[2020] EWHC 3117 (Fam)

IN THE HIGH COURT OF JUSTICE – FAMILY DIVISION
SITTING AT THE LIVERPOOL FAMILY COURT

Case No: ZC16C00911

The Law Courts
35 Vernon Street
Liverpool
L2 2BX

9.45am – 11.29am
Monday, 18th May 2020

Before:
SIR MARK HEDLEY

B E T W E E N:

LONDON BOROUGH OF SOUTHWARK

And

A Family

The applicant local authority is represented by Mr Goodwin QC and Mr Parker (instructed by local authority solicitors)
The 1st respondent is represented by Ms Bazley QC and Ms Kelly (instructed by Freemans Solicitors)
The 2nd respondent was represented by Mr Bagchi QC and Ms Wilson (instructed by Imran Khan & Partners)
The 3rd to 5th respondents are represented by Mr Samuels QC, Mr Bain and Ms Daly (instructed by Edwards Duthie & Shamash Solicitors)
The 7th respondent is represented by Mr Twomey QC and Ms Tyler (instructed by Miles and Partners Solicitors)
The intervenor is represented by Mr Tughan QC and Mr Singh Basi (instructed by Harris Temperley Solicitors)

JUDGMENT

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

SIR MARK HEDLEY:

Part 1

Introduction

1. On Sunday 20 November 2016, probably in the early hours of that day, S then aged 10, died in her bedroom at the family home. This case is concerned with the question as to whether the circumstances of her death pose a risk to her younger siblings so as to require the intervention of the state.
2. The family home was that of her parents. Also living there were two older brothers, E and W. S also had three younger siblings, a sister X and two brothers, Z and A. Apart from them, nobody else lived in the house.
3. On the night in question the whole family were present in the house, but, at least so far as they were aware, there was no one else. In due course, I will have to consider whether in fact an intruder entered during the night.
4. S went to bed happy and well at about 10.30pm or a little after on the Saturday night. It is said that she was found by family members in the morning. When she was formally pronounced dead at about 10.30 that Sunday morning, it is clear that she had in fact been dead for some time.
5. S shared a room with X and sometimes Z slept with them and sometimes he slept with his brothers. That night it is said that he slept with his sisters.
6. During that night, S suffered a fatal injury. The formally recorded cause of death was a compression injury of the neck. On the day in question, the provisional view of the police was that S had died as a result of a tragic accident. That view was radically revised after the post-mortem examination to a sexually motivated homicide. That was because not only did the pathologist conclude that strangulation was the most likely cause of death, but they had found genital bruising suggestive of a sexual assault.
7. The parents have never been able to explain how S met her death. Their conclusion is that this was a tragic if inexplicable accident. Certainly, they assert that neither they nor any member of their family bear any culpability for what happened.
8. The Local Authority's case is that S had died at the hands of one or more of the parents and two older brothers, having suffered a sexual assault. It is further alleged that the family then engaged in obfuscation and the erection of a wall of silence to impede and distract the investigation of their daughter's death. At the end of the day the question which the court must decide is reasonably clear: can the Local Authority prove on the balance of probabilities that S suffered a sexual injury and was strangled and, if so, whether that was a result of a culpable act by one or more of the four named family members and if so, was there a concerted determination to impede the investigation which would thus expose the younger children to the risk of significant harm? The question might be clear, but its answers are far from easy. That much appears clearly from the next part.

Part 2

9. The younger children had been accommodated under police protection orders on 25 November 2016, and X and Z had been placed in foster care, though A remained with his mother. The London Borough of Southwark issued Part IV proceedings in respect of all five children on 29 November 2016. There were then a series of procedural orders that amongst other things, included the return of X and Z to the mother and the older boys to the parental grandfather.
10. On 13 November 2017, the first fact-finding began before Francis J, who on 22 December 2017 gave a judgment dismissing the claim, something confirmed by the order of the court made on 8 January 2018. Subsequent to that judgment, the family were reunited.

On 25 July 2018, the Court of Appeal allowed the Local Authority's appeal and set aside the order and directed a retrial.

11. On 21 January 2019, the retrial began before Hayden J. On 7 June 2019, Hayden J gave judgment in which he found that S had died at the hands of the mother as a result of a failed attempt at FGM and this was confirmed by the order of the court on 14 June 2019. On 14 November 2019, the Court of Appeal allowed the family's appeal and set aside the order and directed a third fact-finding trial. Shortly thereafter, the case was assigned to me by the President and there have been a number of procedural orders, but the matter culminated on 26 March 2020 by the opening of this third fact-finding trial.

12. That is a history unique in the experience of all involved in this case. The reasons for this retrial are set out in the judgment of the Court of Appeal, but were no doubt influenced by the fact that two wholly conflicting decisions had both been overturned.

13. There are a number of consequences of all this so far as this trial is concerned. Everyone has given evidence in court three times. The experts have both lodged reports, had two experts' meetings and some have answered written questions. The family members have in addition made statements in these proceedings and statements to the police, both in the capacity of witnesses and in two cases in the capacity of suspects. All this means that the evidence before me must now be weighed with particular care, making proper allowances for all these matters. This trial has presented a most formidable forensic challenge.

Part 3

14. When I first came to this case on 17 December 2019, I made a number of matters clear. First, that I wanted to treat this as a new trial. Secondly, that I did not intend to read the transcripts of the first or second fact-finding hearings. Thirdly, that I did not actually intend to read the judgments in those hearings, though of course parts have been drawn to my attention as will appear.

15. I have, however, read both judgments of the Court of Appeal. I also made a direction that there should be no reference to previous evidence unless it was to put an alleged inconsistent statement. I did not detect any real resistance to this approach.

16. During the trial there were occasional references to the earlier proceedings, but save where there was a plainly inconsistent statement, it was immediately apparent that any such investigation involved the real risk of having to explore the context in which the statement came to be made. Accordingly, I remained firm, save for that one exception of inconsistent statements, in discouraging or even preventing reference to earlier proceedings.

17. Although there was clearly some forensic risk inherent in this approach, it was my view that that risk was very significantly outweighed by the benefit of the clear management of the evidence actually advanced before me. Given the skill and experience of leading counsel in this case, I am satisfied that no injustice was done by my approach. To the contrary, I believe the evidence emerged with a clarity that I found most helpful.

18. This trial began on 16 March 2020 at the Royal Courts of Justice. It was during this week that the Government announced the civic lockdown as a result of the Covid-19 virus. It was clear that we were not going to be able to resume on 23 March as a conventional trial at the Royal Courts of Justice.

19. For entirely good and indeed obvious reasons, all parties were most anxious that we should not be faced with a long adjournment. That, given the history of this case, would not only have been undesirable but in my view, unjust. The proposal was floated that we could continue the trial in a virtual court by the use of Zoom. All including, it has to be said, the judge agreed to explore this option.

20. On Friday 20 March, we had a dry run. It involved the parties, counsel, solicitors, and witnesses in over 20 different locations. The system was organised by 1GC Family Law

Chambers with Miss Gemma Kelly, junior counsel for the mother, acting as host. As a result of this, all parties agreed to continue this case in a virtual court and a consent order to that effect with my express approval was drawn.

21. The police evidence had been heard in the conventional form. However, all the expert evidence and the lay evidence, including the relevant family members, was heard via Zoom. After the evidence had finished, parties put in written submissions, printed, and arranged for me with cooperation of a clerk in the Liverpool Family Court, with a further Zoom hearing to allow counsel to speak to those submissions. This judgment is being given via Zoom, but in accordance with the advice of the President of the Family Division, it is being given in a courtroom, in this case Court 27 in the Liverpool Family Justice Centre.

