twelve hours prior to death;

iv) Partial fracture to fifth left rib 13mm from the costochondral junction, two to twelve hours prior to death;

v) Partial fracture to the sixth left rib 6mm from the costochondral junction, **caused within two hours of death** (my emphasis);

vi) Partial fracture to the seventh left rib 5mm from the costochondral junction, caused two to twelve hours prior to death.

12. It is also important to record, at this point, that the Post-Mortem identified a three-centimetre mesenteric bruise in the upper abdomen, centred about the mid-line, and bruising to the internal chest.

13. The rib fractures and associated mesenteric bruising were caused by a significant compression of A's chest, either by squeezing from side to side or by pressing on his rib cage from front to back. All agree on this aspect of the evidence and neither parent has proffered any explanation, despite accepting that they were inflicted. Professor Mangham, Consultant Osteoarticular Pathologist, examined the rib fractures with radio graphs, naked eye inspection and with microscope. He considered, based on the microscopic findings, that after the rib fractures were sustained, A survived for a period of at least two hours or possibly longer.

14. On 11th July 2018 Dr Newbould, Paediatric Pathologist, Professor Mangham, Consultant Osteoarticular Pathologist, Dr Lumb, Forensic Pathologist, and Dr Morrell, Consultant Paediatrician, were present at an experts' meeting. Mr Spencer distilled the extent of the agreement between these experts, which I set out in full. Where agreement is not recorded, it reflects deference to appropriate expertise.

Schedule of Concurrence

ISSUE	***AGREEMENT***	***DISAGREEMENT***
Composition of bones	Agreed that the composition of the bone is normal. There is no evidence of any underlying bone disease.	None
Mechanism of fractures	There were six fractures. Rib fractures were caused by chest trauma, specifically chest wall compression, either in a front to back or a side to side direction. CPR did not cause the rib fractures.	None
Timing of Fractures	The rib fractures occurred within hours of death. Timeframe of between 2 and 12 hours prior to death for five of the fractures. The sixth fracture lacks a feature that would confidently	None

	place it within that timeframe but could have occurred at around 2 hours prior to death. Likelihood is that all occurred at the same time but it is not possible to completely exclude that they occurred during separate incidents during the timeframe.	
Patent Ductus Arteriosus	Anatomical finding. No evidence at all in the clinical records that A had heart failure, or any evidence of cardiac compromise. No evidence in post-mortem of any cardiac compromise. No evidence that it was a physiological finding. Patent ductus arteriosus is not relevant to cause of death.	None
Time of Death	Death medically registered at just after 19:30. Circumstances described allow for time of death to be an hour or two prior to that time. Time of death likely to be between 17:30 and 19:30	None
Cause of Death:	Sudden and unexpected death. Cause of death unascertained on post-mortem examination. Asphyxial death cannot be excluded nor can other causes of death which leave no pathological features.	None
a. Presence of the rib fractures.	Presence of rib fractures implies a compressive force applied to the chest. Such a compressive force could also produce asphyxia but may not necessarily do so. Both rib fractures and asphyxia can be caused by the same mechanism – compression of the chest. It is possible that compression of the chest over time could have produced rib fractures and then further compression of the	None

	chest could cause asphyxia. Presence of rib fractures and their age indicated that the chest was being compressed, at least, two hours prior to death which itself may make a subsequent event of chest compression more likely. In this case, the compression of the chest which caused the rib fractures could not have, at the same time, caused death but subsequent compression of the chest could have caused asphyxia.	
b. Presence of undigested/unchewed food stuffs in the stomach	Post-mortem examination revealed the presence of large pieces of apricots. These were not chewed and were swallowed whole. Raises the possibility of airway obstruction by food bolus. This would leave no pathological features but relevant observations and/or history would be expected.	
c. Presence of hemosiderin deposits in the lungs	No significant hemosiderin deposition within the lungs – There was insignificant hemosiderin staining. Non-specific feature. No relevance to the cause of death.	
d. The description of the mother having subsequently stated that "she had been feedings the baby and he just stopped breathing"	Very unusual history to be given in a sudden and unexpected death. Significance of the statement is unclear on the limited information presented. If further information is obtained would require consideration.	
e. The consanguinity of the parents	No relevance to the rib fractures. Consanguinity increases likelihood of autosomal recessive disorders, in particular, metabolic disorders,	

	some of which have been associated with sudden death in childhood. A underwent various investigations which did not reveal any metabolic abnormalities – including checking of amino and organic acids and post-mortem blood spot testing. Neonatal blood spot test results have not been found but assumed to be normal. No history given which is suggestive of metabolic type illness. Metabolic abnormality is very unlikely to be cause of death. Death as a result of metabolic abnormality would be accompanied by preceding signs and symptoms. Very difficult to establish any relationship between consanguinity to A's sudden and unexpected death.	
f. A's history of poor weight gain	A did have a failure to thrive and developmental delay, the cause of which is not clear. It is possible that that was the way a metabolic abnormality could present. However, there would need to be other evidence of some underlying metabolic abnormality – which is absent in this case. Another possible explanation for the history of poor weight gain and developmental delay would be neglect. A lack of weight gain consequent to a poor supply of food may make a person more vulnerable to choking due to hunger.	None
g. The presence of streptococcus pneumoniae	No evidence of infection in histology or any other investigations, for example, the CSF urea. No history that the child was ill at the time of his death.	None

