Neutral Citation Number: [2021] EWFC B31

IN THE FAMILY COURT SITTING AT SWINDON CASE NUMBER SN20C00029

BETWEEN:

WILTSHIRE COUNCIL

Applicant

AND

M

First Respondent

AND

F Second Respondent

AND

THE CHILDREN
(By their Children's Guardian, Ms Sandra Bryant)

Third Respondents

WRITTEN JUDGMENT OF HIS HONOUR JUDGE EDWARD HESS

DATED 6th MAY 2021

This judgment was delivered in private. The judge has given leave for judgment to be published, but only in this form.

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.

INTRODUCTION

1. This written judgment follows a hearing before me on 26th, 27th and 28th April 2021, during which I have heard detailed oral evidence from Dr Michelle Cutland, a Consultant Paediatrician and Clinical Director of the Bridge Sexual Assault Referral Centre which is part of the University Hospitals Bristol NHS Foundation Trust and from Mr Peter Greenhouse, recently retired, but formerly a Consultant in Sexual Health (Gynaecology & Genito-Urinary Medicine) at the Weston General Hospital, with a long and distinguished track record in the field of sexual health, including

holding several national positions in the British Association for Sexual Health & HIV (BASHH), the leading national body in the specialty of sexual health.

2. The hearing arose out of care proceedings brought by Wiltshire Council (to whom I shall refer as "the local authority") in which the headline issue has been the possible sexual abuse of R, a girl now aged 4),

3. The care proceedings relate to R and her older brother, whom I shall refer as "N".

4. The representation before me was as follows:-

    (i) Mr Colin Morgan (Counsel) for the local authority;

    (ii) Mr Andrew Grime (Counsel) for M (to whom I shall refer as 'the mother');

    (iii) Mr David Josty (Counsel) for F (to whom I shall refer as 'the father'); and

    (iv) Ms Anna Lavelle (Counsel) and Ms Louise MacLynn (Counsel) for the children's guardian.

    I want to thank all the advocates for their assistance to the court and to commend their high levels of skill and the admirably hard work they have put into this case on behalf of their respective clients.

EVENTS LEADING UP TO THIS HEARING

5. The mother and the father commenced a relationship in about 2010 and were together for nearly a decade, during which time N and R were born to them.

6. In about June 2019 the parents separated, the father moving out of the family home. The separation seems to have been relatively amicable with no significant acrimony, both parents accepting that they had grown apart. The children remained living with the mother, but had regular contact with the father, including a good amount of overnight contact. There was no court involvement in settling the new living arrangements. There never seems to have been any suggestion of domestic abuse or substance misuse by either parent. There was no involvement of the local authority with the parents and there were no concerns expressed by anybody about their care of their children. Both parents have been the subject of detailed parenting assessments by experienced social workers in the course of the current proceedings (the mother by Ms Natalie Welch dated 5th June 2020 and the father by Ms Lana Dredge dated 28th May 2020) and these reports are both very positive (assuming, of course, that no findings of sexual abuse are made against them respectively).

7. After the separation the mother remained single, the father has commenced a new relationship; but both parents appear to have been fully committed to the welfare of their children.

8. In the course of January 2020, in a perfectly normal way, R attended Nursery on most weekdays and also attended a number of other children's group play activities away from the nursery.

9. At the very end of January 2020 R appeared to have a problem of conjunctivitis in her right eye, giving a sticky and inflamed appearance. On 1st February 2020 advice was sought from a local chemist who supplied some eye drops.

10. On 4th February 2020, the eye condition having worsened, and because of "*pus discharging out of her eye socket*", R was taken to her GP and on the same day referred to the Royal United Hospital in Bath to see an Ophthalmologist, where "*Right-sided mucopurulent conjunctivitis with periorbital cellulitis*" (an eye infection considered to be serious of which Gonorrhoea is one of a number of possible causes) was diagnosed. She was given a number of doses of intravenous antibiotics (ceftriaxone) which fairly quickly cleared up the eye infection and she remained in hospital only until her discharge home on 6th February 2020. On 7th February 2020 she was seen as an outpatient and given a further dose of intravenous antibiotics and, on discharge, given a week's supply of oral antibiotics (co-amoxiclav). Happily, the eye infection was completely cured by this treatment and there are no ongoing physical consequences for R.

11. Also on 4th February 2020, a swab was taken from R's eye which, on 8th February 2020, was given a Nucleic Acid Amplification Test (NAAT), namely the Aptima Combo 2 Assay test. This test confirmed positive for Neisseria Gonorrhoea. A confirmatory test (this time not the Combo test, but an amplified version of the original NAAT test designed to test the same molecular target) was carried out and was also positive, but no bacteria were grown on culture.

12. It has subsequently emerged that, contemporaneously with R's eye problems in late January / early February 2020, there were three other children in the Nursery who had time away from the nursery with what are thought to have been eye-related problems, two specifically with conjunctivitis. By the time these facts emerged the eye problems had been treated and cured and a scientific or medical investigation into their circumstances was unlikely to be fruitful and has not been pursued. Likewise, only a limited investigation of the social circumstances of the families of these children has been carried out. Nothing is known to enable the establishing of a direct link of any of these families with a Gonorrhea infection; but equally insufficient is known to rule it out. I note the statement of Andy Morgan-Smith, the allocated social worker, dated 29th May 2020, when he said: "*On 04/05/2020 DC Peter Ellison*

(8086), investigating officer, informed me that he has looked into the additional information about other children having conjunctivitis at the time R was infected. DC Ellison stated there was some information about both children that might be concerning, but it was a long time ago. DC Ellison stated that it would not be possible to link the historic information to concerns about R. DC Ellison informed me that it is unlikely that this line of inquiry will be taken further".

13. A finding of Neisseria Gonorrhoea in a child is usually considered to be a 'marker' or a 'red flag' for child sex abuse. I shall discuss below why that is the case and what this means in the context of these proceedings, but it suffices for present purposes for me to note that the finding caused the medical team to refer the matter promptly to the local authority and also to the Wiltshire Police, who properly referred the matter to The Bridge Sexual Assault Referral Centre in Bristol.

14. Both parents have vehemently asserted, and continue to assert, that they have not themselves ever sexually abused R or having ever done anything to R which may have caused her Gonorrheal infection and have never themselves been infected with Gonorrhea or any other sexually transmitted disease.

15. On 13th February 2020 R was taken to see Dr Michelle Cutland at The Bridge Sexual Assault Referral Centre. Dr Cutland took a fresh eye swab from R's right eye (during the taking of which the mother held R still by applying her hand to R's forehead) which tested negative for Gonorrhea. Dr Cutland also examined R's vaginal area and was able to observe some Erythema (redness) between the labia majora; but R was very active and resisted Dr Cutland's attempts to take a vulval swab and the taking of a swab was only made possible by the mother taking it under the direction of Dr Cutland. This swab was tested by the same type of test used earlier on the eye swab, namely the Aptima Combo 2 Assay NAAT test. Like the earlier eye swab test, this confirmed positive for Neisseria Gonorrhoea and a confirmatory test (again, not the Combo test, but an amplified version of the original NAAT test designed to test the same molecular target) was carried out and was also positive, but again no bacteria were grown on culture. Dr Cutland's conclusion from the positive tests from the eye swab taken on 4th February 2020 and the vulval swab taken on 13th February 2020 was that "*it is more likely than not that sexual contact is the mode of transmission and thus R is likely to have experienced sexual abuse*" and this conclusion (the basis of which I shall discuss below) was transmitted to the Wiltshire Police and the local authority.

16. Both the mother and the father were tested on 13th February 2020 for Gonorrhea and both tested negative. Each has consistently denied ever having suffered from Gonorrhea. Some others who had had sole care of R in the weeks leading up to February 2020 were also tested negative for Gonorhhea. The investigation thus far carried out has revealed no relevant individual who has tested positive for Gonorhhea.

17. On 27th February 2020 further swabs were taken from R, all of which were negative

for Gonorrhea, indicating (it is common ground) that the infection had been cured by the antibiotics.

18. On 3rd March 2020 Care proceedings were issued by the local authority. On 16th March 2020 I made interim supervision orders, but (with the agreement of all parties) both children remained in the care of the mother and the father was permitted to have ongoing overnight contact. Life on the ground for R and N has carried on fairly normally, though of course the parents and other family members have had to carry the weight of the February 2020 test results and what might flow from them.

19. In the course of the proceedings two matters emerged which are worthy of comment in the context of the court's investigation:-

    (i) On or about 24th February 2020 the father informed the social worker that in about October/November 2019 R had started asking people, including both her parents, if they had willies or vaginas and whether she could touch them. The police subsequently saw R and asked some questions in consideration of a possible formal ABE interview, but she "*made no disclosures*" and the ABE interview was not pursued.

    (ii) On 15th July 2020 there was an incident at the nursery in which R was involved, reported as follows: "*At quiet time after lunch R was lying down next to a female friend when she began tickling her between her legs. The other child lifted her legs. A staff member separated the two children*".

20. The care proceedings have progressed through a number of case management hearings with the aim of compiling appropriate evidence to enable the court to make proper decisions in the best interests of the children. All those involved have thought carefully and anxiously as to how the matter should proceed forensically, taking into account the risks to R and other children who might be affected and also the procedural fairness of the legal process. As part of the case management process, I listed the case for a five day final hearing before me commencing on 30th November 2020 with a pre-trial review hearing on 21st October 2020.

21. By 20th October 2020 the local authority had, after careful and anxious thought, decided that the appropriate way forward was to apply for permission to discontinue the care proceedings. Such an application was formally made and was heard by me on 21st October 2020.