22. Having reflected on this experience, which was in this form certainly new to me, I have concluded that it has served the interests of justice. Certainly, I was denied the advantage of being able to see how the family reacted to the evidence as it was given. However, as this would have been the third time of hearing, I would have had to be very cautious in evaluating any such reaction.

23. Insofar as this was a disadvantage, it was significantly outweighed by the benefits of being able to continue the trial and not having an indefinite adjournment. I will have something further to say in the epilogue to this judgment about this matter.

24. It has to be said that it would have been nigh impossible to conduct this hearing without the fulsome cooperation of all involved: counsel, parties, and witnesses. I am very grateful to all of them. Special recognition should be accorded to Miss Kelly, who has acted throughout as host and undertook the responsibility of seeing that daily recordings were provided to the Royal Courts of Justice. I should record that at no point did anyone suggest that the interests of justice were no longer being served by this method of conducting this trial or indeed the means by which it was done.

25. Amongst the matters that required cooperation were the willingness of parties to opt out of being seen on the screen, though they could of course see and hear everything, and to self-mute. The latter was particularly important as the screen picture is sound sensitive and so a cough, noises off (and in this case everyone I think was working from home), or even noisy page turning could suddenly result in a figure appearing on the screen and disrupting the witness actually giving evidence. The one exception was to allow family members to be able to see their own counsel whilst being cross-examined by others.

26. I do not intend to express any view comparing this approach to the conventional case. That is a judgment for others to make. I will only say that I was satisfied in this case and in these circumstances that the interests of justice were properly served by the continuation of this trial in this format.

Part 4

27. The evidence fell essentially into three parts. First, the evidence of the police and emergency services, both at the scene and in the subsequent investigation. Secondly, the evidence of the experts, namely the pathologists and the other medical evidence, together with other expert evidence in relation to DNA, photography and so on. Thirdly, the evidence of the lay witnesses, the family and the other lay evidence adduced by them, both written and oral.

28. There was also contextual evidence relating to the welfare of the children, the capacities of the parents, contact and similar issues, both from Local Authority witnesses and from the Guardian. None of this evidence was challenged but, as will be seen, it does in part provide relevant and very important context.

29. The evidence from the emergency services other than the police, provides a description of their arrival, what they found, the pronouncement of death and the general ambience. The evidence was effectively unchallenged and fits with other evidence in setting the scene for

that Sunday morning.

30. The police evidence is in two starkly contrasting parts. Initially, they believed that they were dealing with a tragic accident and a crime scene beyond the bedroom, and that was closed later that day, was simply not preserved. However, after receipt of Dr Cary's post-mortem report, the whole approach was changed to one of sexually motivated homicide.

31. That contrast is vividly illustrated by comparing the police interview of the father on 22 November 2016 when he was being interviewed as a significant witness and assured that no one was to blame, and the interview of the father on 26 November 2016, which opened with direct questions as to whether he had murdered, raped, or sexually assaulted his child. Although the police took the decision to take no further action, this case remains open.

32. The police investigation has been the subject of stringent criticism, fully rehearsed in the judgments of the earlier judges and now accepted by all parties. Its effect is in relation to lost opportunities for proper investigation of whether this really was an accident, whether there was or might have been material forensic evidence and whether there had been an intruder involved. Those were all potentially relevant issues on which the court simply does not have the evidence that it might have done. There was also firm and justified criticism of the arrest and subsequent interview of W, who was then aged 13.

33. The court heard from five pathologists whose evidence will have to be reviewed in more detail in due course. For now, it is sufficient to say that they agreed that the cause of death was a compression injury to the neck. They all regarded manual strangulation as the primary potential explanation, but there were a variety of nuances when they were asked to consider other explanations like accident or atypical hanging.

34. They were also agreed that there was evidence of bruising to the labia minora suggestive of penetrative injury. There were potentially different views about damage to the hymen or possible bruising to the labia majora. That will be relevant to the question as to whether there had been a straddle injury. I think it would be fair to say that any other signs that might have been suggestive of injury were agreed in all probability to be either post-mortem artefacts or not to add to those already found.

35. In addition to the pathologists, the court also had the advice of a forensic examiner who was clear about the damage to the hymen. Her view was that the genital injuries were strongly suggestive, but not diagnostic, of attempted penetration by an object. The pathologists were generally willing to defer, not over what could be seen but over its interpretation.

36. There was other expert evidence, but it was mostly of a negative nature. Nothing fresh was to be learnt from such DNA evidence as had existed. The post-mortem photographs were suboptimal but not further distorted by enlargement. The evidence of Dr Miller in relation to stomach contents put the death in the early hours of the morning. That is indeed consistent with the probabilities of this case.

37. The oral lay evidence was focused on the events of Saturday and Sunday. Subject to the question as to whether S did or could have suffered an injury during the Saturday, it is essentially uncontroversial up to the time when S went happily to bed at about 10.30pm or so. The focus of controversy is really on the period between then and 12 hours later when S was formerly pronounced dead. That evidence will require close examination.

38. That then is an outline of the evidence that has been explored in this case. However, before turning to an evaluation of the evidence and a consideration of the inferences that it might yield, it is necessary to set out the legal framework that governs that undertaking.

Part 5

39. In one sense, this being a fact-finding hearing, the law can be stated shortly and simply. This case is brought under Part IV of the Children Act 1989, and thus the Local Authority must prove the threshold criteria prescribed by Section 31(2) of the Act and they must prove each

material fact to the standard of the balance of probabilities. The two previous hearings that have gone wrong are, however, eloquent indicators that in this case things may be a little more complicated. It is nevertheless essential not to be sidetracked from certain basic principles.

40. The first is that the burden of proof is and remains throughout on the Local Authority. If it be the case that the respondents advanced suggestions of accident or the intrusion of a third party, then a failure to establish that does not, as we shall see, of its own, support the assertion of the Local Authority. Of course, it might, if any such suggestion were dishonestly advanced, but even there caution would be necessary.

41. The second is that the facts must be proved on the balance of probabilities. Something alleged must be treated as either having happened or not. It cannot after a trial remain simply an allegation. This must be considered further.

42. It is important in cases like this to remember that the consequences of a mistake either way are equally serious. If I were to find the Local Authority case proved and if I were to be wrong about that, that would not only be a grave injustice to the parents, it might have life-changing effects so far as the lives of the younger children are concerned. If, on the other hand, I wrongly failed to find proved something which should have been found proved, then obviously the younger children in particular would be exposed to unacceptable risk, vividly illustrated in this case by the fact that X is now almost of the age that S was when she died. There is simply no escape route for the judge in a case like this.

43. As ever, in the consideration of these issues one must start with *Re B (Children) (Care Proceedings: Standard of Proof)* [2008] UK HL 35. The sharpest analysis of the standard of proof is to be found at paragraph 2 in the speech of Lord Hoffmann where he says this:

> 'If a legal rule requires a fact to be proved (a "fact in issue"), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened'.

44. That is clearly the law, although as everyone will immediately recognise, it does not accord exactly with the realities of human life as it is experienced, but it is perhaps inevitable if we are to have a system of law that we have a rule of that sort. The task of a judge in a case like this is described in the same case by Baroness Hale at paragraphs 31 and 32 of her speech where she says this:

> 'My Lords, if the judiciary in this country regularly found themselves in this state of mind, our civil and family justice systems would rapidly grind to a halt. In this country we do not require documentary proof. We rely heavily on oral evidence, especially from those who were present when the alleged events took place. Day after day, up and down the country, on issues large and small, judges are making up their minds whom to believe. They are guided by many things, including the inherent probabilities, any contemporaneous documentation or records, any circumstantial evidence tending to support one account rather than the other, and their overall impression of the characters and motivations of the witnesses. The task is a difficult one. It must be performed without prejudice and preconceived ideas.

