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IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/06/2022

Before :

MRS JUSTICE LIEVEN

- -

Between :

A LOCAL AUTHORITY

Applicant

and

AA

First Respondent

and

BB

Second Respondent

and

Y and Z
(Children represented by their Children's Guardian)

Third and Fourth Respondents

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Mr Andrew Norton QC and Ms Judy Claxton (instructed by **a local authority**) for the **Applicant**
Leslie Samuels QC and Ms Helen Compton (instructed by **Sills and Betteridge**) for the **First Respondent**
Brendan Roche QC and Ms Hari Kaur (instructed by **Ringrose Law**) for the **Second Respondent**
Ms Rachel Langdale QC and Ms Lubeya Ramadhan (instructed by **Care Solicitors**) for the **Third and Fourth Respondents**
Hearing dates: **5 – 13 May 2022**

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Approved Judgment

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MRS JUSTICE LIEVEN

This judgment is being handed down in private on 15 June 2022. It consists of 175 paragraphs. The judge does not give leave for it to be reported until it has been anonymised by counsel and approved by the judge.

Mrs Justice Lieven DBE :

1. This case concerns care proceedings in relation to two children, Y aged 4 and Z aged 22 months. At the heart of the case also lies X who died in 2016 aged 8 months. The parents are BB ('the Father') and AA ('the Mother').

2. The local authority ('the LA') was represented by Andrew Norton QC and Judy Claxton, the Mother was represented by Leslie Samuels QC and Helen Compton, the Father was represented by Brendan Roche QC and Hari Kaur, and the Guardian was represented by Rachel Langdale QC and Lubeya Ramadhan.

The issues

3. This is a judgment at the end of an 8 day fact finding hearing. The central findings that the LA seek are:

    a. The Father deliberately inflicted injury, namely intentional suffocation, on X, Y and Z. In the case of X, this led to her death;

    b. The Father induced allergic reactions in the Mother;

    c. The Father exaggerated and fabricated his own medical symptoms;

    d. The Father engaged in domestic abuse of the Mother, including both physical and sexual assault, and coercive control;

    e. The children suffered emotional harm as a result of the abuse;

    f. The Mother has failed to protect the children from the impact of domestic abuse;

    g. The Mother has failed to protect the children by failing to alert professionals to the risks that the Father posed;

    h. The Mother has exaggerated the Father's medical symptoms

The Facts

4. The parents started a relationship when the Father was 17 and the Mother was 15. I will set out the chronology in respect of the children, and then make separate reference to the presentation of the parents.

5. X was born in 2015 at 41 weeks. Her new-born checks were all normal.

6. On 28 December 2015, when X was 5 weeks old, the Father called the ambulance service reporting that X had stopped breathing. When the paramedics arrived, the Father said that she had vomited and then stopped breathing for 30-60 seconds. She had had no symptoms of illness before. On admission, examination and tests were all normal. She was observed in hospital for 48 hours and all the relevant tests were again normal.

7. Dr Samuels (Consultant Respiratory Paediatrician) said the most normal explanation for an event such as this in a 5 week old would be a viral respiratory infection. However, there were no signs of infection and no repeat of the episode during the admission. X did not subsequently develop any neuro development disorder or any other disorder which would account for the episode.

8. On 30 December the Father called the ambulance service saying X had been vomiting and she was taken back to hospital. Again, relevant tests revealed no cause.

9. On 10 January 2016 the Father called the ambulance service saying that X (by then 7 weeks) had stopped breathing. He told the paramedics that she had been lying on the carpet, she went glazed and limp, and he did chest compressions on her about 30 times. The paramedics found her lying on the floor, pale and looking glazed and limp. She recovered on the way to hospital. She was admitted for observations and all tests were normal. Dr Samuels said choking or aspiration were possible explanations, but there were no subsequent consequences such as a secondary chest infection which might support such an explanation.