22. The application was supported by a statement from Ms Julie Stoten, the allocated social worker. She said:-

    "…having reviewed all the information presented within the court bundle and in particular the most recent 'Further Question Report' from Mr Greenhouse, dated 9th of October 2020 the local authority is concerned that Mr Greenhouse's reports are contradictory and the timeline for the likely primary site of infection (i.e. the vagina)

is ambiguous and could be anywhere from a couple of days to a couple of months to a couple of years. This causes significant evidential difficulties in terms of identifying a perpetrator or pool of perpetrators. Mr Greenhouse reports: "With regard to a timeline it remains more likely that R was infected vaginally asymptomatically some time – perhaps a few months – before she developed overt eye infection. However, he reports at E60, it is not possible to estimate the incubation period for RM's asymptomatic vaginal infection with gonorrhoea and thus the time point of acquisition must remain speculative unless a clearly defined incident of possible exposure within approximately the previous year can be identified by other available evidence. In addition there continues to be a lack of clarity in respect of the additional children at R's nursery that were reported to have presented with eye infections."

23. In his written submissions, Mr Morgan, appearing as Counsel for the local authority, argued:-

"The difficulty the local authority have in formulating a case on the basis of findings sought in terms of the threshold criteria is the nature of the evidence of the original site and likely time frame for R's gonorrheal infection. In his first report Mr Greenhouse was originally neutral as to which of three potential sources and sites of infection (vagina, face, innocent contamination from another child within the nursery) may have caused the original infection. For reasons that are not entirely clear, although appear related to evidence in relation to sexual talk (re willies and vaginas) from R in the previous November, in his June addendum report Mr Greenhouse is advising the most likely like site of the original infection was the vagina with accidental self-inoculation to the eye by R herself. In his July addendum (responding to questions from the parties) Mr Greenhouse repeats his assertion that R's vagina was the most likely site of the original infection. Consistent in all reports prior to October 2020 is the assertion that if the original site of infection was the vagina it is either not possible to determine the original incubation period [E31/4.3d], such period is entirely uncertain [E43] or not possible to estimate unless a clearly defined incident of possible exposure within approximately the previous year can be identified [E60]. In his October report Mr Greenhouse confirms innocent self-inoculation from eye to vagina is unlikely however the period suggested for the infection is "perhaps a few months"...Putting aside for the moment the potential effect on the credibility of Mr Greenhouse's expert evidence of the change to the period of incubation there is currently no other probative evidence in relation to the site of the original site of the infection than the opinion of Mr Greenhouse. If the original site of the infection was the vagina – and it is at this point difficult to see how the court could have an evidential basis for an alternative finding – the point in time R was likely to have been infected is uncertain and unascertained. The local authority concern is that the pool of potential perpetrators – those with an opportunity to have infected R with gonorrhea- is widened to such an extent that the inclusion of the parents within the pool (or on the list) – on the basis of real possibility and care provided – goes far beyond any exercise anticipated by the court in the uncertain perpetrator cases. Put differently, in what way can it be contended as in the children's best interests to pursue findings of attributability of harm against the parents when they are merely one of a uncertainly large class of potential perpetrators of albeit clearly established harm?...The local authority on the basis of their analysis of the evidence are not

sufficiently persuaded that there is a reasonable prospect of establishing the threshold criteria in the current proceedings on the basis of the current evidence."

24. This application was supported by both parents; but opposed by the guardian. I gave my decision (which was to allow the application, broadly accepting Mr Morgan's submissions and the local authority case) in a written judgment dated 23rd October 2020.

25. The guardian appealed against my decision to the Court of Appeal and on 18th December 2020 the appeal was allowed and the case remitted to me – the full judgments are reported as *M (Children) v Wiltshire Council & Ors* [2020] EWCA Civ 1717. Amongst the matters included in the judgment of Macur LJ, which I think really capture the thrust of the Court of Appeal's decision, were the following:-

"it appears after a careful examination of the several reports and emails prepared by Mr Greenhouse, that the judge was unintentionally misled as to a crucial fact which would impact upon whether a meaningful investigation of attribution was possible, again assuming that harm is found in accordance with Children Act 1989, s 31(2)a. As indicated above, HHJ Hess refers to Ms Stoten's evidence including the following: " ... the likely primary site for infection (i.e. the vagina) is ambiguous and could be anywhere from a couple of days to a couple of months <u>to a couple of years</u>" (my underlining) in [7] of his judgment and obviously accepts it as the basis of his determination. I note that this error was compounded in Mr Morgan's submissions to us in that the timeframe was said to be up to "two years or more", but " a couple of years" or "two years or more" are assertions that are not founded on the evidence as indicated in [15 (c) (e)] and [20] above. The dormant period of infection differs for good physiological reasons between pre-menopausal female and pre-pubertal children as described by Mr Greenhouse in his 11 May report. The two-year period was quoted specifically in reference to the former. The time frame is considerably less in the latter. I accept Ms Fottrell QC's analysis on this evidential point but think it likely that we have had greater assistance in analysing the evidence than did HHJ Hess, as appears from Mr Morgan's claim that the CG did not dispute the potential size of the pool of perpetrators in the court below. However, HHJ Hess's conclusions in [13(ii)] of his judgment are necessarily undermined.

...

the fact that Mr Greenhouse's opinion was 'developed' (as Ms Fottrell QC describes it to be) in response to a repeated and regular succession of written questions and follow up requests for clarification, suggests that it was simply not compatible with a paper interrogation and called for oral cross-examination; not least since his opinion formed a corner-stone in the proceedings, and the criticism of it was centre stage to the LA application. I have little doubt that HHJ Hess would have benefitted from hearing Mr Greenhouse's evidence under challenge and may well have rejected or finessed the LA analysis otherwise put before him, with obvious implications as to the utility of proceeding further in accordance with the child protection and welfare principles he refers to in [13 (i) and (v)] of this judgement.

47. Further, I regard it right to observe that whilst Mr Greenhouse attaches several meaningful caveats to his opinion which may not have 'assisted' the LA to a clear view, and which may well account for the way in which the judge articulates the issue in [13(iii)] and, in fairness to the parents have at least contributed to their scepticism that R has been sexually abused at all, that it is right that he should have done so in accordance with his duty as an expert witness to bring any matters that may undermine the integrity of his opinion to the attention of the court. The caveats do not undermine his "credibility" or otherwise undermine his expertise or reliability

….

48. Realistically, I would accept HHJ Hess's conclusion regarding the improbability of a confession from the witness box and see the potential limitations in the "circumstantial evidence" against the parents

…

The cross-examination of Mr Greenhouse and others may reveal further 'known unknowns' which are incapable of resolution and may even militate against a finding of harm on the balance of probabilities, or otherwise confirm the impossibility of narrowing down the pool of potential perpetrators for any practical welfare purpose and substantiate the decision reached by HHJ Hess now under review. However, it is also possible that a more certain picture will emerge which will inform future care planning – if state intervention is warranted at all.

49. A shorter time frame of possible non-accidental infective process, if that is what the judge hearing all the evidence determines it to be, makes the identification of a definitive pool, which may include either of the parents, a more feasible proposition.

…

50. Consequently, for the reasons I give above, I am satisfied that the application to withdraw the proceedings was premature and the judge's decision to have been made in error. I would allow the appeal."

26. The matter therefore came back before me for directions on 8th January 2021. All parties agreed that it was appropriate (in the light of the Court of Appeal judgment) for me to convene a hearing in which I would hear the oral evidence of just Dr Cutland and Mr Greenhouse and the hearing was framed as a discrete preliminary hearing "*to determine the issue of the nature, primary source and timescales for incubation of R's gonorrheal infection identified in February 2020*".

27. This was originally listed before me on 18th and 19th March 2021. We all convened on the morning of 18th March 2021, but the hearing could not take place because one of the Counsel had an unfortunate accident just before the hearing began which required hospitalisation. I felt it was important to move forward to resolve the issues arising and I therefore cleared my diary for 26th, 27th and 28th April 2021 so that not too much further delay would occur and the hearing has proceeded on these dates as planned. I have now heard the full oral evidence and cross-examination by all advocates of Dr Cutland and Mr Greenhouse. I reserved judgment at the end of the evidence and have

received detailed written submissions from all the advocates. I indicated that I would produce a written judgment at the earliest opportunity, which I now do.

28. Because of the nature of this hearing the focus has been on the medical evidence. The main written medical evidence at the focus of this hearing consists of the following:-

    (i) the reports of Dr Cutland dated 19th February 2020, 20th February 2020, 10th March 2020 and 2nd October 2020; and

    (ii) the reports of Mr Greenhouse dated 11th May 2020, 18th June 2020, 10th July 2020, 17th August 2020, 21st August 2020, 18th September 2020 and 9th October 2020.

29. I have in addition, though, received a full bundle which contains a good deal of background and assessment material as well as other medical disclosure, police and local authority disclosure and relevant scientific articles and issued guidance, in all some 2,000 pages or so of material in electronic form.

FACT-FINDING LAW

30. The task upon which I am now embarked, i.e. "*to determine the issue of the nature, primary source and timescales for incubation of R's gonorrheal infection identified in February 2020*", is in essence in the nature of fact-finding, though (as I am reminded in the submissions made on behalf of the guardian by Ms MacLynn and Ms Lavelle) this is not necessarily a complete fact-finding exercise because there is a wider canvass of evidence which I have not heard and the guardian's strong view, even after having heard the medical evidence, and not shared by the other parties, is that it would be necessarily wrong to draw a line under this case at this stage.