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

That is a pretty direct statement, not, I am bound to say, wholly reflected in my long experience as a trial judge, but the essence of what is being said is plain to be seen.

45. She then goes on to deal with the burden and standard of proof itself and at paragraph 70 and 71, she says this:

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

46. Thus, the three questions requiring final answer in this case are: (1) Is it more probable than not that S was sexually assaulted by a member of her immediate family? (2) Is it more probable than not that she died as a result of a culpable act by a member of her immediate family? (3) Is it more probable than not that members of her immediate family decided to conceal events surrounding her death so as to avoid findings of culpability and in so doing exposed the younger children to the risk of significant harm? There are of course many other issues in the case, but it is the answer to these questions that will dictate whether the threshold criteria have been established, thereby justifying the involvement of the state in the private life of this family.

47. I referred to the burden of proof being throughout on the Local Authority. In that context, it may be wise to bear in mind the words of Moses LJ in his introduction to the judgment of the court in *Henderson v Others* [2010] EWCA Crim 1269. That was a criminal appeal concerning three baby shaking cases, but the principle holds firm for all cases of child injury. At paragraph 1 of his judgment, he says this:

> 'There are few types of case which arouse greater anxiety and controversy than those in which it is alleged that a baby has died as a result of being shaken… The controversy to which such cases gives rise should come as no surprise. A young baby dies whilst under the sole care of a parent or childminder. That child can give no clue to clinicians as to what has happened. Experts, prosecuting authorities and juries must reconstruct as best

> they can what has happened. There remains a temptation to believe that it is always possible to identify the cause of injury to a child. Where the prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative cause, it is tempting to conclude that the prosecution has proved its case. Such a temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude, beyond reasonable doubt, an unknown cause. As *Cannings* [177] teaches, even where on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown'.

48. I was a member of that court and subsequently I held that the same principle applied in care proceedings; see *Re R (Care proceedings: causation)* [2011] EWHC 1715 Fam. At paragraph 10, I said this:

> 'The temptation there described is ever present in family proceedings too and, in my judgment, should be as firmly resisted there as the courts are required to resist it in criminal law. In other words, there has to be factored into every case which concerns a disputed 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'.

49. At paragraph 19 of that judgment, I went on to say this:

> 'In my judgment, a conclusion of unknown aetiology in respect of an infant represents neither professional nor forensic failure. It simply recognises that we still have much to learn and it also recognises that it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism. Maybe it simply represents a general acknowledgement that we are fearfully and wonderfully made'.

I was gratified that in a subsequent case, namely *Re M Children* [2012] EWCA Civ 1710, the Court of Appeal, through Munby LJ, as he then was, expressly endorsed those sentiments.

50. I have been referred to much authority and have considered all the submissions made. I do not think it necessary to repeat all that has been helpfully drawn to my attention, not least because it is essentially uncontroversial and what has been said above highlights the law immediately applicable in this case. That said, I acknowledge gratefully the summary of principles involved in a forensic exercise such as this set out by Baker J, as he then was, in a *Local Authority v Mother, Father, L and M (Children)* [2013] EWHC 1569 Fam.

51. It is important in these cases to distinguish between propositions of law and propositions of fact-finding technique derived from individual cases. The former must be followed whilst the latter, however valuable may be the guidance contained, are simply just that, guidance on the techniques of finding facts. Each case is unique and must be approached and determined as such. Hence, I have kept my review simple. This case in the end will be about the burden and standard of proof.

Part 6

52. I turn to the police evidence which falls into three parts: first, the initial arrival; secondly, the determination of accidental death; and thirdly, the investigation subsequent to Dr Cary's report. As I have said that report transformed the police approach in this case from a working hypothesis of a tragic accident to one of a sexually motivated homicide. However, the

post-mortem was held four days after death. The critical time for investigation of homicide and in particular the gathering of forensic evidence is day one. There were then always going to be difficulties.

53. The first officers to arrive encountered a distraught scene that had its inevitable impact on them. This was vividly illustrated in the evidence of PC Tottman-Shaw, who was in fact the first at the scene of death. There is no doubt that by then S's body had been moved by her father. Indeed, the officer, a trained medic, had believed that she had come to save life but found it already extinct.

54. She was clearly unsure as to what had happened. 'Something wasn't right' was how she put it in evidence. Although she said that it appeared that the bottom bunk had not been slept in, that was not the focus of her attention and her evidence is an insufficient foundation for such a finding.

55. Two other officers who attended the scene did speak to family members; in particular, they spoke to X. She told them two things. First, that she had found her sister and had told her father and, secondly, that she had heard a bump in the night, had called out, but no one had come and she did not call out again because she did not want to get into trouble for waking the house up.

56. Understandably, she could not put these matters in any time frame. Although unlikely, they may even have been the same event. I am satisfied not only that she said these things but they represented something that had indeed happened to her that night.

57. Detective Inspector Purvis was the on-call detective inspector for South London that day and he attended the scene. His view that day, although he had changed his mind once or twice, was that he was dealing with a tragic accident. He regarded both murder and suicide as unlikely and further noted that there were no signs of disturbance or struggle in the bedroom or the house, a now uncontroversial fact.

58. He was also of the opinion that the family reaction was as he would have expected in the circumstances of a tragic accident. He had thought that in these circumstances there should have been a special post-mortem, but in the event a standard post-mortem took place some four days later. Although the bedroom was for a time that day secured as a crime scene, everything else was governed by the conclusion that this death was not suspicious.

59. The clearest account of the approach of the police after the post-mortem is to be found in the evidence of Detective Inspector Sidaway, who on 10 February 2017 became the senior investigating officer in the case. She made it clear that the case remained open as a homicide, but that there was insufficient evidence to identify a perpetrator or indeed what was described as a credible suspect.

60. The police had discounted the possibility of third-party involvement and of suicide. If this was a murder, then the murderer was a family member. That said, neither the mother nor E had ever been treated as suspects. W had been discharged from bail and the detective inspector had regarded the father as genuine in interviews.

61. Unsurprisingly, the case had become stuck. There was no clear motive, not least because none of the risk factors associated with domestic murder or sexual assault were present in this case, something that must be revisited in more detail later. On the other hand, there had never been an investigation of the possibility of accident that she regarded as statistically very unlikely. She did add, however, that the theory of accident would be much easier to accept if there had only been the injury to the neck and no genital injury and I certainly accept that.

62. Reconstruction was no longer possible because there was no proper knowledge of the knotting of the netting where S was found or other material information. There was a period when FGM was considered, but there was no evidence to support such a theory and it has not been raised as an issue in this trial.

63. The detective inspector accepted that there had been shortcomings in the investigation that now inevitably left potentially important questions unanswered. The case may be left open but short of discovery of wholly unforeseen new information, no further action was likely.
64. The shortcomings of the police investigation have been thoroughly identified in an earlier hearing. They are also set out in appendix 1 of the written submissions of leading counsel on behalf of W. They are accepted by the Local Authority in this case. I do not propose to rehearse these and have only identified those that are relevant to my findings in this case.
65. The plain fact is that this case was treated as a non-suspicious death until Dr Cary reported, by which time it was too late to remedy the earlier forensic deficiencies. All four members of the family had been interviewed as material witnesses and had given no grounds in those interviews for altering that status. I should add that X and Z were ABE-interviewed in due course.
66. Those deficiencies operate both ways in this case. They weaken a case of sexually motivated homicide, but they also undermine any attempt to establish an accidental mechanism as well as the proper evaluation of a third-party intruder suggestion. Although the police evidence is deficient, it remains material, as I am satisfied that those officers who gave evidence to me did so in a spirit of wanting to assist the court. I shall draw on that evidence when it comes to the position of trying to see the evidence as a whole and to discern what, if any, picture the evidence discloses.