	Sudden unexpected death is not associated with death due to serious bacterial sepsis. Would have some evidence of illness, or some histological evidence of tissue damage. No evidence of inflammatory process. No evidence of pneumonia in the lungs. Very likely to be artefact.	
h. The finding of possible hypoxic change within the hippocampus of the brain	In order to make a diagnosis of death due to a seizure disorder a relevant history is required. Absent such a history relevance of finding cannot be stated. Only a 'possible' change. Cases of death from seizure activity usually have very strong history leading up to death, rather than it being the first seizure. Entirely non-specific feature of this case which does not assist in determining events and cause of death. No significance to cause of death.	None
i. The comments, noted by Dr Morell at [E196]. from A's nursery in the few weeks preceding his death as to him having "shown episodes of vacancy	Difficult to interpret relevance from limited statement. No investigations were undertaken following reports – no EEG.	
Further Assessment	**Prof. Mangham**: No further testing required. In the absence of any histological evidence of manifestation of any genetic abnormality or mutation there is no real evidence of bone weakening. Therefore, even if a mutation in a Type I collagen gene were shown to be present, it would still have no bearing on strength of A's bones. Histologically, his bones appeared entirely normal, away from the fracture sites.	

	Dr Morrell: If positive result returned on testing for any cardiac arrhythmia on DNA samples then could give "*a clue as to cause of death*" but would not "*prove anything*". Testing for inherited epilepsy syndromes would not help to "elucidate the cause of death". Agrees with observations of Dr Newbould and Dr Lumb. **Dr Newbould:** In the absence of a family history it is very difficult to establish what would be helpful investigation. Even if further genetic testing is done, then interpretation of result to individual case can still be difficult. "*Though its technically possible, I'm not sure what it would actually achieve*". **Dr Lumb:** Even if genetic testing undertaken and positive results for cardiac arrhythmia gene, or epilepsy gene, were returned his conclusions would not be altered. "*Just because the individual has that gene doesn't necessarily mean they have died of if. And also, we'd still not be in a position of not being able to differentiate between upper airway obstruction, traumatic asphyxia, and all these other things*".	
Relevance of APEP research for analysis and conclusions of Prof. Mangham.	APEP was a short study into the significance and evidence of interpreting zonal osteocyte necrosis. Outcome of APEP research was that it can be measured objectively – in fractures of a certain age the nuclear staining intensity reduces as one examines further away from the fracture line. This feature becomes evident in fractures around two hours following fracture occurring, and persists, depending on the size of the fracture and the bones involved.	

	It has not been peer reviewed. It is not ready to be formally written up and published. The relevant literature relied upon is reviewed and detailed with addendum report from April. Position remains unaltered.	

15. As no direct causal link, was identified in the pathology, to establish a cause of death, the ultimate finding was that cause of death was 'unascertained'. This is, as all agree, not uncommon where, as here, a question of possible asphyxiation arises.

16. In these circumstances the Court is required to survey the wide canvas of evidence available to it and to evaluate whether the pathology in the context of the other available evidence establishes a cause of death to the requisite standard of proof.

17. The law is now settled in this area. It is crystallised in the case of **Re: B (Care proceedings: standard of proof) [2008] UKHL 35** and in **Re: SB (Care proceedings: Standard of proof) [2009] UKSC 17.** It requires, briefly, to be set out. In **Re: B**, at paragraph 2, Lord Hoffman states as follows:

> *"If a legal rule requires a fact to be proved (a fact in issue'), a judge or jury must decide whether or not it happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof If the party who bears the burden of proof fails to discharge it, a value of nil is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened." And at paragraph 13 "I think the time has come to say, once and for all, that there is only one civil standard of proof and that is proof that the fact in issue more probably occurred than not".*

18. Baroness Hale amplified the principles in this way:

> *"In this country we do not...require documentary proof. We rely heavily on oral evidence, especially from those who were present when the alleged events took place. Day after day up and down the country, on issues large and small, judges are making up their minds whom to believe. They are guided by many things, including the inherent probabilities, any contemporaneous documentation or records, any circumstantial evidence tending to support one account rather than the other, and their overall impression of the characters and motivations of witnesses. The task is a difficult one. It must be performed without prejudice and preconceived ideas".*
>
> At paragraph 32 Baroness Hale made this point

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

19. The 'broader canvas' in this case is extensive. I have received transcripts of ABE interviews from M and F as well as from Z and J. I have a transcript of the 999 call and have listened to it, with the parties, in court. I also heard oral evidence, by video link, from Z herself. All the police material from the extant investigation has been filed within these proceedings. I have, in addition, been shown emails which the parties have agreed are significant. From the body of material, the court is required to sift and analyse that which informs the investigation and that which can properly be discarded.