31. I propose to keep firmly in mind that I have not heard all the evidence and the conclusions I can reach will have to be appropriately tailored in the light of that fact. Nonetheless, all parties agreed that this limited investigation of the medical evidence was appropriate in the context of the particular facts which exist here and the uncertainty as to the extent of the factual investigation which might follow from different conclusions about the medical evidence.

32. In any event I still need to remind myself of some law pertinent to fact-finding in general and relevant to the particular issues now before me.

33. A useful summary of the relevant law is included in the judgment of Baker J (as he then was) in *Re IB and EB* [2014] EWHC 369 (Fam):-

"81. The law to be applied in care proceedings concerning allegations of child abuse is well-established.

82. The burden of proof rests on the local authority. It is the local authority that brings these proceedings and identifies the findings that they invite the court to make. Therefore, the burden of proving the allegations rests with them and to that extent the fact-finding component of care proceedings remains essentially adversarial.

83. Secondly, as conclusively established by the House of Lords in Re B *[2008] UKHL 35, the standard of proof is the balance of probabilities. If the local authority proves on the balance of probabilities that the injuries sustained by I and E were inflicted non-accidentally by one of her parents, this court will treat that fact as established and all future decisions concerning the children's future will be based on that finding. Equally, if the local authority fails to prove that the injuries sustained by I and E were inflicted non-accidentally by one of her parents, this court will disregard the allegation completely.*

84. In this case, I have also had in mind that, in assessing whether or not a fact is proved to have been more probable than not,

> *"Common-sense, not law, requires that in deciding this question, regard should be had to whatever extent is appropriate to inherent probabilities," (per Lord Hoffman in* Re B *at paragraph 15)*

85. Third, findings of fact in these cases must be based on evidence. The court must be careful to avoid speculation, particularly in situations where there is a gap in the evidence. As Munby LJ (as he then was) observed in Re A (A Child) (Fact-finding Hearing: Speculation) *[2011] EWCA Civ. 12,*

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

86. Fourth, when considering cases of suspected child abuse, the court "invariably surveys a wide canvas," per Dame Elizabeth Butler-Sloss, P, in Re U, Re B (Se*rious Injury: Standard of Proof)* [2004] EWCA Civ. 567*, and must take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth observed in* Re T *[2004] EWCA Civ.558,*

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

87. Fifth, amongst the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental head injury, is expert medical evidence from a variety of specialists. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. In A County Council v K D & L *[2005] EWHC 144 (Fam) at paragraphs 39 and 44, Charles J observed,*

> *"It is important to remember (1) that the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision."*
>
> *...*

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

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

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

91. Ninth, as observed by Dame Elizabeth Butler-Sloss P in Re U, Re B, *supra*

> *"The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research would throw a light into corners that are at present dark."*

92. This principle, inter alia, was drawn from the decision of the Court of Appeal in the criminal case of R v Cannings *[2004] EWCA 1 Crim. Linked to it is the important point, emphasised in recent case law, of taking into account, to the extent that it is appropriate in any case, the possibility of the unknown cause. The possibility was articulated by Moses LJ in* R v Henderson-Butler and Oyediran *[2010] EWCA Crim. 126, and in the family jurisdiction by Hedley J in* Re R (Care Proceedings: Causation) *[2011] EWHC 1715 (Fam):*

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

93. Finally, when seeking to identify the perpetrators of non-accidental injuries the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator (see North Yorkshire County Council v SA *[2003] 2 FLR 849. In order to make a finding that a particular person was the perpetrator of non-accidental injury the court must be*

satisfied on a balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interest of the child, although where it is impossible for a judge to find on the balance of probabilities, for example that Parent A rather than Parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to do so (see Re D (Children) *[2009] 2 FLR 668, Re SB (Children) [2010] 1 FLR 1161)".*

34. In addition to this helpful summary, I remind myself of a number of other citations which may be pertinent here:-

    (i) In saying that the burden of proof lies on the local authority, it follows that there is no pseudo-burden or obligation cast on the respondents to come up with alternative explanations: see *Lancashire County Council v D and E* [2010] 2 FLR 196 at paras [36] and [37]. In *Re X (Children) (No 3)* [2015] EWHC 3651 these thoughts were endorsed by Munby P: "*It is the local authority that seeks a finding that FM's injuries are non-accidental. It is for the local authority to prove its case. It is not for the mother to disprove it. In particular it is not for the mother to disprove it by proving how the injuries were in fact sustained. Neither is it for the court to determine how the injuries were sustained. The court's task is to determine whether the local authority has proved its case on the balance of probability. Where, as here, there is a degree of medical uncertainty and credible evidence of a possible alternative explanation to that contended for by the local authority, the question for the court is not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability'*."
    In similar vein are the words of Peter Jackson J (as he then was) in *Re BR* (Proof of Facts) [2015] EWFC 41: "*When assessing alternative possible explanations for a medical finding, the court will consider each possibility on its merits. There is no hierarchy of possibilities to be taken in sequence as part of a process of elimination. If there are three possibilities, possibility C is not proved merely because possibilities A and B are unlikely, nor because C is less unlikely than A and/or B. Possibility C is only proved if, on consideration of all the evidence, it is more likely than not to be the true explanation for the medical findings. So, in a case of this kind, the court will not conclude that an injury has been inflicted merely because known or unknown medical conditions are improbable: that conclusion will only be reached if the entire evidence shows that inflicted injury is more likely than not to be the explanation for the medical findings*."

    (ii) I remind myself of the words of Peter Jackson LJ in *B (Children: Uncertain Perpetrator)* [2019] EWCA Civ 575: "*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. 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'.

(iii) Further, I remind myself of the words of Wilson LJ (as he then was) in M (A Child) [2010] EWCA Civ 1467: "*Before consigning the mother to a pool of possible perpetrators of the December injuries, with all the possibly devastating consequences thereof for her future life, did the judge, in the context of this case, not need to find one iota of evidence, beyond the mere fact of her joint care of E during the days when they must have been perpetrated, which would cast doubt on the continual excellence of her care of E? There was no iota of such evidence; and, in reaching her fall-back conclusion, in favour of consignment of the mother into the pool, the judge did not, so far as I can see, recognise that such evidence did not exist. By contrast – and such is the context of this case – the evidence in relation to the father was quite otherwise."*

(iv) I have been reminded of 'the Bolam principle' - see *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 – in support of the proposition that the court should pay proper respect to the existence of different views as between two medical professionals if they are both properly regarded as being consistent with a responsible body of medical opinion.

35. With all these legal principles in my mind I now turn to an assessment of the evidence that I have heard, i.e. the medical evidence.

ASSESSMENT OF THE MEDICAL EVIDENCE

36. I shall start this section of my judgment by saying that the court was greatly assisted by hearing oral evidence from Dr Cutland and Mr Greenhouse, two distinguished and experienced medical experts with great expertise in their distinct, but overlapping fields of specialty. In my view they both properly deferred to the other where appropriate and both bent over backwards to assist the court by patiently and carefully analysing many aspects of the issues arising here in an objective and professional manner. Mr Greenhouse, with all his great experience, several times referred to this case as amongst the most difficult cases he had ever encountered, certainly in terms of attributability, and I take this to be an indicator of a professional trying his very best

to assist rather than an indicator of unreliability.

37. It is correct for me to have in my mind that Mr Greenhouse was instructed as an independent Single Joint Expert (SJE), whilst Dr Cutland has been involved because she was the treating consultant at the time of the initial referral, though her evidence has of course been a mix of factual evidence (what happened during the testing and treatment stages in which she was involved) and opinion evidence (both on the appropriateness of her own testing and treatment and on issues of wider principle). It does not, I think, follow from the fact that Dr Cutland was not formally instructed as an SJE that I should disregard her opinion evidence (and nobody has suggested that I should) but it is right for me to note the difference in status of the two experts in the context of the different tasks which they have been asked to carry out and the extent to which they have had full access to the court bundle (although Dr Cutland, in advance of her oral evidence, was provided with a fair portion of the trial bundle).

38. I think it is a fair criticism of Mr Greenhouse for me to note that in some important areas relevant to this case his opinion has varied over time (or '*developed*' as the Court of Appeal described it), but the Court of Appeal's observations that I may "*have benefitted from hearing Mr Greenhouse's evidence under challenge"* and that *"The cross-examination of Mr Greenhouse and others may reveal further 'known unknowns' which are incapable of resolution and may even militate against a finding of harm on the balance of probabilities, or otherwise confirm the impossibility of narrowing down the pool of potential perpetrators for any practical welfare purpose and substantiate the decision reached by HHJ Hess now under review"* have undoubtedly proved to be apposite and, at the end of his oral evidence, my view is that he has clarified his final view on the issues which appeared to have a degree of inconsistency in his earlier written contributions.

39. I propose to deal with this section of my judgment by seeking to answer the following sequence of questions:-

    (i) Is it established on a balance of probabilities that the two positive tests for Gonorrhea in R (i.e. the eye swab test from 4th February 2020 and the vulval swab test from 13th February 2020) were true positives?

    (ii) What should a medical practitioner faced with a finding of one or more positive tests for Gonorrhea in a young child do as a result of such a finding?

    (iii) What can be established on a balance of probabilities on the medical evidence as to the likely cause of the Gonorrheal infection in R?

    (iv) What can be established on a balance of probabilities on the medical evidence as to the likely timescale of the cause of the Gonorrheal infection in R?