10. On 19 March X attended A&E as she had hit her head. All observations were normal.

11. On 20 March the Father called the ambulance service to report X (4 months) had been choking and stopped breathing, she went floppy and blue. Some of the clinical findings are illegible, but all observations were normal. She underwent a cranial ultrasound and chest x ray, both were normal. She was discharged on 21 March.

12. In mid 2016 X died. The Father found her in cardiac arrest and called an ambulance. The parents reported that they had put her to bed at 23.00. X had been using an apnoea alarm, but on the night that she died the batteries had gone flat so it was not working.

13. The Father says he woke up in the night to go to the toilet, checked on X and found her not responsive. When the paramedics arrived, the Father was performing CPR. She was taken to hospital where she was declared dead. All the normal investigations after a sudden infant death were completed and were normal. There were no indicators of current infection.

14. A post-mortem was carried out and no cause for her death was found. The death was considered a Sudden Unexplained Infant Death and that was the finding of the Coroner.

15. In 2018 Y was born at 39 weeks. All his new-born checks were normal and his subsequent growth was normal. In the early months he was seen regularly by the health visitor and there were no concerns reported. In June he had an infected toe and was prescribed antibiotics. In mid-October he had a cold and cough. On 17 November he was taken to the GP with a rash, cold and cough. He was then seen four times in the next 2 weeks with a runny nose and vomiting, eczema, and then blisters on his forehead.

16. On 18 December 2018 the Father called the ambulance service to say Y (6 months) was constantly being sick. He then called again a few minutes later to say Y could not stop vomiting and was not really responsive. Examinations at hospital were normal and he was discharged.

17. Over the following 15 months Y was frequently taken to the GP with coughs, vomiting, rashes and eczema. There was an incident in January 2020 when he scalded his arm on hot coffee and was given antibiotics.

18. On 30 March 2020 the Father called 111 to say Y had fallen and hit his head on a cupboard. Y was taken to A&E and was discharged with reassurance.

19. On the following day the Father called the ambulance service and said that Y had gone limp and floppy and had briefly lost consciousness. The account given by the Father was that he and Y were in the garden when the incident occurred, and the Mother was in the kitchen and did not see what happened. When he got to hospital Y was seen to be alert and playful and normal. An ECG was normal and he was discharged home.

20. It is difficult to know what to make of this episode. There was no medical cause found despite extensive investigations. Y was 2 years old, so if the Father did in some way induce the episode it would have been physically much more difficult to do so than with a younger child, further one might expect Y to have become scared or at least wary of his Father, and there is no evidence that happened. I do not think it is possible to reach any conclusions on this episode, and I have discounted it for the purposes of my ultimate findings.

21. On 3 August 2020 the Father called the ambulance service to report Y had fallen and had a cut on his leg. 40 minutes later he called again to say Y had also banged his head and was now drifting in and out of consciousness. Again, all subsequent investigations were normal.

22. In 2020 Z was born at 39 weeks, weighing 3.28kg. His new-born checks were all normal. He was seen at the GP surgery on 7 September with a rattly chest and white tongue.

23. In the period between 11 and 23 September there were seven emergency calls from the parents' home in 12 days. On 19 September the Father called the ambulance service reporting that Z (5 weeks) appeared to have choked on milk, gone blue and vomited, and had fitted with body jerks for about 30 seconds. On arrival at hospital the observations were normal.

24. On 21 September the Father called the ambulance service to report that Z was blue, blotchy and not really responding. The Father said Z had been in the living room. When he arrived at hospital he was pale in colour but had good breathing and circulation. The ambulance crew who attended noted the parents' lack of emotional response to the fact that Z had apparently required an emergency call out.

25. On 23 September the parents called the ambulance service at 21.54 reporting that Z was not breathing and the Father was doing CPR. The Father had been in the bedroom with Z whilst the Mother was in a room opposite. The Father said Z had been not breathing for about 1.5 minutes.