20. It is also convenient at this point to consider the evidential impact of lies told by a witness. As Ms Isaacs QC recognises, on behalf of the father, F has lied under oath, having sworn on the Koran on several occasions. In his oral evidence, F was driven to acknowledge this. In **R v Lucas (R) [1981] QB 720**, the Court of Appeal, Criminal Division stressed that people sometimes tell lies for reasons other than to conceal guilt. In addition, Charles J, in **Re: R (Care proceedings) [2002] 1 FLR 755 at 765**, also emphasised the flaw in reasoning that just because a person is lying about point (a), he must therefore be lying about point (b). In this case I have had these principles at the forefront of my mind.

21. The starting point in assessing the evidence is the conclusive expert opinion that the rib fractures, sustained on 2nd July, were a consequence of at least one episode of chest compression. In their oral evidence, as I have stated above, neither F, M nor Z referred to any incident in the course of the day which could conceivably explain the findings.

22. M was assessed by Dr Parsons, a Consultant Forensic Psychologist. Some aspects of his conclusions require to be highlighted:

    i) M is able to understand the significance and 'honesty of her answers';

    ii) There was a significant risk that M would be confused at times and she is to be regarded as susceptible to being influenced by direct questioning, especially leading questions;

    iii) She understands the nature of the oath;

iv) M is, with appropriate assistance, able to accurately and coherently answer questions.

23. In his initial report, in May 2018, Dr Parsons had taken a very pessimistic view of M's competence to give evidence and of her capacity more generally. He did not consider that her understanding of the process would be sufficient to enable her to provide coherent answers. It requires to be said that his views changed considerably. He explained this by identifying that his original report had been "entirely based" on his own clinical interview with M, alongside the psychometrically determined cognitive functioning tests. In his second clinical interview he noted M's presentation 'had changed'. He observes M was able to give longer answers, she was more spontaneous and she was able to read aloud in Urdu. It was this, he explained, which caused him to change his opinion. Ultimately, his evidence was that M's competency was not static but amenable to change. It was necessary, therefore, for me to require him to attend prior to M giving her evidence to be sure that she was sufficiently competent on the day. Dr Parsons considered that she was, which conclusion was reinforced by my impression of her evidence.

24. I am bound to say that I have not found Dr Parson's clinical method to be clear or consistent. When he was asked to identify where in his reports he established the test for 'competency to give evidence' and 'capacity to instruct', he was unable to do so. In short, they are not included. Notwithstanding this, for the reasons above, I was satisfied that M was competent to give evidence.

25. As I indicated above I consider that the assistance of the intermediary in this case has been invaluable. She was alert to questions which were phrased in too complicated a structure and fastidious in identifying them to counsel. She prepared an excellent timeline diagram with drawings, illustrating different events in the day. She was helpful in shaping the formation of the questions and topics prepared by counsel in advance. M gave her evidence by video link from an assigned video conference room in the court building. In consequence of all these efforts I am satisfied that M was able to give of her best in the process. With the assistance of counsel, solicitors and highly efficient court staff the entire process of M's evidence was, in my view, a model of its kind. I was satisfied that M was aware of the significance of her evidence and fully cognisant of the importance of telling the truth.

26. I very much regret to say that I am entirely satisfied that M did not tell me the truth. On her own evidence and throughout the day on 2nd July 2017, she was with or close to Z. She gives no account, at all, of any incident which might have led to the six rib fractures. I conclude, with little hesitation, that this is a deliberate omission.

27. In her evidence M also supports F's account, at this hearing, that he left the home that afternoon to attend a seminar at a nearby Mosque. For reasons which I will set out below I reject his account. It follows, accordingly, that on this point to I do not accept M's evidence either.

28. Before I turn to the key features of the evidence surrounding the events of the afternoon of 2nd July 2017, one important aspect of F's evidence requires to be highlighted. In his conversation with Ms Holt, the key social worker, F is recorded, by her, as saying that when he returned from the Mosque he saw blood on A's face. To a social worker of Ms Holt's obvious ability and experience that was plainly an

important piece of information. Ms Holt made an immediate note of it in her notepad, which has been exhibited to her statement. F has now denied that he saw any blood that day. As I understand his evidence, he now suggests that he was mistaken and had confused A's red face with a blood stain. I have endeavoured to set his account out as neutrally as I can, but it is, however carefully expressed, entirely implausible. F is an intelligent man and what is recorded by Ms Holt is an earlier account by him of his son in either a moribund condition or dead. Moreover, it is entirely inconsistent with the preponderant descriptions of A as "pale" and "yellow". In the same note Ms Holt records F as telling her *"I thought my wife or [B] might have done something to the baby"* This strikes me as consistent with his report that A had "blood on his face". I have no difficulty in accepting that F described blood on A's face to Ms Holt (though he has been equivocal as to whether this was said) and this was precisely what he observed. His change of evidence on this point is, I find, significant. Logically, I find that F saw blood on A's face that afternoon.

29. From their different perspectives, each counsel, in their closing submissions, submit that a precise chronology of the events of that afternoon cannot be established with any degree of confidence. F has accepted lying on oath during his evidence. M faces obvious challenges in precise timing, entirely distinct from the observations I have made about her credibility. Z is a sixteen-year-old young person, estranged from her family, in foster care, giving evidence in the most difficult of circumstances. I agree with counsel that a clear picture can not be established. However, the central issue, as it has emerged, is whether I can be clear as to who was in the house at the time A was injured.