Is it established on a balance of probabilities that the two positive tests for Gonorrhea in R (i.e. the eye swab test from 4th February 2020 and the vulval swab test from 13th February 2020) were true positives?

40. Mr Josty and Mr Grime, on behalf of the parents, have sought to challenge the validity of these tests and a number of lines of their attack fall to be considered. They have raised:-

    (i) the general possibility of contamination in Dr Cutland's clinic on 13th February 2020;

    (ii) contamination from the particular way the vulval swab was taken from R on 13th February 2020; and

    (iii) the testing methodology used by the laboratory for both of the eye swab test from 4th February 2020 and the vulval swab test from 13th February 2020.

    I need to deal with these challenges separately and propose to do so in the succeeding paragraphs.

41. **First**, Mr Greenhouse raised the issue as to the possibility of contamination by a general lack of cleanliness in Dr Cutland's clinic on 13th February 2020. Dr Cutland responded in writing on 2nd October 2020 saying:-

    "The room in which R was examined was the paediatric room at the SARC. This room is used solely for the examination of children and young people in whom sexual abuse is suspected or disclosed. As forensic sampling takes place in this room, the room, including the equipment, flooring and seating, is cleaned to a forensic standard before every examination. Additional deep cleaning by crime scene cleaning takes place every month. The room is locked in between examinations. In my opinion it would not be possible that any STI samples taken in this room could be subject to contamination by equipment or surfaces".

42. Dr Cutland strongly maintained this position in her oral evidence.

43. Mr Greenhouse was happy to accept Dr Cutland's explanation and I am satisfied that the evidence I have heard clearly indicates that contamination in this way was highly improbable and can properly be discounted in my analysis.

44. **Secondly**, Mr Greenhouse raised the issue as to the possibility of contamination by the way the vulval swab was taken from R on 13th February 2020. It was established before me that whilst Dr Cutland took a swab from R's right eye the mother held R

still by applying her hand to R's forehead and that a short while later R was very active and resisted Dr Cutland's attempts to take a vulval swab and the taking of a swab was only made possible by the mother taking it under the direction of Dr Cutland, but without the mother wearing gloves. It was common ground that asking the mother to perform this task was reasonable in the circumstances, but also that once it was decided that the mother should perform this task she should have been asked to wear surgical gloves and in that sense the testing methodology was deficient; but it is necessary for me to analyse whether this deficiency is such as to undermine the validity of the test.

45. Mr Greenhouse's written reports included the following comments:-

"there remains a possibility that successfully treated and non-viable fragments of gonococcal material from the child's eye would still have been present at this time and could have been inadvertently transferred from the mother's finger to the swab she took from the vagina while it was being handed back to the paediatrician to put into the transport medium thus giving a false positive result on the vaginal swab. The more restless the child may have been at the time of examination then the more likely it is that this event may have occurred. Thus the possibility of a false positive result cannot be definitively excluded".

…

"However as in my supplementary report of 11 July 2020 at paragraph S2.1 the swab taken by Dr. Cutland directly from the eye at that time was negative thus it is highly unlikely that any discharge of material from or around the eye could have been the source of a positive result on the vaginal swab. Thus, notwithstanding my comment, taken together the evidence very strongly supports the supposition that the result of the vaginal swab taken on 13.2.2020 was a true positive"

46. In his oral evidence Mr Greenhouse expressed the view that, whilst the possibility of contamination on this basis could not be completely ruled out, on a balance of probabilities the vulval swab taken on 13th February 2020 was unlikely to be contaminated and should not be regarded as being other than valid for this reason. I accept his evidence on this, in particular in view of the negative eye swab taken on 13th February 2020. I am satisfied that this factor can properly be discounted in my analysis.

47. **Thirdly**, Mr Josty and Mr Grime have raised the issue as to whether the testing methodology used by the laboratory for both of the eye swab test from 4th February 2020 and the vulval swab test from 13th February 2020 can be regarded as being reliable.

48. The argument is perhaps most forcefully developed in Mr Josty's closing written submissions:-

"Before attempting to consider the nature of any infection, the starting point must be to consider whether the court can be satisfied that the microbiology testing and the results therefrom that triggered the local authority and police involvement with this family are such that the court safely may proceed on the basis that R presented with a gonorrhoeal infection. Referring to the Nucleic Acid Amplification Test (NAAT) assays undertaken in this case, cross reference was made by Mr Greenhouse to the most recent and detailed guidance of the British Association for Sexual Health and HIV (BASHH) at paragraph 6.3.3 of the National Guideline published on 10th March 2021 (which the court will note mirrors the draft 2019 BASHH guidance):-

> *'NAATs for the detection of N. gonorrhoeae or C. trachomatis are not licensed for use in extra-genital specimens, and have not been evaluated in genital specimens from children. Evidence for the use of NAATs in children is limited. 4,5,6 However in adult populations, NAATs are more sensitive than culture and can be used on non-invasive specimens, and therefore on balance, their use is recommended for testing in children.*
>
> *The prevalence of these infections in the paediatric population is low, and therefore the positive predictive value of a reactive test is low. In order to reduce the risk of false positive results, it is essential that all reactive NAATs for N. gonorrhoeae or C. trachomatis are confirmed by using another NAAT which detects a different molecular target from the initial test.'*

Mr Greenhouse accepted in his oral evidence that despite the clarity of the BASHH guidance, the molecular target of the confirmatory NAAT assays undertaken in this case were the same as those for the screening tests. It was the evidence of Mr Greenhouse that the same section of the 16s ribosome RNA was targeted within the screening and confirmatory tests and that the confirmatory test merely involved further amplification of that same section.

The BASHH Guidelines are clear that it is essential that the molecular targets should be different to reduce the risks of false positives. It follows from this that there is now within the evidence uncertainty in respect of how the court might assess the validity of the results from the various NAAT assays in this case (both in respect of the genetic material within R's vulval swab and that within the swab from her eye)."

49. The submissions of Ms MacLynn and Ms Lavelle forcefully make the counter-argument:-

"Dr Greenhouse was clear in his oral evidence that the Aptima Combo 2 test is the most reliable (being the test with the highest sensitivity and specificity) that is currently available. NAAT testing is significantly better than culture testing as it is much more sensitive. There are many cases in which a culture test will be negative when a NAAT test will be positive. The Aptima Combo 2 is the best available NAAT test in terms of sensitivity and specificity.

It is recommended that culture tests also be undertaken in cases with a positive result for gonorrhoea. This was done by Dr Cutland but these were negative. The reason for

this is clear because R had been treated with Ceftriaxone beginning seven days previously. This is stated by Mr Greenhouse [E24,E41]. In contrast an Aptima 2 Combo test may remain positive for up to two weeks after correct antibiotic treatment has rendered the infecting organisms non-viable [E6, E24].

The BASH Guidelines published this year also state that "it is essential that that all reactive NAATs for N. gonorrhoeae or C. trachomatis are confirmed by using another NAAT which detects a different molecular target from the initial test". In this case this did not happen. The confirmatory test used in this case used the same technology and the same amplifiers (Aptima 2 Combo) but with a greater degree of specificity – looking specifically at N. gonorrhoeae but at the same molecular target as in the initial test. Mr Greenhouse's evidence on this was that the laboratories in this county do not have the technology to complete a confirmatory test using a different testing system and that the majority of cases for testing of all STI's in this country (in every lab potentially save one) is done with the confirmatory test using the same testing system. Mr Greenhouse was confident that the NAAT testing in relation to the eye and genital infections reflected true positives in spite of the testing not having been for two different molecular targets for the following reasons:

- *R had very obvious signs of infection in the eye. Given R had these symptoms we can be 100% positive that the infection was caused by gonorrhoea following the test result. Mr Greenhouse also made the point that there are very few causes of such an overt and severe infection in the eye (which of course would have led to the hospital ordering the test in the first place).*
- *The positive predictive value in both tests was high because the child had been diagnosed with gonorrhoea in another bodily site and therefore the prevalence of disease in this child is 100%. In short R had two positive results of gonorrhoea from two completely different samples taken at different times.*

The court should therefore find that on the balance of probabilities both the positive NAAT test result for N gonorrhoae in the eye and the result from the vulva were true positives. The court is also asked to find that the testing done by way of the Aptima 2 Combo test is reliable.

50. On this point I agree with and accept and adopt the counter-argument put forward by Ms MacLynn and Ms Lavelle. They have, in my view, accurately reflected the views expressed by Mr Greenhouse, which I found persuasive.

51. I commend Mr Josty for his forensic diligence in seeking out full detailed information to challenge the validity of the The Aptima 2 NAAT test, including his extensive analysis and use in cross-examination of the article published in Hawaii in 2004 under the title *False-Positive Gonorrhea Test Results with a Nucleic Acid Amplification Test: The Impact of Low Prevalence on Positive Predictive Value* by Katz et al, which discussed some false positive results obtained in Hawaii in 2002/2003; but I was persuaded by Mr Greenhouse's evidence in response to Mr Josty's cross-examination that the material in this article, in particular the placing of the present case in the positive predictive value graph in figure 1 of that article did not undermine the two positive tests that we have in the present case. Mr Greenhouse gave the clear view that the Aptima 2 NAAT test is the best available test in terms of sensitivity and specificity and that I am satisfied I can attach weight to that view, notwithstanding the

arguments developed by Mr Josty.

52. It follows from all the above, that having rejected the three challenges to the validity of the tests, I accept that the court can and should proceed on the basis that R had true positive test results for Gonorrhoea both in her eye (on 4th February 2020) and in her vulva (on 13th February 2020).