Part 7

67. The expert evidence falls into two convenient categories, the medical evidence, and the other evidence. As explained in the introduction, it is unnecessary to discuss the non-medical expert evidence as in the case it shines no real light on the contentious issues in the case, although it is of course informative in its own right. The initial medical evidence effectively comprises that of the two pathologists who conducted the post-mortem, Dr Marnerides a paediatric pathologist, and Dr Cary, a forensic pathologist.
68. During the course of the proceedings, three further pathologists were instructed, each of whom gave evidence: Dr Kolar, a forensic pathologist, Dr Malcomson, a paediatric pathologist and Dr Leadbeater, a senior lecturer in pathology. The latter three, all of whom had to work from photographs, acknowledged by all, unusually, to be suboptimal, as well as having access to histology slides, all accepted the advantages of observation enjoyed by those who were actually present at the post-mortem.
69. At the suggestion of Dr Leadbeater, there was also instructed Dr Lipetz, a consultant gynaecologist who is also trained and experienced as a forensic medical examiner. In addition, because she brought an experience unique amongst these expert witnesses to bear on the case, her evidence will require separate consideration. Generally speaking, the pathologists, whilst not willing to defer to her over what could be seen, were willing to do so in relation to the interpretation of those findings relating to genital injury. Her evidence was of course confined to the question of injury to the genitalia.
70. There was little relevant dispute between the experts over what could be seen other than whether there was an injury to the hymen and whether there was external bruising to the labia majora. The differences between them were essentially as to the inferences that could be drawn from what could be seen. They were, however, all agreed that sexually motivated homicide was top of the list of differential diagnosis. That is why the police changed course.
71. As far as the neck injury is concerned, that was the injury causative of death. The question is how it happened. Unusually perhaps, in this case there is no direct evidence but only inferences, speculation, and submission.
72. There is agreement amongst the experts that strangulation by a third party would be the most likely explanation. No one was prepared to rule out accident, although it would be unusual

in this age group because they could normally escape from any such problem and it would probably have to have involved the ligature being wound round the neck first. It was further complicated by the fact that the position of the body after the fatal injury could not be clearly established.

73. Dr Leadbeater reminded us that it is difficult to attach probative weight to individual findings. Pathology alone cannot provide the answer. Dr Kolar reinforced that view. Forensic pathology is merely part of the jigsaw.

74. Moreover, Dr Cary recognised both that sometimes we never know what has happened and that he had dealt with cases which in the end turned out to be bizarre accidents, impossible to visualise until, as it was put, the penny drops. All that said, whilst none could affirmatively exclude an accident, none could visualise how such could have occurred and, for each, sexual assault and homicide remained at the top of the list of differential diagnoses.

75. It is important to say something more about the evidence of Dr Lipetz, who was as I have indicated, uniquely qualified in this case. She was a careful, competent, and experienced witness whose motivation was to help the court understand what had happened in this case. She was giving evidence for the third time, as were the pathologists.

76. Importantly, her experience was with live children who first, could give a history of what had happened; secondly, could move so as to afford different views of the same area as things might look differently from a different view; and thirdly, could be examined by a colposcope.

77. Here, of course, Dr Lipetz was working from suboptimal photographs. She had no expertise in histology, or indeed in the examination of dead bodies and she did not in fact examine the histology slides. It follows that however careful and skilled her examination may have been, it was attended by disadvantage not of her own making.

78. The interpretation of what was seen must await discussion later in this judgment. However, I propose to set out here my findings as to the injuries themselves. First, it must be stressed that there were none beyond the fatal injury to the neck and injury to the genitalia. There is broad agreement about the injury to the neck evidenced by a mark that lacked the raised point normally associated with hanging. This injury is consistent with strangulation, though the pathology cannot exclude an atypical hanging.

79. As to the genitalia, I am satisfied that there is significant bruising of the labia minora consistent with blunt object trauma. What was seen was moreover a result of an injury in life and not a consequence of death like for example hypostasis. There are vaginal petechiae, but I accept that they are consistent with and of themselves add nothing to the bruising.

80. I find, on balance of probabilities that there was no external bruising to the labia majora, although both Dr Kolar and Dr Leadbeater thought it possible, first because none was seen at post-mortem and secondly, as Dr Cary pointed out, there was no evidence of bruising underneath the labia majora when viewed histologically.

81. I am satisfied that there was some irregularity of the hymen. The pathologists at post-mortem described it as ragged. Dr Lipetz is more precise in identifying an injury at seven o'clock. I am satisfied that there was some irregularity there, though I need to exercise caution over its interpretation given the difficulties of working from photographs of a dead body, as acknowledged by Dr Lipetz. I am satisfied that any other suggestion of injury in the anogenital region is either a post-mortem artefact or such that no further inference of causation can properly be drawn.

82. The consequence of these findings is very much to leave sexual assault and homicide at the top of the list of differential diagnosis, but as all experts have said, the pathology does not prove what has happened, notwithstanding a stray statement of Dr Cary to which I will return in the discussion part. Accident is not excluded on the evidence available to the medical experts; it is very unlikely, and none could visualise how it could happen. The court must

then turn from the police and expert evidence to that of the family.

Part 8

83. The evidence of the family conveniently falls into three sections. First, the general background evidence of this family and in particular of S's place within it. Secondly, the evidence of what the family and S in particular did on Saturday 19 November 2016 and thirdly, the evidence of what happened in the home in the period of 12 hours between S going to bed shortly after 10.30 on the Saturday and her being pronounced dead on the Sunday morning.

84. The background evidence is uncontroversial but quite extensive. Indeed, much of it comes extraneously from Social Services, schools, and the police, as well as the Guardian. As will be seen, it effectively speaks with one voice to the credit of this family.

85. The Local Authority does not seek to challenge the evidence advanced by the family as to the events of the Saturday. I will, however, have to consider whether, if S suffered a genital injury, she had done so before going to bed on that Saturday night and, if so, when and how that had occurred. Obviously, the evidence of what happened after 10.30 on that night is highly contentious and will have to be carefully evaluated by the court.

86. The general background evidence derives essentially from Social Services and education, although there is evidence from other family members and the Muslim community. All the children at school have done well there and there is effusive praise for the two older boys. That progress has, with some wholly understandable glitches, been sustained since S's death.

87. S too was doing well and there was nothing to suggest in her any more than in respect of the other children that there were any signs for concern. The family had had no statutory dealings with Social Services prior to November 2016.

88. Since their reunification in the wake of the first trial, they have inevitably been subject to social work scrutiny. That scrutiny essentially reveals an effective and well-functioning family, supporting wholly the earlier evidence. That there were effective and well-functioning relationships was demonstrated by the contact records during the familial separation.

89. As indicated by Detective Inspector Sidaway, there was not a single risk factor for sexual or bodily assault to be found in this family. Moreover, the police, both in their time in the house and in interview, took the view that this family and its individual members behaved as they would have expected those bereaved by an unexplained tragedy. It is important to stress that all this evidence was not just positive but often congratulatory of the family.

90. It is right that relationships between the family and the authorities have not always been smooth. However, for the most part they were cooperative and open. Two particular matters have been highlighted. First, the breakdown in relations with the police family liaison officer and secondly, a withdrawal of X at one stage from counselling.

91. It must be observed that both were temporary. In the context of the particular history of this case, it would in my judgment be wrong to draw inferences pointing to parental culpability from these events. They were temporary glitches, not permanent ruptures.

92. In addition, because this background is uncontroversial, it has not been explored in oral evidence. Nevertheless, it remains very important. It does not of course establish that no family member was culpable in S's death, but it is highly relevant to the unlikelihood of their being so. It must carry serious weight in the discussion about where the probabilities in this case lie, not least because what is alleged here, unlike, for example, a shaking case, is not a momentary loss of control but something much more calculated in a sexual assault.