30. At this point it is necessary to consider the differential diagnosis proffered by Dr Lumb, who gave evidence before me. He analysed the possibilities in this way:

Trauma to the chest as a causal or contributory factor in death;

On this theory Dr Lumb considered the following to be relevant: the rib fractures were un-displaced and had not caused any internal organ injury; and there was no significant haemorrhage associated with any of the internal injuries. He did, however, consider that sustained pressure to the chest, from front to back, could cause respiratory compromise. Further he considered that mechanical disruption to the chest by the rib fractures could also impair breathing. He emphasised that, whilst there were no asphyxial signs, this was not uncommon even in fatal cases. He considered that an association between the rib fractures and death could not be completely excluded.

Airway obstruction;

In his report Dr Lumb again stressed that external upper airway obstruction, such as smothering, may leave no pathological traces. In A's case, given his age and the fact that he had teeth, Dr Lumb anticipated some injury to the lips had smothering taken place. He was pressed by Ms Delahunty on the absence of bleeding either to the mouth or on post-mortem examination of what was visible of the nasal mucosa. Dr Lumb readily accepted that the absence of these was a contra indicator to upper airway obstruction of the nose or mouth. However, he was very clear that if the court found as fact that there was blood on A's face that would shift the differential diagnostic pointedly to this direction.

Choking;

The post-mortem records and notes that it is 'of interest' that there were large pieces of un-chewed food in the stomach. Dr Lumb's report notes that there was no history of food becoming trapped or expelled from the airways. From a purely pathological perspective therefore, he could not exclude choking on a food bolus (i.e. a small rounded mass) as the cause of death. I should interpolate Dr Morrell's view that given no food of obstruction was identified post-mortem he considered this explanation to be unlikely, whilst not excluding it theoretically.

Natural disease;

Although no natural disease was identified at autopsy or any subsequent ancillary investigation, Dr Lumb properly highlights that there are some fatal conditions which leave no trace. Virology and toxicology showed nothing of significance.

31. Both Dr Morrell and Dr Lumb agreed, accepting Professor Mangham's conclusion, that death, in this case, must have occurred following an earlier episode of chest compression, by whatever mechanism, which lead to fractures. They considered that this precluded the possibility of a compression causing fracture and leading to death two hours later. As Mr Rothery, on behalf of the Local Authority, summarises their view, both would have expected considerably more wide-spread hypoxic ischaemic injury if that were the case; neither could accept that death could follow two hours after the compression was released. Both agreed that if the interval between compression, deprivation of oxygen and death was very much shorter then compression of the chest might very well be associated with death. One aspect of the post-morbid anatomy which is potentially supportive of this explanation is the evidence of very early hypoxic changes in the brain.

32. Though industrious effort has been made to establish a sequence of events or a 'timeline' for the 2nd July 2017, I do not propose to address the evidence on the basis that there is any clear or unequivocal evidence that enables that exercise to be productive. On their own evidence M and Z were in the house at all times. So too was B. Nobody at any point has suggested that there was a real possibility that Z was responsible for the injuries to A. They are correct not to. I do not consider, on the totality of the evidence, that J was in the house at the time of A's death, for reasons which I will expand below.

33. What has been controversial in the evidence is whether F was likely to have been in the house at the time the fractures were inflicted or, if there were two assaults on A, at the time of A's death. F's account is that on that afternoon he had attended at a particular Mosque in Rochdale, to listen to a seminar by a particular Cleric. He asserted that he had been directly involved in setting this event up and, as I understand his evidence, it was to have been one of a number that he had planned. The general theme, again as I understood it, was to raise awareness within the local Muslim community of some of the key issues of the day. I hope this captures the essence of what F told me on these points, but I must record that all his answers to virtually all questions asked were characterised by a torrent of rapid and not obviously relevant statements. He often became agitated and occasionally sought to present himself as a victim of some unspecified conspiracy by the professionals. Mr Spencer, in his written submissions, proffers the following summary of F's evidence: "*he appeared to*

demonstrate an exceptional focus on himself; he demonstrated little, if any, evidence of critical reflection on the circumstances surrounding A's death; he dissembled and lied throughout his evidence." I agree.

34. In her interview Z repeatedly talks of J going to the Mosque that afternoon. It is conspicuous that she does not refer to F going at the same time. Her entire account, properly analysed, points to F being present in the house for most of the afternoon. In particular Z states that her father was in the same room as her whilst B was being given a bath that afternoon. She was pressed by Ms Isaacs QC, on behalf of the father, to the effect that she was or could have been mistaken and that F was himself at the Mosque attending an event. Z, in common with her brothers, is polite, well-mannered and respectful. All the professionals have described the children in this way and properly, in my view, attribute it to an aspect of their care, by their parents, which was both good and nurturing. In her oral evidence Z was occasionally diffident and inclined to hide behind a self-effacing giggle. Ms Holt, in her own evidence, had foreshadowed this. Z accepted politely that there was a possibility that she was mistaken on this point but it was clear to me she was responding to a hypothesis. In response to Ms Isaacs last question she said, *"I do remember him* (i.e. F) *saying that he was going to collect J from the Mosque"*.