53. I shall finish this section of my judgment by noting one particular issue touched upon during the evidence in this hearing, that is how to treat the word '*essential*' in paragraph 6.3.3. of the 2021 BASHH guidance ("*it is **essential** that all reactive NAATs for N. gonorrhoeae or C. trachomatis are confirmed **by using another NAAT which detects a different molecular target from the initial test**"* (my emphasis in bold). Mr Greenhouse acknowledged in his oral evidence that 'essential' was a strong word, but felt that (certainly on the facts of the present case) it overstated the case and that the use of a second NAAT test detecting a different molecular target was less than essential and that more nuanced wording might be more appropriate for the guidance. He accepted that in the present case there was no use of another NAAT test which "*detects a different molecular target from the initial test*", leaving the process open to the criticism from the guidance that an essential step had not been undertaken, but this did not prevent him from advising the court that the two tests were valid on a balance of probabilities. He expressed the view, however, that the requirement in the BASHH guidance (if taken strictly, which might be thought reasonably to follow from the use of the word essential) was likely to impose a considerable practical problem because it was unlikely that any laboratories (with the possible exception of the Colindale Laboratory at Public Health England) would have the equipment necessary to execute two different NAAT tests with a different molecular target and, certainly in some cases, including the present case, it was not necessary to execute a different test (for the reasons articulated above). In his post-hearing email to me and all parties he said "*This has been an exceptionally difficult case from the medical viewpoint, given the uncertainties about mode of acquisition etc, and some details of perceived inadequacy in laboratory procedures, which are important enough to be relayed back to my specialist organisation for action at national level*". I anticipate publishing an anonymised version of this judgment on BAILII in due course and Mr Greenhouse is, of course, free to draw this issue to the attention of BASHH for their consideration.

What should a medical practitioner faced with a finding of one or more positive tests for Gonorrhea in a young child do as a result of such a finding?

54. It is common ground that a finding of Neisseria Gonorrhoea in a young (pre-pubertal) child is usually considered to be a 'marker' or a 'red flag' for child sex abuse. To this extent I make no criticism at all of the decisions made by the treating medical professionals after the positive tests to involve the local authority and the Police, indeed they were undoubtedly correct.

55. It appears to me, however, that some of the wording in the relevant published guidance in this area is expressed in a way which could be better nuanced and may

have caused some difficulties in the present case in terms of the way the referral to the local authority and the police was presented.

56. At paragraph 10.2 in *The Physical Signs of Child Sex Abuse,* published in May 2015 by the Royal College of Paediatrics and Child Health (RCPCH) it is stated: "*If a child presents with confirmed non-ophthalmic Gonorrhea, the possibility of sexual contact should always be considered and* ***it is likely that the child has been sexually abused****…The diagnosis of Gonorhhea in a child under 13 years necessitates an urgent referral to child protection services*" (my emphasis in bold).

57. At paragraph 5.2 of the *BASHH National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People,* published on 10th March 2021 it is stated: "*When children with gonorrhoea have been evaluated for sexual abuse, a significant number were found to have been abused, suggesting that sexual contact was the mode of transmission in these cases… Limited evidence suggests that most abused children with gonorrhoea have a history of vaginal or anal penetration… If a child presents with confirmed gonorrhoea, the possibility of sexual contact should always be considered and* ***it is likely that the child has been sexually abused****…The diagnosis of gonorrhoea in a child under 13 years necessitates an urgent referral to child protection services"* (my emphasis in bold).

58. In the initial report produced by Dr Cutland she follows this general and non-case specific guidance to inform her conclusions, as follows:-

"There have been relatively few studies where children with a particular STI have been evaluated for the possibility of CSA. This has resulted in a limited evidence base to determine whether a particular STI is a marker of CSA. The most notable study of a number of pre pubertal children in the UK was published in 2014. It revealed of only seven children in a 25 month period with gonorrhoea, five were classed as having been sexually abused at case conference or court or sexual abuse was likely based upon additional physical findings or disclosure. In a different study in New Zealand in 2011 of 10 pre-pubertal children with gonorrhoea, four had acquired it through sexual abuse and one from 'sexual play' from another child. These two studies involve such small number of children it is difficult to draw firm conclusions. It would be reasonable to say however that in the limited research available in 50% to 70% of pre-pubertal children with gonorrhoea sexual contact was the way in which they became infected…Based on the research available in pre-pubertal children, in my opinion it is more likely than not that sexual contact is the mode of transmission and thus ***R is likely to have experienced child sexual abuse****"* (my emphasis).

59. It is appropriate to recognise that in giving this opinion Dr Cutland was acting as a safeguarding practitioner and not as an SJE giving an overall considered view based on all the known facts, but it is, I think, not unfair to make a number of criticisms of this analysis. Whilst Dr Cutland notes the very small number of children involved in the two studies to which she draws attention (which were probably statistically insignificant) and the difficulties of drawing firm conclusions from them, she did

exactly that, indeed used them as a base for the mathematical presentation that 50% (5 out of 10) to 70% (c. 5 out of 7) of pre-pubertal children with gonorrhea have been sexually abused and then used this mathematical presentation together with the wording of the guidance to conclude that "*R is likely to have experienced child sexual abuse".* The use of generalised statistical data to reach a conclusion in a particular case, without a proper investigation of the necessarily individual circumstances of the particular case, is, I think, really quite dangerous, more so when the statistical data is derived from such small samples (indeed Dr Cutland herself acknowledged in her oral evidence that "*the research base is pretty woeful*"). The danger is enlarged by the fact that at the time she wrote her report she did not know about the other children in the nursery who had had eye infections at the same time as R and she accepted in her oral evidence that, had she known that, she would have advised that these infections were investigated to ascertain their relevance because if, for example, another child had a gonorrhea related eye infection, that would substantially change the analysis. It may be that Dr Cutland could fairly point to the precise wording in the guidelines set out above to explain or justify her position; but that, it seems to me, calls into question that very wording. Should it really be said in formal guidance that the simple fact of a finding of gonorrhea in a pre-pubertal child, without any analysis of the particular circumstances of the case, makes it "*likely that the child has been sexually abused"*?

60. Mr Greenhouse chose to present the guidance in a rather different way in his written report when he said: "*The current conventional wisdom among both UK & US paediatricians as stated in their guidelines is that the finding of gonorrhoea in a pre-pubertal child over four years old must be taken as prima facie evidence of sexual abuse until proven otherwise*". He is, of course, not a lawyer; but a lawyer might be troubled by this presentation, with its apparent adoption of the methodology of the reversal of the burden of proof, surely conflicting with the authorities discussed above: *Lancashire County Council v D and E* [2010] 2 FLR 196 and *Re X (Children) (No 3)* [2015] EWHC 3651.

61. Having considered all the above it does seem to me that it is dangerous that a safeguarding practitioner in the role occupied in this case by Dr Cutland should, at such an early stage in the investigation, reach a conclusion of the sort that she did. It may be that all she could properly say, all that she should have said, was that a finding of Gonorrhea in a pre-pubertal child is **strongly suspicious** of child sex abuse (or some equivalent wording) and **strongly recommend the local authority and the police to investigate the matter** and consider what other possibilities there might be. It may be that the RCPCH and BASHH should consider whether the wording in their guidelines is expressed entirely appropriately (Mr Greenhouse was, I think, troubled by the wording in the guidance and may wish himself to raise the point with the national bodies).

62. As far as the present case is concerned, this difficulty, and the way in which Dr Cutland dealt with it, has caused me to have doubts about how much weight I can attach to her conclusions. In any event, she was content really to defer to Mr Greenhouse on these issues in view of his greater speciality in this area and I am satisfied that his evidence on these issues was rather more derived from his

knowledge, expertise and experience than from the tramlines of the guidelines and that I should attach rather more weight to his evidence than that of Dr Cutland.

What can be established on a balance of probabilities on the medical evidence as to the likely cause of the Gonorrheal infection in R? What can be established on a balance of probabilities on the medical evidence as to the likely timescale of the cause of the Gonorrheal infection in R?

63. I shall deal with these two questions together because there is an inter-relationship between them. I shall begin by setting out some general propositions in relation to Gonorrhea before seeking to apply them to the particular situation with R.

64. The following general information relevant to this question can be extracted, mainly from Mr Greenhouse's evidence.

65. In terms of the infection and its general consequences:-

    (i) Neisseria Gonorrhoeae, the causative organism of the infection known as Gonorrhoea, is a fragile bacterium which causes infection by adherence via specialised surface organelles (pili) to columnar epithelial cells of moist mucous membranes.

    (ii) It is transmitted by direct inoculation of warm secretions onto a surface with near neutral pH. This is because the organisms can only survive and multiply in specific types of tissues in warm moist humid conditions at around body temperature. It does not grow on or infect normal external bodily skin but may languish there for a short time. Nor even does it infect or reproduce on the moist epithelium (skin) of the inside of the mouth or the vagina in adult women.

    (iii) The infectable body tissues include the cervix, the urethra, the rectum and the nasopharynx conjunctiva of the eye.

    (iv) Although Gonorrhea does not infect the vagina in adolescent and adult women, it causes vulvovaginitis in prepubertal girls as the hypo-oestrogenic vaginal epithelium is thin with a neutral pH.

    (v) In and around the eye this invasive mechanism causes superficial gonococal conjunctivitis to spread and develop into the more severe form of periorbital cellulitis.