93. I turn then to the evidence of Saturday, 19 November 2016. As it is not, subject to one question, controversial, I will deal with it briefly. The evidence is, however, not unimportant.

94. The father was at work from about noon until 10pm, his work being about half an hour away

by bus and walk. He had got up late and had arrived home in time, both for Match of the Day at 10.30 and to say good night to the younger children.

95. The oldest boy had spent his day variously in revision lessons at school, being out with friends, getting a haircut and watching football on television. He too settled down with the father to watch Match of the Day at half past 10 in the evening.

96. The mother, W and the younger children had been out that day. The mother had been housebound since the birth of the baby and today was the first day when she was to go out. She left home late in the afternoon and went to a family member's home where they spent several hours, including having a meal and later a snack.

97. They arrived home soon after 10 o'clock and the younger children, S, X and Z, took themselves to bed, saying goodnight to the mother, the father, and their brothers as they did so. The mother had gone to the parental bedroom and remained there with the baby during the night.

98. There is one strange feature in this evidence. The mother rang and told the father that she was coming straight home. In fact, she had planned to visit another family member called N, but she did not do so as that person was not at home. Oddly enough, the father met that woman at the bus stop as he was on his way home.

99. The Local Authority invite the court to draw an adverse inference from this lie admitted insofar as the mother's evidence is concerned. I confess that I find it strange, but I can see no proper basis for treating it either as indirect evidence of culpability or as significantly tainting the mother's general credibility.

100. More important is the evidence relating to S. It established that she had a good, happy day with nothing in it to blemish that. There was no emotional inconsistency, no evidence of any injury and no complaint of injury or interference. Indeed, she had never made any such complaint.

101. In this context, the court must be mindful of the expert evidence that the genital injury would have caused real pain and there was no reason why S would not complain of any such pain had she suffered it. I am satisfied that when S went to bed at 10.30 that evening, she was wholly uninjured. Insofar as she had suffered injury then it must have been after she went to bed.

102. I must now turn to the controversial evidence, namely that of the 12 hours that elapsed between S going to bed and her being certified dead. In doing that, it is necessary to look at the individual evidence of each family member. However, it is necessary to say something first about the house.

103. It was a three-story town house. The ground floor had a kitchen, living room and bathroom. The first floor had the parental bedroom and what I think was the main living room. The top floor had two bedrooms and a bathroom.

104. The parental bedroom was at this stage used by the mother and the baby. The baby had not been sleeping well and the father had decamped to the bedroom of the older boys, especially when he was working. That bedroom was on the top floor. The other bedroom on the top floor was the girls' bedroom used by S and X. Z seems to have moved between the two.

105. Each bedroom had a set of bunks and a bed and these are illustrated in the police photographs. The girls used the bunks with S using the top one. The boys used the bunks and the father had his own bed in the boys' room.

106. The father went to bed sometime after midnight. He says that he was called by W, but he was only half awake. He got up and W pointed him to the girls' room. What he said after that was this:

> 'I had stayed upstairs. I went into the room. S was facing the bed. It was dark in the room. I don't think there was a light on. Her arm was near what

was around her neck. Something was wrapped round her neck more than once. She was facing the bed near the ladder. The head was raised back. Her fingers were clawed. I do not think she was holding anything. Her two knees were on the wood [by which he meant the floor]'.

107. When he then put her on the floor, her knees were angled up. She was resting back on her legs. He said:

> 'I tried to take off the fabric. I had to take her onto my knee. I could then undo the lace round her neck. I couldn't pick her up, so I had lifted her onto my knee, and she was there on the ground until the first police officer arrived just a few minutes later. It was like a hard body. I couldn't straighten the legs. I think someone, the mother's sister, came in and went straight out. I spoke to a lady on the phone and I understood help was on its way. I didn't make the call. I don't know how I got to the phone. Someone gave it to me. I was with S throughout. I was crying and was very distressed'.

He says that he was not suspicious of foul play.

108. The mother said that after saying goodnight to the younger children, she was alone all night with the baby. She said:

> 'I didn't go upstairs to the bathroom. A was awake for part of that time during the night. I heard nothing from upstairs. I couldn't have heard X if I'd been asleep and I saw no one during the night. I heard shouting in the morning which woke me up, something about S. They were horrible shouts. I called 999. I knew something was wrong with S. I was shouting to my husband. He was not listening to me. I was going to go upstairs but was completely unable to do so. I don't think I completed the 999 call'.

Other members of the family had arrived during that day, but until the mother was told of her death, she was in the parental bedroom.

109. During that night she had been up because she had had an unusually long phone call with another female relative, which finished around half past one in the morning and the baby had also woken again for a feed around about five or six o'clock.

110. E told the police that he went to bed at about 11 to 11.30, but he told me that it was after the Stoke - Bournemouth game on Match of the Day, so it must have been much nearer 12 o'clock. What E said was this:

> 'I remember Z woke me up. I was on the bottom bunk with W on the top one. Z was by the doorway. Dad was still asleep in bed. I don't know when Dad woke. I don't know what time I woke. It was close to when the ambulance came, no more than 30 minutes. I went downstairs to brush my teeth with an electric toothbrush. While I was doing my teeth, I heard a noise but was not particularly interested. It was just a noise. I didn't take much notice. I never went into S's room. I didn't need to'.

111. According to that evidence, he would have got up about 10 o'clock. Important evidence was obtained in relation to his mobile phone, which he said was usually turned off at night. The mobile phone activity that morning began at 9.17, though there was no actual use of the phone. That yields the highly probable inference that he switched the phone on at 9.17. That, experience suggests, does not require a further inference that a teenage boy on a Sunday morning got up at that time or even stayed awake.

112. No other immediate family gave evidence to me, though I did have evidence from N's

daughter. I do, however, have W's police interviews and statements, the achieving best interviews of X and Z, comments allegedly made by X and Z to the foster carer and what X said both to the police and to the mother. All of that is relevant.

113. Moreover, the evidence is not always consistent, nor has it ever been. One of the difficulties in this case, given its peculiar history when dealing with inconsistencies in evidence, is determining when a simple lapse of memory becomes a deliberate invention or obfuscation. To that I must return in the discussion.

114. The evidence relating to X, Z and the foster carer is controversial. The foster carer made records of what the children said, which are not accepted. The foster carer gave evidence at the last hearing but could not be traced for this hearing. There was no evidence of deliberate evasion by her, but the fact is she did not give evidence. Moreover, evidence was disclosed that she did not always appear in a good light as a foster carer.

115. I think that I should approach this evidence with caution. I have no reason to think that her written records were tainted with malice. On the other hand, whether they evidenced children under parental or family pressure not to disclose or whether X, for whatever reason, did not want things said to strangers, will require careful consideration. This is particularly so in relation to Z's reported comment that someone was slapping Ss face, but she did not answer.

116. That in outline was the evidence given, though when coming to conclusions about credibility and inferences to be drawn, it will be necessary to look at some details elicited in cross-examination. It is now necessary to see how the parties put their respective cases.

Part 9

117. The case for the Local Authority as will be seen is a strong one. It is however inherently improbable, as is every other case that has been advanced for consideration here, whether suicide, third-party intruder or freak accident or accidents. This is a case in which the inherent probabilities, so often a valuable guide in these cases, have perhaps a very much lesser role to play.

118. The Local Authority case is really put like this; whatever the inherent probabilities may be, there are certain stark facts in this case that must have an explanation and that explanation can only be found in imputing culpability to the family.

119. In relation to the genital injury, there is an injury. There is bruising to the labia minora and damage to the hymen. It is an internal injury. There is no equivalent injury in the labia majora.