35. Though I ultimately concluded that J should not give evidence and thus I am conscious that his ABE interview has not been challenged, I note that J describes his afternoon's attendance at the Mosque that day in common place and mundane terms. He describes having visited Mosque for a study circle where the tutor *"teaches basics, like basic stuff"*. None of this resonates with F's description of the afternoon. In my judgement this accords more easily with Z's account which, it must be emphasised, contains supportive detail. In particular, she talks of A falling asleep as J left. Though she is undoubtedly wrong in her timing, she also talks of F going to pick J up from Mosque (in the body of her interview). Perhaps most tellingly, set in the context of the above, F's solicitors wrote to the Local Authority, by email, in December 2017 (i.e. five months after A's death) stating in entirely unambiguous terms that F had attended the Mosque for "evening prayers and to collect J". I conclude that as of December 2017 those were F's instructions. Nobody has sought to persuade me otherwise. Plainly, F has changed his account on this as on other matters. Mr Rothery identifies the following inconsistencies in F's evidence. These are largely, perhaps even entirely, accepted by F. He proffers no explanation for his changes of account:

(i) In his account at the hospital F says that he went to his parents' house with J at about 6 pm and then onto the mosque.

(ii) In that account he says he was playing cricket at around 5pm.

(iii) In his first police interview F says he left the house for his parents' house after 5 pm and that he took J to the Mosque at 6 pm.

(iv) In the email of 13 December 2018 his solicitors wrote "My client instructs that for mid-day prayers he attended the Feizan-e-Madina Mosque in Rochdale [cf statement of Mr Urfan of that mosque: "F did not attend for prayers on 2nd July")] and of the

evening prayers ***and to collect J*** he attended the Al Quba Mosque on 1 Copenhagen Street in Rochdale" (emphasis added).

(v) In his first interview father says he was leaving the house when A was being fed; in his second interview the father says he was in the house when A went to sleep. That puts him in the house rather later than he has sought to portray.

If there is a discernible objective in his lies it points towards a determination to exculpate himself from presence in the family home that afternoon. I have very little hesitation in concluding that he was present when A was injured.

36. During F's evidence, I noticed that he was dismissive towards Z when her evidence conflicted with his own. More than that, there was an underlying hostility towards her. I note also that whilst Z wishes to have contact with her father she has indicated that she would wish it to be supervised. She has not asked for the same restriction to be placed on her contact with M. Indeed, she would prefer contact with M to be as relaxed and informal as possible. Z plainly loves her family and, in my assessment, does not wish to criticise them. Her evidence to me has to be evaluated in this context. She is trying to support her family. Thus, her evidence which identifies F as being in the house on the afternoon of 2nd July has added validity.

37. Though the advocates did not confront it in cross-examination of Z, the fact remains that A was very seriously injured that afternoon. Z, on her own account, was present in this small terraced house. She purports to have heard and seen nothing at all that could explain A's injuries. I must conclude that she is being less than candid with the Court. In this omission in her evidence, I am satisfied, Z is seeking to protect her parents. I also record that the Guardian told me in her evidence that Z had, in her opinion, developed a real capacity to disassociate herself from her circumstances. In the midst of chaos, she was able to focus in on her studies and with very great effect. As I listened to Z I formed a similar impression. She struck me as having defended herself very heavily from the grief of losing her brother. I include this as an observation which may assist those who work with her in the future but, I emphasise, it is not intended to be critical of her in any way. I am inclined to think that Z has managed to insulate her thoughts about what happened that afternoon and is to some extent unwilling to revisit the events of the day. This does not, however, cause me to draw back from my conclusion that her evidence deliberately falls short of telling me the truth.

38. During cross-examination Z told me that she had changed A's clothes that day. As best she could remember this was around lunch time. Again, on this, I did not find her recollection of timing to be clear, nor did she seek to advance it in accurate terms. In my assessment she was simply doing her best, on this point, to describe what she saw. I do not think she perceived the point as evidentially significant. She told me that she had changed A's upper and lower clothing because both were wet. She agreed that they had become wet during the course of A's feeding. As the background history of this family shows they are not fastidious in matters of clothing and general presentation. For Z to have burdened herself with the responsibility of changing A it must have been obvious to her that he simply could not be left in that condition. I note also that it was Z and not either of the parents who took responsibility. With A's history of reluctant feeding and M's undoubted difficulties in managing it, I infer that

there had been some difficulty in getting A to feed that afternoon. A's reluctance to feed was causing real distress to this family. Not only did it make M very sad, on her own account, but it subjected F to the scrutiny of social services which, I find, was injurious to his pride and, as he perceived it, belittling of his status within his community.

39. Accordingly, I am clear this was a household under stress. It is inherently unlikely that anybody would injure a seventeen-month-old child for no reason at all. It is much more likely that the child was distressed and the carer simply not coping. Sufficient force was caused to fracture six ribs. All present in the house would have known about it. All, I am satisfied, did.