66. In terms of how the infection is transmitted:-

    (i) As an overwhelming generality, certainly in terms of adult sufferers, Gonorrhoea is transmitted most usually by penetrative sexual intercourse or direct genital exposure to freshly-produced genital secretions and/or

ejaculate during sexual activity including finger-to-genital transfer of fresh ejaculate or pre-ejaculatory fluids or sexual activity including ejaculation on to the face. It is because this is the most usual form of transmission that Gonorrhea is regarded as a sexually transmitted infection.

(ii) There are, however, other methods of transmission which need to be carefully considered where a presumptively non-sexually active person such as a pre-pubertal child is concerned.

(iii) If a mother has a Gonorrheal infection at the time of giving birth, it is well established that the Gonorrhea can be transmitted from mother to child at birth, often causing neonatal conjunctivitis in the first few days of the baby's life. Before the availability of antibiotic medication this was the most common form of blindness in infants.

(iv) Gonorrhea can also be transmitted by direct inoculation from fomites (i.e. physical objects, for example shared towels or sex toys) very recently exposed to fresh genital secretions. The extent to which this happens in practice is controversial amongst medical professionals, but Mr Greenhouse has drawn attention to an article in the *Journal of Forensic and Legal Medicine* under the title *What is the evidence for non-sexual transmission of gonorrhea in children after the neonatal period? A systematic review by Felicity Goodyear-Smith MBChB, MGP, FRNZCGP (2007),* the abstract of which states:-

"International consensus guidelines state that Neisseria gonorrhoeae infection in pre-pubertal children is always, or nearly always, sexually transmitted. A systematic literature review does not concur with this. N gonorrhoea was believed to solely sexually transmitted when first identified in the 1880s. However it became recognised that when the infection was introduced into children's institutions, it rapidly spread among pre-pubertal girls. The medical literature records over 40 epidemics involving about 2000 children in Europe and the United States. Communal baths, towels or fabric, rectal thermometers and caregivers hands were identified as means of transmission. Although sensitive to heat and drying, gonorrhoea may remain viable in pus on cloth for several days. Several unusual accidental transmissions are reported, often due to contamination from laboratory samples. Indirect transmission occurs in epidemics of conjunctivitis in third world rural populations. Spread of infection can occur via contaminated hands of infected caregivers. While all paediatric cases of gonorrhoea must be taken seriously, including contact tracking and testing, forensic medical examiners should keep an open mind about possible means of transmission. Doctors and lawyers need to be cognisant of the large body of literature demonstrating both sexual and non-sexual means of transmission of gonorrhoea in children."

Although Mr Greenhouse has identified this article as being controversial amongst some professionals, he was clear that it had to be regarded as a serious professional opinion and certainly not to be disregarded (this discussion took place in the context of the *Bolam* principle referred to

above).

(v) Gonorhhea can also be transmitted by inadvertent accidental self-inoculation by genital-to-finger-to-eye touching or eye-to-finger-to-genital infection of freshly produced secretions. This includes transmissions between individuals, most likely children, where the finger of one individual comes into contact with the infected eye of another and then into contact with that person's own eye or genitals. The *Goodyear-Smith* article referred to above recounts six separate outbreaks of "definite" child-to-child gonococcal conjunctivitis totalling over 1000 cases since 1981, although these are principally in Australian tropical or sub-tropical settings.

(vi) A sexual transmission of Gonorrhea can be effected by an infected person, whether or not that person is a man or a woman. Mr Greenhouse was asked the following question:-

"Some readers of your reports in this case are left with the impression that if R has been sexually abused, the perpetrator is more likely to be male than female. Please could you confirm whether in your opinion, if the court finds that R has been sexually abused it is possible to say whether the perpetrator is more likely to be male than female. Please set out the evidence which supports your view either way".

His response was as follows:-

"If some readers of my reports have the impression that the perpetrator was more likely to be male than female I can offer no explanation of this possibly erroneous assumption other than the simple but unfortunate fact that the majority sexual assaults on children are performed by men rather than women as can be attested by any systematic review of such cases coming before the Courts. Regardless of any possibly more frequent motivation on the part of men than women to perpetrate such incidents it remains a biological fact of life that it is considerably easier and more efficient for a man than a woman to transmit gonorrhoea to a child (or anyone else) by simple fact of anatomy. This is due to the more ready availability and producibility of dischargeable infected material from the man and the more direct means of depositing it on or around or in another person's genital region via the penis. For a woman to infect a child with gonorrhoea it would require direct inoculation of her vaginal fluids into or onto the genital area of the child. This could most efficiently be achieved via a vaginally self-inserted finger or other implement such as a sex toy then being introduced into or around the victim's genitalia. It could also occur with less likelihood of successful transmission by direct genital to genitalfrottage and finally with less likelihood still from oro-genital contact by a woman with covert pharyngeal infection because of the much lower transmission efficiency of this route. Thus on the balance of probabilities in any such case it is more likely for a man to be the source of this infection than a woman.
However in the absence of any other evidence as stated at point 1 above I

would respectfully suggest that this principle is a somewhat less than robust method of reliable adjudication in this case."

67. In terms of what happens if the infection is untreated:-

(i) If the infection remains asymptomatic and untreated it can exist about two years (possibly up to three years, but almost certainly no more) in the human body before the immune system gradually diminishes and clears the infection.

(ii) The statistical probabilities of an infection becoming symptomatic and, in symptomatic cases, the incubation period between an infection of Gonorrhea and the development of symptoms, has a high degree of variability, depending on the location of the infection and various other factors.

(iii) In males with a urethral infection some 90% will have significant (often very severe) symptoms within 14 days (most likely within 7 days) of infection.

(iv) The incubation period for gonococcal eye infection in males and females is likely to be very short, similar to that of urethral infection in males, i.e. within 14 days, most likely within 7 days. Asymptomatic ophthalmic carriage of gonococcal infection is most unlikely because of the vulnerability and exposure of the bodily tissues involved.

(v) In males and females with a rectal or pharyngeal infection, 95% will remain asymptomatic.

(vi) In adult premenopausal women the genital infection usually lies in the endocervix (neck of the womb) deep inside the vagina and not on normal thicker skin of the vaginal wall or mouth lining or external skin surfaces. As a consequence the majority of adult pre-menopausal women infected with Gonorrhoea will have no obvious symptoms and the infection will simply remain for about two years (possibly up to three years) before the immune system gradually diminishes and clears the infection.

(vii) By a similar analysis it is possible to rule out the possibility that an infection was acquired at birth if the infection is detected after child is more than two years old (almost certainly three years old).

(viii) Where the vaginal infection is in a pre-pubertal female the analysis is necessarily different because the epithelium (skin surface) of the vagina is thin with a neutral pH and is therefore more prone to an inflammation causing gonococcal vulvo-vaginitis. Nonetheless, in some cases, probably a minority of cases, such an infection can remain asymptomatic. Some research carried out in 1997 (*Vaginal Gonococcal Cultures in Sexual Abuse Evaluations: Evaluation of Selective Criteria for Preteenaged Girls* by Ingram et al) suggested that the minority could be as small as 5%, but

Mr Greenhouse pointed out that this research was carried out at a time when NAAT tests were not available so that it was necessary to use culture tests in the study, which were much less sensitive to identifying the existence of the Gonorrheal infection, so that it could be presumed that there were significant numbers of infected pre-pubertal girls in the study where the infection was not detected. On this basis the figure of 5% asymptomatic cases was likely to be a significant underestimate, but Mr Greenhouse was unable to give an evidence-based estimate of the true figure. Mr Greenhouse was asked a good number of questions as to how long an asymptomatic genital infection could remain in a pre-pubertal girl. I think it would be a fair observation of his evidence on this that he did give a number of different answers to this question. Mr Morgan's submissions perhaps best summarise his evidence on this:-

"Mr Greenhouse has offered a variety of timescales for the likely incubation period for an (asymptomatic) vaginal infection. In his written reports he has stated : it was not possible to ascertain how long the infection may have incubated for until its identification in February 2020 [E31/4.3d], such period is entirely uncertain [E43/5.3] or [it was] not possible to estimate unless a clearly defined incident of possible exposure within approximately the previous year can be identified [E60]…In his oral evidence he accepted at various points the possibility of a period of 5 months (on the basis the sexual talk indicated a possible time for infection), less than 3 years, 6-9 months and [its] almost like a law of diminishing returns. The further way infection could have been from self-inoculation, the less likely it is that happened. I cannot give an end point. 18m/2y almost certainly not the case. Closer the time, the more likely. I cannot give a cut off [cxLA]. In answer to a question on the same issue by mother he stated : if asymptomatic it could have been there for indeterminate and indeterminable time. In answer to a question from the court the following exchange took place :
Q: 5 months. Your view on timescale that could be possible ?
A : Impossible to calculate timescale because no evidence in infants as to how long can stay present. Know in adults if don't treat in women ends to burn out in 2 years. None of that information is available for infants and work done in 1930s when no treatment for Gon. Probably at least a year but once again conjecture,
Q : Best you could do is for a prepubertal child, can't say if 2 or 3 years but could be asymptomatic for at least a year
A : Possible. We are confident that this could not have been there from birth. Less than 3 years. Suspect much less than that. Absolute maximum unlikely to be present more than 6 to 9 months. Once again that is an educated guess"

It is, I think, quite hard to extract from this evidence a hard answer to the question; but in saying this I do not intend to criticise Mr Greenhouse, but instead to draw attention to his observation of the absence of proper research evidence on this point. The principles derived seem to be these. A pre-pubertal girl infected with genital Gonorrhea is significantly less likely to remain asymptomatic than an adult woman with the infection, but where

an infection is asymptomatic it is difficult to identify a specific maximum time period for it to remain asymptomatic save to say that it is likely to be less than an adult woman with a similar infection, which is estimated to be two years. It is unlikely to be more than 6 to 9 months, perhaps a year, but this is really no more than an educated guess.