26. When Z presented at A&E he was seen by Dr G. On arrival he was crying but in no respiratory distress and had normal circulation but with cold hands and feet. A blood gas test was undertaken with a pH of 7.25 and the lactate reading was 8.5 (normal is 2.5). The heightened lactate levels are a result of inadequate oxygen being carried to

the body's tissues. This is a consequence either of inadequate circulation, possibly as a consequence of an infection, or a respiratory issue. Dr Samuels (expert Respiratory Consultant) said this was a life threatening event ('ALTE').

27. Dr S, who was the treating Respiratory Paediatrician, saw no signs of infection. However, Z received intravenous fluid and antibiotics as a precautionary measure. The lactate levels resolved within a few hours and he had an MRI head scan, CT head scan, EEG and full ophthalmology review, all of which were normal.

28. Dr G initiated a safeguarding referral. The parents were interviewed by the police on 28 September. Z remained in hospital until 2 October.

29. An Interim Care Order ('ICO') was made on 2 October and both children were placed with the maternal great grandmother ('MGGM').

30. Z was seen by the health visitor on 8 October. He was feeding well. Since that date Z has had regular medical reviews by health visitors and by various consultants, and no concerns have been raised. There have been no subsequent calls to emergency services, and no critical medical incidents in respect of either child. Z was fitted with an apnoea monitor which has quite frequently alarmed. All the relevant clinicians, and both Dr Robinson and Dr Samuels have considered that this is a function of the monitor and the way small children breathe rather than indicating any health problem.

31. The children have remained with MGGM since the making of the ICO. They have had no significant health incidents since that time. Both parents have had supervised contact with the children, the Mother at MGGM's home and the Father at a contact centre. All the records of contact have been positive and there is no issue about the parents' appropriateness and indeed love for the children since the making of the ICO.

32. In February and April 2021, the Mother took videos of the Father having seizures, and I have watched one of those videos. On 7 April 2021 there was an incident when the Father called an ambulance and reported that he had lost consciousness for 1-2 minutes. He later told the family worker that he had lost consciousness for 40 minutes. The Mother said in oral evidence that he had lost consciousness for 10 to 15 minutes.

33. On 9 March 2022 the Mother and Father separated. On 10 March the Mother told the social worker, Mr P, that the Father had been abusive to her over many years. On 16 March the Mother gave a statement to the police setting out this abuse, which she alleges included serious physical violence, an incident when the Father forced her to continue with sexual intercourse against her will, and more generalised coercive control. On 18 March the Father called the Mother at 2am and the Mother recorded the conversation. I have listened to that recording. The Father is both angry and upset on the call and is highly abusive to the Mother, including a great deal of swearing at her. If it were not for the background to this case, I would not consider the contents of the recording particularly surprising in the context of the apparently unexpected breakdown of a long relationship. However, it is noteworthy that the Father is very unpleasant and demeaning to the Mother, including calling her a "retard", which supports her case that he undermined her confidence and made her feel that no-one else would want to have a relationship with her.

34. On 23 March the Mother applied ex parte for a non-molestation order and the order was made; on the return date the Father made no admissions but did not oppose the making of the order.

The parents' medical histories

35. The Father was diagnosed with epilepsy at the age of 7 or 8. There was a history of him being presented very frequently for medical attention by his mother. The notes are clear that his mother found it very hard to manage his behaviour and frequently sought medical advice and medication to deal with his behaviour. Mr Norton casts doubt upon the accuracy of that original diagnosis and I will return to that matter below when considering the evidence of Dr Yogarajah. There is no independent record of either the school or any clinician observing these episodes. However, that may be a coincidence of timing, or it may be that some of the records have been lost.

36. The Father ceased having seizures for a period between about the age of about 11 until after X died. However, even in these earlier periods there are records of the Father calling an ambulance for severe headaches and attending A&E for chest pains. After X died there starts to be a pattern of very frequent calls to the ambulance service and trips to A&E for a variety of symptoms. I will not record all of these, but they are set out in the CLINCO health chronology.