40. The Local Authority has, throughout, tried to find the kindest or most benevolent explanation for the cause of A's death. Initially and understandably in the context of the history of the case, they assumed a choking episode, perhaps during the course of overly forceful feeding. The history shows that M had repeatedly been advised on the danger of physically forcing A to eat. The presence, at least potentially, of some undigested apricot identified in A's stomach at the post-mortem seemed to support such a view. However, both Dr Morrell and Dr Lumb ultimately considered this to be unlikely.

41. Mr Rothery then explored the association between the rib fractures and respiratory compromise resulting in hypoxic ischaemic injury to the brain. Dr Lumb did not discount this as a possibility. However, he struggled to reconcile it with the absence of wide spread hypoxic ischaemic injury (see para 31 above). In response to Mr Rothery Dr Lumb stated that if blood had been seen on A's face that would *"entirely change the differential diagnostic"*. In simple terms this would have been most likely to have been associated with an asphyxial cause of death. It is for this reason that I consider F's account of blood on A's face to be significant (see para 28 above). F could not possibly have known the forensic significance of the blood at the time he mentioned it to Ms Holt. It is F's gradual recognition of the importance of the blood that has led him now to assert that he confused blood with A's red face. This is entirely unconvincing. Moreover, in the same conversation (again, see para 28) F talked of his wife or B as having *"done something to the baby"*.

42. Dr Lumb could not see any signs in the post-mortem anatomy of where the blood might have come from but, as he said, it is simply not possible to examine all the nasal mucosa. An obstruction to the airways resulting in bleeding is a separate and, having regard to the totality of the post-mortem evidence, subsequent injury.

43. In order that it is entirely clear I conclude, to the requisite standard of proof, that there was at least one forceful compression injury to A's chest resulting in the six rib fractures and a subsequent obstruction of the airways leading, within minutes, to A's death.

44. There is only one accurately ascertainable fact surrounding A's death. At 1852 hrs the phone records show that there was a telephone call from the main line phone in the home to F. It was only of three seconds duration. This was a signal for F to return the call on his mobile phone, in order to save money. F returned the telephone call. The account is that M rang asking F and J to come home as she had made chips for the children. I was told that she did not usually make such telephone calls. F told Dr

Nawaz, the paediatrician at the hospital, that at around 7pm, while at the Mosque, M telephoned him asking him to come home as she made some chips. Dr Nawaz records that F was very clear that M did not say anything about A. Dr Nawaz goes on to note that F told him that it took five minutes to walk back to the house. He records that F enquired about A and reported that M said he was not breathing. F said he found A in the cot. He looked pale, not breathing and was cold to the touch. F reports calling the ambulance immediately and not initiating resuscitation. In evidence to me F told me that he thought A was already dead at that point. In his first interview (01.08.2017) F said, *"as soon as I got home I saw the baby and like I said I had been called to a lot of community deaths and stuff like that so you know when I looked at the child I knew that he's passed away, you know, his body was* ***so*** *cold, I touched his hand… his forehead, it was* ***completely cold.****"* (my emphasis)**.** In his interview F said that when he got home M told him *"look, you know the baby's been unconscious for half an hour, can you ring the ambulance and find out what's happening…."* These two statements, much closer in time to A's death, strike me as consistent. M describes A as having been "unconscious" for half an hour. In her evidence she shied away from using the word death with a reluctance that was notable. Her proffered euphemism was "unconscious". She occasionally uses the phrase "passed away". I consider that F's observations of A's body, as he describes it, and M's description of A 'unconscious' point to A having been dead for some time, most probably the half an hour to which F refers. On this time scale and on my findings F was present in the house at the time A died.

45. In his closing submissions Mr Rothery invites me to find that "*the fractures to A's ribs were inflicted by M or F"*. For the reasons I have set out above I consider the evidence in support of that submission is compelling and, accordingly, make the finding contended for. Mr Rothery's second submission, as to the findings, is that *"A died as a result of asphyxia arising from compression of his chest by M or F"*. For the reasons I have set out above I do not consider that to accord with the weight of the evidence. It fails fully to recognise the significance of the blood on A's face and the extent to which that renders an airway obstruction causing the asphyxial event the most likely of the differential diagnostics. I find that in addition to the injury which caused the rib fractures there was a separate and subsequent incident involving an obstruction of A's airways, probably the nose, resulting in hypoxic ischaemic insult and death. The post mortem evidence as to the timing of the fractures and the limited extent of the hypoxic ischaemic damage also support this conclusion.

46. Mr Rothery's forensic objective in his cross-examination of F was to draw him into a pool of potential perpetrators. In this case that is limited to M and F. As is clear from my analysis above Mr Rothery achieved his objective. However, F was not cross-examined by him on the basis that he inflicted the fractures or caused A's death. That, in this case, was a perfectly appropriate course to take. The reality of F's own case, however sensitively prosecuted by Ms Isaacs, was to negotiate blame on to M. This was F's response, for the reasons set out above, from the very beginning of the investigation. Ms Delahunty, on M's behalf, told me, on a number of occasions, that she had specific instructions not to advance a case against F as perpetrator. By her 'instructions' Ms Delahunty means, of course, from the Official Solicitor. M does not have the capacity to instruct. Though I enquired as to the reasoning behind that position, Ms Delahunty properly reminded me that this would be to trespass in to an area protected by legal professional privilege. It is not appropriate for me to speculate

as to the reasoning underpinning this approach. It does however raise a question as to the duties and function of the Official Solicitor in these circumstances.