68. In terms of treatment once the infection is observed:-

    (i) A suitable treatment of antibiotic medication is very likely to cure a Gonorrheal infection fully and quickly, hence it can be quickly eliminated once it is detected and hence where antibiotic medication is widely available it is not the major problem it once was, though it can still have long-term consequences such as infertility and is not to be treated lightly. Once the infection has been cured there are no available tests for ascertaining whether or not it was formerly present.

    (ii) Walk-in sexual health clinics are widely available around the country where an adult can be treated anonymously or under an alias and be cleared of a Gonorrheal infection very quickly without anything appearing on that person's medical records. It follows that a negative test in an adult and a clear medical record does not clearly establish that the adult did not formerly have the infection.

69. The matters above can be set out relatively uncontroversially. More difficult is how to apply the principles to the particular circumstances of R's infection. For the purposes of this question at this stage I shall seek to answer the question solely by reference to the medical evidence, not by reference to any of the other evidence.

70. Mr Greenhouse was clear that, whilst R had a vulval Gonorrheal infection, there is no evidence that this was at any time symptomatic. He was clear that it would be wrong to attribute the redness in R's vulva observed by Dr Cutland on 13th February 2020 as being a symptom of the Gonorrhea and was more likely a result of candida (thrush) caused by the antibiotics. He was clear that the symptoms in R's eye were, however, directly related to the Gonorrheal infection in her eye.

71. In his initial report Mr Greenhouse opined:-

    "…she may have been exposed to infected fluids through some form of sexual activity either initially in or over the genital area without developing genital symptoms and with subsequent accidental self-inoculation into the eye causing almost immediately obvious signs of disease. Alternatively she may have been exposed to infected fluids through some form of sexual activity such as ejaculation over the face with subsequent accidental self-inoculation onto the vulva or into the vagina with this latter site of infection remaining symptomless. Finally she may have been exposed accidentally in her eye to gonococcal infection from one or other of the two children with whom she had contact at the nursery who were simultaneously diagnosed with

conjunctivitis of unspecified cause and each removed from the nursery for investigation and treatment in the same week as R

...

There is insufficient evidence for me to judge which of these three possibilities is the most likely source

…

If the original site of infection was genital then the lack of genital symptoms precludes any possibility of determining the incubation period of the original acquisition. In this scenario subsequent accidental self-inoculation into the eye would have occurred no more than an absolute maximum of two weeks – and most probably one week or less – prior to the first development of ophthalmic symptoms being noticed. Likewise if the original site of infection was ophthalmic then the incubation period was most probably one week or less".

72. In subsequent written reports it appeared that Mr Greenhouse was expressing a rather different view, but in his oral evidence he returned to his original view and explained why he appeared to have departed from it. The sequence of events is described, I think accurately by Mr Grime in his closing submissions, as follows:-

"He concluded in his first report that there was insufficient evidence for him to judge which of these three possibilities was the most likely source. In his second report, dated 18 June 2020 [See E39 et seq] there is a change of emphasis from his first report to inclining towards asymptomatic infection of the vagina having preceded overt infection of the eye which was influenced by reference reports that R used language in October/November 2019 that she 'started asking people if they had willies or vaginas and whether she could touch them'. Mr Greenhouse stated in his response to questions, dated 10 July 2020, that he was not an 'expert in paediatric development or behavioural psychology' and that he 'may have overstepped (his) brief' [See E46(Q1.2)]. Further, in response to a question from the learned judge he was clear that he wished to retreat from the way that affected his addendum report… Mr Greenhouse was clear throughout his oral evidence and under cross examination from all four counsel that the court cannot be satisfied that the most likely scenario is that we have two positive tests for gonorrhoeae, the primary site being the child's vagina and the eye as a result of self inoculation. He stated "No, it can't be because we have the evidence of 4 children with conjunctivitis, we don't know if that is gonorrhoeae but the concordance of that number of children in one nursery, with one diagnosed with severe gonorrhoeae and the need to consider other possibilities. One of the possibilities for the original infection was into the vagina of R, she then touched her eye and that infection infected the other children, she could have been the original source but it is also perfectly possible that other way around and the other children are the source. It is unfortunate as so many other possibilities and insufficient evidence. I cannot ascribe which of them on the balance of probabilities it would have been. It would be unsafe for me to presume. Any of these possibilities could have happened". Mr Greenhouse was clear in his oral evidence that "with the information in front of me and the information now, I have got to be neutral. The only thing I can be absolutely sure about is R had a gonorrhoeae eye infection but can't be sure where it came from, innocent or non-innocent or self inoculation from vagina. I cannot find anything in evidence to say one is more likely than the other".
Mr Greenhouse accepted that his initial interpretation of the sexualised language in

his addendum report may have clouded and influenced his judgment at that time. However, he was clear in his oral evidence that that is a piece of non-medical circumstantial evidence that had influenced his decision at that time. He was clear that such evidence was "flimsy and its all we have got to go on, its not enough for me to come down on a balance of probabilities". Mr Greenhouse was clear when questioned by the learned judge that the fact that there were 4 cases at exactly the same time the "more one has to be concerned that there is no sexual abuse in this case whatsoever".

73. It is, in my view, a proper interpretation of Mr Greenhouse's final considered view of the existing medical evidence that:-

    (i) On a balance of probabilities R had Gonorhheal infection both in her eye and in her vulva.

    (ii) It is not possible on the medical evidence to identify on a balance of probabilities which area of infection came first; but whichever did come first, it is likely that R self-inoculated to cause the other by eye-finger-genital or genital-finger-eye self-inoculation.

    (iii) If the eye infection came first then the timing of the source of the infection can be placed as up to 7 days (possibly 14 days) prior to the symptoms emerging.

    (iv) If the vulval infection came first then the timing of the source of infection is much wider, possibly 6 to 9 months, possibly a year or possibly even longer before the emergence of symptoms.

    (v) It is possible that R was sexually abused by somebody causing the Gonorrheal infection in her vulva which she self-inoculated in her eye or in her eye which she self-inoculated in her vulva. It is possible that R acquired the infection in her eye from an eye-finger-eye self-inoculation from another child in her nursery and then in her vulva by an eye-finger-genital self-inoculation. It is not possible on the medical evidence currently available to identify on a balance of probabilities which of these causes is more likely.

    (vi) In an ideal world a proper investigation would and should have been contemporaneously carried out into whether or not the three other children in the nursery who had eye infections in January/February 2020 had Gonorrheal eye infections, and the results of this may have changed the equation, but this was unlikely to have been possible when these circumstances eventually emerged and certainly is not possible now.

    (vii) Mr Greenhouse accepted that he had allowed himself in his later written reports to express some views which included his being influenced by material beyond the medical evidence (i.e. the possibly sexualised talk/behaviour) and he was now clear that he was not qualified to do this and wished to retreat from the statements made in which such matters had

influenced him.

74. I shall conclude this part of my judgment by dealing with the criticisms made Ms Lavelle and Ms MacLynn in their closing submissions where it is asserted: "*Mr Greenhouse's evidence was unsatisfactory in some respects…There was a real sense that he struggled with applying the concept of the balance of probabilities in giving his evidence. Mr Greenhouse's oral evidence also changed from that set out in his most recent written reports with little by way of explanation*". They accordingly invite me not to adopt some of his important conclusions. I think it is fair to say that in some of his written reports Mr Greenhouse strayed away from a focus on findings being made on a balance of probabilities and also that he allowed himself to stray away from the scientific and medical evidence and to place reliance on, in particular, the possibly sexualised talk/behaviour; but I am satisfied that he has remedied these possible difficulties in his oral evidence under cross-examination and explained the previous inconsistencies, hence I am able to derive from his evidence the conclusions I have set out above. Overall I am satisfied of his expertise and reliability and I am satisfied that I can and should attach substantial weight to his conclusions.

WHAT NEXT?

75. Having reached these conclusions about the medical evidence, it is necessary for me to consider what should happen next in these proceedings. At the conclusion of the medical evidence I expressly invited all the parties to deal with this in their respective submissions based on what they respectively asserted should be my findings in relation to the medical evidence.

76. Mr Morgan's closing submissions on behalf of the local authority include the following comments:-

"The local authority were clear in October 2020 that there was a basis in the expert evidence for a finding that R was sexually abused. On the basis of Mr Greenhouse's oral evidence specifically the clear rowing back on his conclusions contained in all of his reports after his initial report this is no longer a realistic finding the LA can seek. Mr Greenhouse at one point stated : One possibility is original infection to Rs vagina and she touched her eye – she could have been original source. Also perfectly possible could have been the other way around Because so many possible leads I can't ascribe any balance of probabilities as to any outcome. There does not appear, on the current state of the evidence, to be any clear basis on which to assert that R has suffered sexual harm attributable to the care of her parents. The potentially persuasive factor relied on by the court of appeal and the CG as pointing a way forward in narrowing the timescale (and therefore the pool), namely the observations of Mr Greenhouse at E29/4.2.c3, was itself the subject of further oral evidence from Mr Greenhouse indicating the percentage may be far higher than the original 5% figure due to the lack of specificity in the testing available at the time. There is, in the local authority's view, also a paucity of evidence over and above the expert opinion evidence in this case, to enable the local authority to advance a clear preference for a

vaginal as opposed to an ocular infection as the original source of infection. sexual mode of transmission This leaves, it is submitted, no firm evidential basis on which to prefer the option of a sexual mode of transmission over the possibility of infection of R by another child (or another adult) within the nursery. It seems to the local authority highly unlikely that evidence could now be obtained – even were the participation of the parents of the other children within the nursery within these proceedings achievable – to identify the nature of the eye infection of the other children within the nursery. The expert evidence suggested the symptoms may not have mirrored R's more serious eye symptoms and may themselves have been treated successfully with topical eye drops without the parents being aware their child had been infected with something more serious. The undefined time period for likely infection raises the same problems for identifying a meaningful pool of perpetrators that were originally raised by the local authority in October 2020. The court is also referred to the size of the potential pool identified in the LA case summary in March [A75-76] were the timeframe to simply go back to November 2019. The local authority will need to evaluate the way forward once the court's judgment on the main issue identified is available. In the event the court is able to isolate a mode of transmission and timeframe that allows for meaningful findings on threshold to be pursued, the local authority remains willing to pursue such findings. However in the event the court accepts the local authority analysis of the evidence advanced above it is highly likely, subject to the terms of the court's judgment, that the LA will be renewing its application to withdraw proceedings."