120. That injury is a blunt trauma injury. When seen, it is usually consistent with attempted penetration with an object, most likely a finger. It is simply not realistic to explain it by accident, given that there is no external injury and given that she went to bed uninjured. It could only have occurred when a family member was present.

121. The neck injury, this is the fatal injury, is essentially consistent with strangulation by a third-party rather than hanging. This is shown really by the total encirclement of the neck and the absence of any rise associated conventionally with hanging. It must have happened in the early hours of the morning. It is really inconceivable that it is not involved with the genital injury. It therefore occurred when only the family were present.

122. Both ideas of suicide and a rogue intruder may be excluded as deeply improbable. Likewise, a freak accident is deeply improbable, not only because there was a safety bar to prevent rolling out, but the question is: how could any such accident have happened?

123. In addition, as to a conspiracy of silence, the family, it is said, decided to erect a wall of silence. There was a significant delay in summoning help via 999. There was then the telling of a common story that the inconsistencies in the evidence effectively undermine and there is evidence that the younger children were instructed to keep silence.

124. There is X's behaviour with the foster carer and the withdrawal of X from counselling. Was

this at a time when they feared she was about to say something? Moreover, the Local Authority rely on the general credibility of the family, the unlikelihood of some of the evidence that they have given and an unusually frequent retreat into, 'I don't remember' or 'I don't know' and to excessive defensiveness when asked about possible difficulties within the family.

125. Importantly and rightly, the Local Authority stressed the need not only to look at the details but also to look at the whole picture in the round. When that is done, says the Local Authority, there is really only one answer available. What is needed is a unifying explanation at the point of death and that is provided by familial culpability.

126. The Local Authority accept that the evidence may not permit the court, even if satisfied that this was a case of culpable sexual assault and/or homicide, to identify the individual perpetrator. What they seek is the identification of an exclusive pool of perpetrators, here said to be the parents and the two teenage boys and a finding that the parents with the older boys colluding, knowing that S's death was culpable, of deliberately erecting a wall of silence to deflect any enquiry into the truth of what has happened.

127. Further, and this was a matter raised by me, the court might also have to consider a case where one family member was responsible for the assault and death on S and the others are genuinely ignorant of that. Whilst that is of course a most unlikely scenario, it has, as I have observed, just that in common with every other suggested scenario in this case. I mentioned it as one amongst many possibilities in this case,

Part 9

128. Each of the four alleged perpetrators is separately represented and thus each has an individual case to present. However, in the particular context of this case, there is a sufficiently common thread to the case advanced to treat it in broad terms as a common case but with individual features. The essence of the case is that the Local Authority cannot prove the facts necessary to sustain the conclusion for which the Local Authority contend. They say that the court may have to conclude that what happened to S can never be known or explained. It is, they contend, one of those rare cases in which the burden and standard of proof are decisive.

129. Although that is the true thrust of the case, the family also offers some suggestions as to what might have happened without contending that any of them could be securely established. They mentioned, but understandably do not press, suicide as an explanation. They mention the possibility that T, a relative, was a culpable intruder, though the parents themselves were most unwilling to press that point. The question of some other intruder is posited. However unlikely that may be, they contend that it cannot be excluded because the earlier failures in the police investigation do not allow it to be excluded.

130. Again, they raised the possibility that S sustained her genital injury during the Saturday, either by accident or at the hands of another. However, at the heart of the arguments was an invitation to conclude that injury and death were the consequence of a freak accident in the early hours of that Sunday morning.

131. There are a number of matters to which they can point, beyond the inherent unlikelihood of these parents doing these things to this child, given all that is known about this family. S loved dressing up and the netting in which she was enmeshed when found dead could have been used as dressing up material. Secondly, although the parents disapproved of the netting and the father had once removed it, S persisted in retaining it and having it in her bed.

132. Thirdly, X heard a bump but no more than that during the night. Fourthly, the police found no signs of force or of a struggle beyond the neck injury. Fifthly, that S was on the top bunk and could have jumped or fallen at a time when she may only have been partially awake. Next, in so falling, she became fatally enmeshed in the netting and coincidentally suffered a straddle injury.

133. Next, everything that happened subsequently from Father going to S and disentangling her body from the netting was consistent with what would have been expected of parents bereaved in an inexplicable incident. Lastly, if X had spoken as the foster carer had recorded, and that is not accepted, that was because she had decided to block out everything to do with this accident, as the mother had explained in saying that X would not talk with her about this after the day of the death itself.

134. As I say, the parents are not contending that they can establish any of these explanations. Their stance is that they do not know what happened and are desperate to discover the truth if that can be done. The essential case advanced on their behalf and one they are entitled to advance is that the Local Authority cannot prove the conclusions for which they contend, even if that means the court having to accept that what has happened to S cannot be determined.

135. After all, Dr Cary acknowledged that that was the outcome from time to time in the very many forensic cases in which he, over a long career, had been involved.

Part 11

136. The court must now weigh up the contentions of the parties, decide the primary facts and the proper inferences to be drawn from them. In so doing, however, the court must remain sharply aware of the question that finally has to be answered. This is not to declare what happened to S that night, it is to decide whether the Local Authority have proved to the requisite standard that S's death involved culpable conduct by the four alleged perpetrators or any of them and what that conduct was. If that explains what happened to S, so much the better, but I must not lose sight of the true question.

137. The court must also bear constantly in mind the context in which this case falls to be considered. True it is that this child died from a compression injury to the neck and at any time in the 12 hours before she died, she had sustained a genital injury. Nevertheless, every scenario presented for consideration remains of itself highly improbable.

138. This is the third full trial of the reasons why S died, she having done so on 20 November 2016. For the witnesses, expert and lay, they have given evidence in court for the third time of asking. I must therefore remind myself not only of the vagaries of memory but also of what has been described as story-creep. Moreover, repeatedly giving evidence can impact on experienced experts who may be drawn into hardening their opinion as time goes on and challenges are repeated. In a tone almost betokening despair, Dr Lipetz at one point observed that everything in this case is atypical.

139. In my judgment, all the expert witnesses were doing their best to assist the court. Their task was unenviable. It is no criticism of Dr Lipetz to say that she worked under disadvantages not of her own making. Indeed, she readily acknowledged them, as I have earlier observed. No more is it a criticism of other experts to observe that the firmness of their views varied from time to time. It was only human that they might do so.

140. Nevertheless, I must bear these matters in mind in coming to my view in this case. A vivid illustration of this was Dr Cary's sudden comment that third-party sexual assault and strangulation was proved to the criminal standard. Such comments simply did not cohere with the carefully nuanced answers that he had given at other points in his evidence.

141. Each expert agreed that this case should be investigated as a sexually motivated homicide, but there was disagreement about how firmly that was established evidentially. In my judgment, the pathologists who urged that proper but not excessive weight should be given to the pathological evidence were right in their observation. There is no doubt that the pathology founds the Local Authority case. It does not, however, prove it.

142. On the other hand, whilst no expert was prepared to exclude an accident, though they did that with various degrees of scepticism, none was really able to visualise how such an accident

could actually have happened. That of course is important but, as all recognised, not decisive.

143. Equally difficult in this case is the evaluation of the evidence of family members. Originally, it was given in a context where it was made clear that no one was being blamed, then the father and W were interviewed as the suspects, then they have made statements in these proceedings and three of them have given oral evidence three times. The context in which evidence is given is not unimportant, not least in terms of attention to detail, which may seem unimportant at the time but which come to assume greater significance in due course. It is clear that the police accepted the genuineness of the evidence they had been given and it remains their view that they have never been able to identify what they describe as a credible suspect.