47. Ms Delahunty makes the following points as to the ambit of the Official Solicitor's role when acting on behalf of a protected party in Care Proceedings:

i) *In summary: the OS acts on behalf of a protected party (PP) and has a duty to conduct litigation fairly and competently on the PPs behalf. The OS is more than the PP's statutory advocate. The OS does not, however, have the role akin to that of the children's guardian for the PP. The Children's Guardian is appointed to represent the interests of the child. The duties of the children's guardian re wide ranging and, crucially, involve an investigatory and reporting role that is very different to a litigation friend (as the OS is).*

ii) *The OS will assess where the PPs best interests lie and will identify the risks and benefits of the various options before the court. The OS will consider all relevant matters to assist in putting a case on behalf of the PP the OS instructs the solicitor to act on their behalf with the PP. The OS does not take on an investigatory role: they will act on the basis of the information available to them from the evidence filed and from the PP through meetings with them by their solicitor. The OS will, in due course, instruct trial counsel as to what course to adopt for the PP based on all the material available to the OS to decide on PPS best interests in litigation.*

iii) *The OS is not bound to advance a case that is not properly arguable (e.g.: re that the ribs were spontaneously caused by less than reasonable force through some undetected bone disease or by CPR post cessation of the blood supply to the body).*

iv) *The OS is able to advance a case contrary to the PP wishes and feelings but to do so is to breach the PP rights under Article 6 and 8 ECHR. The stronger the conflict between the arguments advanced in PPs name and PPs now wishes the greater the interference with the PPs rights and the more important the need for the litigation friend to proceed with caution and to fully analyse the material before the court and the potential outcomes for the PP from it on the basis of alternative courses open to the Litigation Friend*

48. Engaging directly with my concerns, Ms Delahunty submits that there is a "significant difference" in "leaving the matter for the court to decide and advancing a case contrary to the ascertainable wishes and feelings of PP". She asserts that it is very

important for PP not to hear their litigation friend appearing actively to argue for a conclusion which is contrary to their wishes, feelings and expressed views. The logic of this approach drives Ms Delahunty, in what are headed 'Approved Closing Submissions', to submit the following (which I set out in full);

> *i. The mother has been clear in her police interviews and in her narrative to the court that the father was not at home in the period that the experts say that A sustained his ribs fractures. The court will determine the family's movements based on the totality of the evidence it has heard and read.*
>
> *ii. The OS does not positively advance a case that the father inflicted any injury upon A whether as the sole perpetrator of his fractures and a participant in his death or as a person who should be within the pool of perpetrators; even if the consequence of that litigation position would be dilute any findings against the mother The position advanced on the mother's behalf by the OS reflects his assessment of the mother's best interests and the legal advice he is given which not only take into account of the range of findings open to the court but also how each finding impacts upon the mother in the context of her needs and functioning in the society she moves in and the relationships she has in it.*
>
> *iii. As one would expect of a capacitious client, the likely consequences of each course of litigation action and decision have been factored into the OS's response to the case as pleaded and the evidence as heard. The OS has taken cognisance of the fact that the mother, at no stage, whether to Dr Nawaz, the police, Dr Margison or Dr Parsons, has said that the father had any knowledge of the circumstances that led to A's injury and demise and had specifically placed him as 'out' of the house in the afternoon in the relevant window.* ***The OS cannot and does not advance a hypothetical case on a protected party's behalf: there needs to be a factual foundation for the position advanced. As with other cases, it is not unusual that a case may be taken up on behalf of an involved party even if they themselves do not advance it.*** *(my emphasis).*

49. Whilst Ms Delahunty is entirely right to say that it is not unusual for another party to advance a case which has the collateral effect of assisting a third party, that was not the case here. As I have stated, nobody has attempted to identify F as perpetrator of the injuries. Moreover, in an investigative (sui generis) legal framework, guided throughout by the paramountcy principle, an exploration of the facts predicated on records, documentary evidence, hearsay and legitimate inferences is both proper and necessary. As such, it is not strictly 'hypothetical'. The predominant concern must always be to avoid injustice to the protected party. It is an uncomfortable experience to read a submission presented through the Official Solicitor that seeks, for example, to minimise the forensic significance of F's observation of blood on A's face whilst

declining to explore the possibility both that it may have been there and that F may have been responsible for it.

50. I emphasise here that I do not intend to be critical of Ms Delahunty in any way. To assuage her concern it is, I hope, clear from my reasoning that I recognise that she and the Official Solicitor have taken a different view of the Official solicitor's role in these circumstances. I am not suggesting that there has been any lack of attention to the detail of the case, the reverse is true. I do wish to highlight my real concern that the Official Solicitor should formulate clearer guidance for the profession as to the scope and ambit of his role in these circumstances, which arise with sufficient regularity to require a clear and consistent approach.