77. The views of the parents are, as they were before, that the court should allow the local authority to withdraw the proceedings.

78. The view of the guardian, even after the conclusion of the oral medical evidence, remains that I should proceed further with the case and should not permit the local authority to withdraw the proceedings. In the words of Ms Lavelle and Ms MacLynn:-

"In the event that the court concludes that R's infections were sexual in origin, the guardian's position remains that the court should conduct a further exercise to attempt to identify a perpetrator. At a maximum, this would appear to be 8 staff members (including two student workers with limited involvement), the police having already made this inquiry (G70). The parents have also identified the paternal aunt and the paternal grandmother having had sole care of R as well as the parents themselves. In view of the issues in this case, apart from the parents, none of the additional witnesses are likely to take a great deal of time in evidence.

Equally, if the court does not feel able to reach a conclusion as to the source of R's gonococcal infections at this stage, it is submitted that it is essential that the court hears from the broad canvas witnesses in this case in an attempt to resolve that issue. That course would normally have been followed in this case. It was not, for sensible reasons, but in the event, it has not been possible to resolve that issue on the basis of the medical evidence alone. The question of how R came by her infections is vitally important to her both now and in the long-term. The court should do all that it can to answer that question if it is not able to do so at this hearing."

79. Although, since the local authority are yet to decide whether to renew their application to withdraw proceedings, and wish formally to see my judgment first before they make a decision on this, and thus I cannot in this judgment close the matter, but I feel that I have sufficiently full information and submissions to express a provisional view which may influence what the parties choose to do next. In particular it seems likely that the views I have expressed above on the medical evidence are in the category of views which render it highly likely that the local authority will renew their application and I therefore anticipate this will be their next step. In seeking to provide an influence in the hope of moving things forward I am cognisant of the ongoing pain and anxiety which the parents will be feeling until this matter is resolved. This is a not unimportant factor, though of course it would have to give way to the welfare of R and N if there was a conflict.

80. If the application to withdraw the proceedings is renewed then the law to be applied is to be found in the judgment of Baker LJ in *GC v A County Council & Ors* [2020] EWCA Civ 848 [2020] 4 WLR 92 and in the judgment of McFarlane J (as he then was) in *Oxfordshire County Council v DP, RS & BS* [2005] EWHC 1593, which can be summarised as follows:-

    (i) Under Family Procedure Rules 2010, rule 29.4(2) a local authority may only withdraw an application for a care order with the permission of the court.

    (ii) The paramount consideration for any court dealing with an application to withdraw care proceedings is the question whether the withdrawal of the care proceedings will promote or conflict with the welfare of the child concerned. It is not to be assumed, when determining that question, that every child who is made the subject of care proceedings derives an automatic advantage from having them continued. There is no advantage to any child in being maintained as the subject of proceedings that have become redundant in purpose or ineffective in result. It is a matter of looking at each case to see whether there is some solid advantage to the child to be derived from continuing the proceedings.

    (iii) Applications to withdraw care proceedings will fall into two categories. In the first, the local authority will be unable to satisfy the threshold criteria for making a care or supervision order under s.31(2) of the Act. In such cases, the application must succeed. But for cases to fall into this first category, the inability to satisfy the criteria must, in the words of Cobb J in *Re J, A, M and X (Children)*, be "obvious".

    (iv) In the second category, there will be cases where on the evidence it is possible for the local authority to satisfy the threshold criteria. In those circumstances, an application to withdraw the proceedings must be determined by considering (1) whether withdrawal of the care proceedings will promote or conflict with the welfare of the child concerned, and (2)

the overriding objective under the Family Procedure Rules. The relevant factors can be stated in these terms:

(a) the necessity of the investigation and the relevance of the potential result to the future care plans for the child;
(b) the obligation to deal with cases justly;
(c) whether the hearing would be proportionate to the nature, importance and complexity of the issues;
(d) the prospects of a fair trial of the issues and the impact of any fact-finding process on other parties;
(e) the time the investigation would take and the likely cost to public funds.

81. My provisional views as to the way in which the factors identified above would fall to be applied on a fresh determination in this case are as follows:-

(i) On the basis of the medical evidence alone I agree with Mr Morgan's view, expressed on behalf of the local authority in closing submissions, that "*There does not appear, on the current state of the evidence, to be any clear basis on which to assert that R has suffered sexual harm attributable to the care of her parents".*

(ii) I further agree with Mr Morgan that the "*the potentially persuasive factor relied on by the court of appeal and the CG as pointing a way forward in narrowing the timescale"* has been closed off by the oral evidence of Mr Greenhouse. If, as the Court of Appeal posited, the timescale had been narrowed down to 14 days then a further investigation might have been more manageable. Given Mr Greenhouse's final views on timescale (assuming the real possibility that the vaginal infection was the first in time) a period of 6 or 9 or 12 months or more would have to be looked at.

(iii) I further agree with Mr Morgan's view in closing submissions that *"It seems to the local authority highly unlikely that evidence could now be obtained – even were the participation of the parents of the other children within the nursery within these proceedings achievable – to identify the nature of the eye infection of the other children within the nursery".*

(iv) The circumstantial evidence (R's possibly sexualised talk/behaviour in October/November 2019 and July 2020) has, in investigation terms, probably been taken as far as it can go and, in my view, it has limited probative value in either adding to the medical evidence to support a finding that she has been sexually abused or, if she has, by whom. My view of this is the same as it was in my written judgment of 23rd October 2020 when I said: "*Whilst somebody might make full admissions in cross-examination, that is fairly unlikely in a case like this where there appear to be no circumstantial evidence pointing to any one person as a greater possibility than any other."* On this point the Court of Appeal expressed the view: "*Realistically, I would accept HHJ Hess's conclusion regarding the improbability of a confession from the witness box and see the potential limitations in the "circumstantial evidence" against the parents*",

which I take to be broadly supportive of my view on this point.

(v) In the circumstances my provisional view is that this is a case where the local authority are likely to be unable to satisfy the threshold criteria for making a care or supervision order, i.e. that this case falls into the first category of cases identified by Baker LJ (supra).

(vi) If I am wrong about that, perhaps on the basis that the present case doesn't meet Cobb J's 'obvious' test, and I accordingly have to consider the factors in a category two case then my analysis now would not be dissimilar to the views that I expressed on such matters in October 2020, including the following:-

(a) Whilst it is almost always in the interests of a child to ascertain as much information about what abuse has occurred by whom and when, especially perhaps sexual abuse with its potentially long lasting psychological effects, where a trial would be unlikely to reach a meaningful conclusion on these matters that interest should have significantly less weight attached to it than when the situation is otherwise.

(b) The evidence suggests that if the timetable were taken at its fullest there would potentially be a very large group of possible perpetrators, perhaps including significant numbers of family members, friends and teachers and helpers at R's nursery, possibly also the parents and families of other children at the nursery who also had eye infections at the same time. The time needed to investigate all these people properly would, in my view, be disproportionately large and unwieldy. Such an exercise would be likely to tie up a disproportionately large amount of local authority, court and legal aid resources with no real likelihood of a meaningful outcome. I do not agree with the comment made by Ms Lavelle and Ms MacLynn about the small amount of time necessary to spend on this.

(c) If, at the end of a trial, a significant number of people were left in the pool of perpetrators, it is unlikely that the actual plans the local authority currently has for ensuring the children's safety would be changed by such a finding. The current evidence suggest that it is most unlikely that a court would be able to find a small group of perpetrators or identify one perpetrator.

(d) Although the courts are loathe not to attempt to protect children by seeking to identify potential risks of future harm (see for example Lord Nicholls in *Re O and N* [2003] UKHL 18) there are some cases, and this it seems to me is one, in which it is not possible to do that in a way which is fair and meaningful.

82. I am circulating this judgment to the advocates by email on 6th May 2021 on the basis

that they may share it with their respective clients.

83. I propose to list the case **at 4.00 pm on Tuesday 25th May 2021** for a 30 minute Teams hearing at which I would hope to establish whether the local authority wish formally to renew their application to withdraw the care proceedings and, if so, whether the guardian wishes formally to oppose it and I shall then make appropriate orders or directions accordingly.

84. My provisional view is that a suitably anonymised version of this judgment should be placed on BAILII and I invite the parties to consider the merits and mechanics for this in advance of the hearing listed above.

HHJ Edward Hess
Swindon Family Court
6th May 2021