144. There are issues in the family evidence on the other hand which excite caution on my part. There are inconsistencies both between and within the evidence of each family member. The parents sometimes surprisingly had ready recourse to, 'I don't know' or 'I don't remember' types of answer. It strained credibility how little they said they had been prepared to talk amongst themselves about what happened or might have happened on that fateful night.

145. There were times too when the evidence became conspicuously defensive as when they were asked about difficulties in the family or between siblings. Any such matters were firmly denied. The difficulty is what is one to make of these features?

146. Are these matters the consequence of delayed and repeated account giving? Are they no more than a defensiveness of family reputation against outside inquiry, bearing in mind the strong Somali Muslim culture of the family? Has the court made sufficient allowances for the fact that although both parents were competent in English, it was for each of them not their first language? Or does this, on the other hand, create such an impression as to lead to a conclusion that this family has consciously and of course dishonestly erected a wall of silence against the state's proper enquiries into S's death?

147. At this point the court must keep in mind the wider context. All who know this family, including school, Social Services, and the Guardian, as well as members of the extended family and the wider Muslim community, speak well of them, not only of their care for their children, but of their openness too. Now, of course, much of that evidence would relate to a time when the parties were not under pressure. However, that positive evidence has now continued without significant qualification over the last three years when they have been living in the shadow of this litigation and the oversight of all welfare authorities.

148. Having reflected with care over this, I have come to the conclusion that I should approach their evidence with caution and exercise great care in allowing it to found specific findings, but I am not persuaded that this was a case of conspiracy of silence contended for by the Local Authority. That does not mean that one person does not know what actually happened, nor even does it mean that there may have been familial anxiety that one of them may have been in some way to blame. It means only that I am not satisfied there was a conspiracy of silence based on the parents in particular knowing what had happened and being determined to cover it up. I do not think that that conclusion can fairly be drawn when the evidence is set in the wide context that this case demands.

149. I have already stated my views about the police evidence. I have indicated the basis on which I approach both the evidence of the experts and that of the family. As it happens, these conclusions taken together only make my ultimate task even harder.

150. I do not think it would be wise, although it is very tempting, to reduce this case to a choice between a family member or members assaulting and killing S on the one hand and a freak accident on the other. That is because to do so would exclude other possibilities, however remote they may be, and of course it would fail to acknowledge a wholly unknown cause, again, however remote that might be. It is inevitable on the evidence adduced and in the way

this case was broadly argued that it will look like a choice of two, but I remind myself that in law it is not. That said, there are three possibilities which can either be excluded or treated as highly unlikely, namely suicide, the actions of T or the actions of an unknown third-party intruder.

151. I intend to find that this was not a case of suicide. S was too young for suicide to be a likely possibility and everything that we know about her points away from that conclusion. That finding has not overlooked the possibility of suicide as a response to sexual assault. The family do not for one moment think it was suicide. I agree and so find.

152. There is no evidence which could justify a finding against T specifically. He has a questionable character perhaps, but nothing in it that would remotely suggest sexual assault or murder. A remote case can be made for his having opportunity, but again, given what is known about S's Saturday, that is deeply improbable.

153. The third-party intruder is less clear. There is wholly insufficient evidence to justify a finding that this is what happened. It has only been advanced as a possibility. It is unlikely that anyone could have gained access to the house that night, have assaulted and killed S without disturbing any of the people present in that small house.

154. The police dismissed the possibility and never investigated and therefore never excluded it. The difficulty in wholly dismissing it on the grounds of unlikelihood is, as I have repeatedly said, that every explanation advanced in this case is unlikely. Clearly family members had the opportunity between midnight and when S died, probably in the early hours, to assault and kill her.

155. It would, however, have been something very difficult to do surreptitiously given the presence of two other children. They would have had to have them moved or S would have had to be moved. It is hard to see how others would not have known. The only actual evidence is X hearing a bang in the night as I find that she did.

156. That is not to say that someone could not have applied a ligature to secure compliance, assaulted her and then killed her because the person did not appreciate how slight a force might secure that end. It is highly improbable but not impossible. One has to recognise that the expert evidence suggests that no very great force was used or required to be used to cause death.

157. A freak accident is of course by definition an improbable explanation. In this case, it would have involved S winding the netting around her neck before going to sleep. Given that there was a safety board around the top of the bed, it would have been very difficult to see how she would fall by rolling out, even if as was the case, she slept in the top bunk. It would have involved her getting up and then perhaps while still half-asleep jumping or falling and getting fatally entangled in the netting.

158. Moreover, she would have had to fallen in such a way as to sustain a straddle injury that mimicked a penetration injury. No expert asserted that that could not have happened, but none had ever seen such an event or was able to visualise it.

159. Quite apart from it not being clear how she ended up, as W and the father give differing accounts as to how she was found and in particular which way she was facing, no forensic evidence was obtained beyond photographs as to the netting and how it was knotted or otherwise affixed to the bunk. Family evidence is that the netting was long and looped down from knobs at each end of the bunk almost to the floor. The evidence also is that the father had gone some days earlier and removed it, but S had taken it back, reinstated it and no one had tried to remove it again.

160. There was evidence, which I accept, that S delighted in dressing up in girlie clothes and that the netting could easily have served that purpose. Did she go to sleep forgetting that it was wound around her? Did she wake up perhaps still half asleep and confused and contrived to

jump or fall? Did she become ensnared by the netting and despite most children of her age being able to free themselves, fall in such a way as to cause a compression injury leading rapidly to unconsciousness, as the expert evidence said it was likely to do, and then to death? Did she, in falling, sustain a straddle injury?

161. The father's evidence is that, when he found her, the netting was so tightly wrapped around her neck that he could not undo it without first lifting her so as to relieve the pressure, whereupon he disentangled her from the netting before lying her on the floor and covering her with a sheet. She was, as I find, in fact dead long before that. He gave a strange description of how he found her arm raised and unsupported. Was that rigor mortis after a failed attempt by her to prevent strangulation?

162. In addition, because of the view taken by the police, a crime scene was not established in the whole house but limited only to the bedroom and that was closed the same afternoon. No forensic tests other than those referred to revealing neutral results were done on the netting or in relation to how it was secured and there was no attempted reconstruction. We simply do not know, for example, whether the netting could or would have supported S's weight.

163. Clearly a strong case can be made against the happening of an accident of the nature described. Equally, clearly, the thesis of sexual assault and murder by a family member or members is not exactly free from difficulty. No other explanation has attributes of likelihood about it.

164. What of course has to be resisted is to dismiss the possibilities of suicide, T, third-party intruder and freak accident and conclude that as night follows day the conclusion must be sexual assault and murder. That line of reasoning is forbidden by law, unless and until consideration has been given to the possibility of an unknown cause.

165. As I have said, all this detailed analysis of proffered explanations must be seen in the whole context that I outlined at the beginning of this discussion. I have set out the various contentions as I understood them. I have not replicated everything set out in the parties' detailed submissions, let alone in the cross examination of all the witnesses, but I have them all in mind though I have been necessarily selective as to what is actually included in this judgment.

166. The other matter to be considered is the evidence relating to X and Z. It is important to remember their ages at the time, six and three respectively, and their very limited grasp of the context in which they were living. Insofar as Z talked of seeing S being smacked, I am satisfied that he is describing an attempted revival of what was in fact a long since dead body.

167. His description of needing help in the toilet relates to the time of chaos when S was found. I am very reluctant to attach significant weight to what he said to the foster carer, not least because the context of those comments remains unexplored.

168. I am clear that X did hear a thud during the night and did call out once. I think the mother is wrong in her evidence that X described S as shivering. I do not know why the mother said it, but it does not for me fortify a contention of dishonest conspiracy.