51. It seems to me that in fairness to M there are certain points which require to be highlighted:

i) Throughout the children's lives M has been their primary carer. Though the standard of her care has, from time to time, dipped considerably below what was acceptable, this is inextricably linked to her "extremely low intellectual ability" and to the challenges arising from her mental health. The history reveals that F has provided little active or supportive help, either generally or at times when M's functioning was significantly impaired;

ii) It is clear that each of the children has a warm, loving and affectionate relationship with M. Z, who was M's primary support in the household, has a particularly close relationship with her mother;

iii) The children are polite, well behaved and respectful. Both the Guardian and the key Social Worker comment that this reflects strong evidence of some good and nurturing parenting having been provided. Whilst I have no doubt that F has contributed to this, it must logically reflect most favourably on M given the predominance of her parenting role;

iv) There is no evidence that any of the children has ever been physically harmed by M or any history that she has lost her temper with them in any significant way. It requires to be restated that Z is now 16 years of age and, accordingly, I am reviewing a substantial parenting history;

v) B had a similar history to A of feeding difficulties. Whilst M did not address them satisfactorily, there was no evidence of her losing her temper with him. I note that she spontaneously described her reaction to A's reluctance to feed as causing her "sadness". Her body language and general demeanour reflected what she said. She betrayed no sign of anger or frustration;

The primary change in the household in the months leading up to A's death was the intervention of the Social Services and the furtherance of the Child Protection Plans. As paragraph nine above makes clear, there were fundamental parenting failures: unsanitary home conditions; unsatisfactory personal hygiene; and failed medical appointments, including neglect of Z's asthma. There is no doubt that F experienced

Social Services as intrusive and belittling of his status within the community. As a man who perceived himself to be respected and who was called upon to help and advise others, the properly identified concerns of the Social Services undermined his status. It is clear from his frequent outbursts against the Social Workers that their presence in the life of his family was difficult for him to reconcile. In his evidence he took every opportunity to emphasise his intellectual ability. He repeatedly described himself as "a graduate". It is manifest that F was under stress;

vi) There is an obvious and striking disparity between M and F's cognitive and social functioning which renders M vulnerable within this relationship. There is some evidence, albeit of poor quality, which suggests domestic violence. Whilst this does not generate a finding, it registers a concern;

vii) F has lied extensively and elaborately with the objective of removing himself from the house on the afternoon A died.

52. All these factors need to be evaluated. They reflect real issues identified by the evidence. It remains the case, however, that none of these points either collectively or individually amounts to evidence of sufficient cogency to permit me to identify the perpetrator of A's injuries and death. None of those within the house on the afternoon A died who were in a position honestly to relate what occurred has chosen to do so. M understands what telling the truth means. For whatever reason she chose not to do so. Accordingly, I am left uncertain as to who the perpetrator was. Future planning for the children's welfare and, in particular, their contact with their parents must be predicated on the premise that either might have been responsible for A's death.

53. In considering the Local Authority's plans for the children I have been exercised by the proposal that Z and J should be separated. Ms Humphries, the children's Guardian, has properly gone to great lengths to review the Local Authority's thinking on this point. She has met again with both children, during the course of the final hearing, to elicit their views as well as their feelings. A placement has been identified for Z, by Ms Holt, which she has been very enthusiastic about. It is a home which she, as a female teenage Muslim, plainly feels more comfortable about than her present foster placement. I know that in saying that she would wish me to be clear that that is not intended as any criticism of the family with whom she is now living. Unlike her brother J, Z has simply not settled. J told the Guardian that he was *"quite sad"* about his sister moving to a separate placement. Ms Humphries notes *"his face portrayed a deeper sadness than he expressed"*. The foster carer reported that J had been quite down since learning about the plan.

54. The welfare of both Z and J is my paramount consideration. The best interest of one cannot be permitted to yield to the other. Z is absolutely clear that she wishes to move to this placement and her views are rooted in a calculation of what it offers to her. She is driven to succeed academically and sees this home as fertile ground for her intellectual development. It is also an entirely female household. I have no doubt that this latter point is important to her at this stage in her life.

55. Though J would like to be closer to his sister and his school, there is no doubt that he is doing well where he lives. His relationship with the foster father is secure and strengthening. For much of the time when Z was with her brother she retreated to her bedroom to study. J's interests are much wider than academic and he has grown to enjoy a range of activities. Ultimately the professional consensus was that J's interests are best met by his staying where he is and by Z being permitted to move. I agree. I should also record that I found Ms Holt's and Ms Humphries' careful consideration of this plan to be extremely impressive. When Social Workers fall into error they are often condemned by the Court. It is right that where the Court sees, as it does here, practice of the highest standard, it should identify and record it. I am pleased to be able to do so.

56. The plan for B is that he will be cared for outside his family in a residential placement. I am satisfied that, given his raft of needs, this is necessary. On this basis I approve each of the children's care plans but I should like the Local Authority to reduce to writing and with greater precision the details of B's plan.