169. I am satisfied that X sought to stop Z talking to the foster carer. I think it no more likely that she was acting on parental instruction than that she herself wanted no such conversation especially with those outside the family. I share the Guardian's surprise that today X is allowed to sleep on a top bunk, but I am not clear that that leads to any inference useful in deciding this case.

170. I acknowledge that some of the evidence was both surprising and strange. It is not the only evidence like that. At one stage the father described W as saying that S had been smacked and then he doubted whether it had been said. It is a curiosity that forms part of the big picture rather than evidence which yields a specific inference adverse to the father. Indeed, all the evidence needs to form part of the big picture, but none of this evidence from the children

affords any further inference that might be helpful in my decision.

171. I have now set out the evidence, both contextual and specific, and have rehearsed the essence of the arguments that have been addressed to me. I have also set out some specific detailed findings. I must now draw all of these matters together and consider to what conclusions they lead.

Part 12

172. I begin my conclusions by reminding myself once again of the question I must answer, a question common in all cases brought under Part IV of the Children Act 1989. Have the Local Authority proved on the balance of probabilities the facts necessary to establish the threshold criteria required by Section 31(2) of the Act?

173. In the context of this case that can be refined into the three questions I set out in the early part of this judgment: (1) Is it more probable than not that S was sexually assaulted by a member of her immediate family? (2) Is it more probable than not that she died as a result of a culpable act by a member of her immediate family? (3) Is it more probable than not that the members of her immediate family decided to conceal the circumstances of her death so as to avoid findings of culpability and in so doing exposed other children to the risk of significant harm? At the end of the day, those are the questions requiring an answer, however fully or otherwise they may serve to explain the tragic death of S.

174. I fully recognise the strength of the case advanced by the Local Authority for that for which they contend and against the alternative explanations that have been advanced. Their case is based on the expert medical evidence and what they contend to be the lack of coherence and integrity in the evidence of the family. At the same time, I remind myself of the wise basis of the expert evidence; that their evidence assists in finding a solution, not in providing one.

175. I recognise too the strength of the case advanced by the family as to the unlikelihood of what is contended for by the Local Authority. That lies not only in the background of this family but in the events of the 12 hours preceding S being pronounced dead. Likewise, I recognise the force of the case as to the failure to exclude other possibilities like a third-party intruder.

176. However, likelihood or unlikelihood has to be assessed in the context of the facts of a particular case. Here the plain facts as I have found them establish that a girl in her own home has died as a result of the compression injury to the neck caused by decorative netting around her bed and at the time of her death had recently sustained a genital injury within but not outside the genital area. Those facts inevitably condition concepts of likelihood and unlikelihood. Of that I firmly remind myself.

177. In the end, counsel for the family advanced as their primary submission on the actual questions that I must answer that the court is simply unable to say what has happened beyond concluding that the Local Authority have not proved their case. They rely on words of mine cited earlier in this judgment and subsequently approved by the Court of Appeal in a different case.

178. However, such a conclusion represents not a forensic failure but merely a recognition of the way the world is. Against that must be put the words of Baroness Hale, also earlier cited, that judges should generally be able to make up their mind without recourse to the burden of proof.

179. I further acknowledge that I have ruled out suicide or malfeasance by T and have recognised the unlikelihood of the intervention that night of a third-party intruder. I also remind myself of the dangers of finding a positive based on the elimination of known alternatives.

180. One matter that has greatly exercised me in the course of this trial is whether one member of the family, unknown to the others, assaulted and no doubt unintentionally killed S and has concealed that wrongdoing from all others. In so small house with so many present that is inherently unlikely, an unlikelihood deepened by the fact that such a ghastly secret has been effectively concealed ever since.

181. In the end, but not without careful thought, I have rejected this possibility. If this was assault and homicide by a family member, it is inconceivable that the parents and probably the older boys did not and do not know of it.

182. If ever there was a case in which the court had to retain the big picture, both for the controversial and the uncontroversial evidence, this was it. Much of my time over the last four weeks in preparing this judgment has been spent not in writing or organising but in careful reflection on that big picture. In the end, I have come to a conclusion that the Local Authority has failed to prove its case to the requisite standard. In reaching that position, I also have to recognise that I have no clear answer to give as to how S died, since, and this is really common ground, none of the canvassed alternative suggestions could be clearly established.

183. I think I can summarise my effective reasons for this conclusion as follows. First, whilst recognising that sexual assault and homicide remain at the top of the differential diagnosis list so far as the medical experts are concerned, their evidence did not, and all accepted this, in fact prove that that is what has happened. Secondly, this family were a rarity in Part IV proceedings in that not only was there no hint of any risk factors associated with sexual assault or violence within the family, but also there was a plethora of independent evidence which demonstrated that this was a high-functioning, effective, coherent and loving family. That does not prove that they did not do it, but it is very important evidence in the big picture, especially where what is alleged involves deliberation rather than a transient loss of self-control.

184. My finding, that whilst I would approach the evidence of the family with caution, I could not conclude that there is established a conspiracy of silence, is highly material in the big picture. It sits in conformity both with the initial police picture that led them to conclude that this was a tragic accident and their subsequent view that they could not establish a credible suspect.

185. Fourthly, in these circumstances, the court is led to the conclusion that despite the expert evidence, sexual assault and murder by a family member simply cannot be established to the requisite standard. The big picture simply does not yield the support that would require to be established as proof in this case.

186. I recognise that a conclusion that the court cannot explain S's death is not one that I view with any pleasure. I can of course take comfort from the fact that that very experienced forensic pathologist, Dr Cary, has found himself in that position not infrequently. As I have repeatedly said, however, my task is not to explain S's death but to consider whether in law the Local Authority are entitled to interfere in the private life of this family.

187. Since this is at least the second time that I have concluded after a long forensic enquiry that I do not know what has happened, I need to ask myself one hard question: is this simply a failure of judicial nerve to make a finding against a family such as this, the finding which is nevertheless required by the evidence as a whole? I ask that question not just because it occurred to me but also because I recognise that decisions in cases like this are not driven exclusively by the process of reasoning.

188. There is an element in human judgment that lies beyond cold rationality as every experienced trial judge soon comes to appreciate. In order to test that, I have reflected carefully upon the position as it would be were I to have found that the Local Authority had indeed established their case and this child had been sexually assaulted and killed by one or more members of a family who had then conspired to conceal the truth from all legitimate enquiry. I discovered that such a conclusion would be an affront to my judicial conscience.

189. It follows that I find that the Local Authority have not established the threshold criteria as required in Part IV of the Act. The only consequence of that can be, and will here be ordered to be, a dismissal of these proceedings.

Epilogue

190. I cannot part with this case without one or two further comments. I wish to record my appreciation for the unfailing assistance and cooperation that I have received from counsel, both in the conduct of the case generally and in the conduct of the virtual trial in particular. As I noted earlier, to do such a case as this in a virtual court is really only possible if everyone involved, including the lay parties, is both ready and willing to be cooperative.

191. In those circumstances, I would want to caution against drawing any general principles about whether to conduct a complex trial in a virtual court from this judgment.

192. This has been an extraordinary case both because of its subject matter and because of its litigation history. Of course, the greatest burden has been born by the parents and the family and I wish specifically to acknowledge that. It has also taken its toll on the witnesses, even those whose profession might be thought to have hardened them against such things. I think that at every point at which I received a surprising answer or response from a witness, this was the key to it. It has also taken its toll of the legal teams, which deepens my appreciation of the assistance I have received. This was in many ways a unique case and one that is unlikely to be repeated.

193. I want to conclude this judgment by observing that at the heart of this case (and I have tried never to lose sight of this) is a young life tragically cut short. S had much to look forward to. My abiding regret is my inability to say exactly how and why she met her sadly premature end.

End of Judgment

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This transcript has been approved by the judge.