37. In the course of these proceedings CLINCO carried out a review of the Father's medical records. They found 117 attendances at A&E from birth to May 2021. There is clear evidence, and this is not disputed by Mr Roche, of the Father exaggerating his symptoms. There was a period when clinicians thought that the Father was exaggerating pain symptoms in order to obtain pain medication. However, there is no suggestion of addiction to painkillers.

38. The Mother was diagnosed with serious allergies to a range of items, including nuts, at an early age. She was prescribed an EpiPen. Until she met the Father, her medical records and her own memory is that she had these allergic reactions under control. Between 6 January 2016 and 11 September 2021 there are records of 19 occasions when the Mother sought medical attention, including numerous ambulance call outs and attendance at A&E for severe allergic reactions.

39. There is no dispute that the Mother suffers from severe allergies. She said that she had believed that her allergic reactions got worse after she gave birth because of hormonal changes. However, it is of note that the allergic incidents continued long after the Mother had given birth.

The Evidence

Treating clinicians and paramedics

Dr G

40. Dr G was the treating Consultant Paediatrician when Z was presented at hospital on 23 September 2020. He raised safeguarding concerns about Z's presentation. On arrival Z presented in respiratory distress with cold around the edges, a high heart rate and blood gas readings that indicated some cells had not received adequate oxygen. He raised the

safeguarding concerns because of the rapid resolution of Z's condition with relatively limited interventions, namely the intravenous fluids and antibiotics, the fact that a previous baby had died, and the paramedics' concerns.

41. He accepted that antibiotics could lead to a rapid improvement where there was an infection. However, in the wider context it was unlikely that the cause of Z's condition was infection given the lack of a temperature and the rapid improvement once he got to hospital.

42. I heard oral evidence from a number of the paramedics and ambulance crew who attended at the parents' home at various incidents. Although some of them referred to the parents reacting in a somewhat odd manner, in my view none of their evidence took the forensic inquiry any further forward. Their recollection of events was unsurprisingly, given the passage of time, limited, and none of their observations carried any particular weight for the determinations I have to make. Although it was the paramedics who first raised safeguarding concerns over Z's incident on 23 September 2020, it is not now their concerns and recollections which form the basis of the LA's case. I therefore do not record their evidence further.

Expert Evidence

43. A number of experts were instructed in this matter, they each reported in writing and attended an experts meeting. None of the experts suggested any likely cause for X's death and the incident concerning Z on 23 September 2020 other than intentional suffocation. I only set out below the evidence of the experts who were called to give evidence.

Dr Samuels – Respiratory Paediatrician

44. Dr Martin Samuels is a Consultant Respiratory Paediatrician at Royal Stoke University Hospital and Great Ormond Street Hospital. He has 30 years experience in paediatrics and has a particular interest in sudden infant and child death in the context of problems around breathing. He has given evidence in a large number of legal cases.

45. In his written report Dr Samuels reviewed the medical records concerning all the serious incidents involving each of the three children, in order to consider their most likely causation. In considering causation he made clear that it was necessary to analyse each individual incident, but then take an overview of the various incidents together.

46. Dr Samuels concluded that the most likely cause of X's death was intentional suffocation. He also thought that intentional suffocation was the most likely explanation for the incidents concerning Z in September 2020. He maintained this view in the expert meeting and in his oral evidence.

47. He pointed to a number of factors in respect of X. There was no evidence of her suffering from an infection when she died. Although it is possible for an infant to have an infection which does not appear in laboratory tests and shows no physical manifestation, it is unusual.

48. X had suffered from three ALTEs. Dr Samuels said he had cases where a child had a series of ALTEs, that being his particular specialism, but even for him it was extremely

unusual to have a child who had two siblings who had also had such events. He said the likelihood was that there was one mechanism to account for all the events before X's death.

49. There was a progression in the severity of the incidents, both with X and Z. In cases of intentional suffocation, it was more common that there was an increase in severity, whereas that might not be the case where there were seizures, breath holding or heart arrythmia disorders.

50. He also pointed to the fact that the Father had been present at the detection/onset of all the incidents.

51. In relation to the incident with Y on 31 March 2020, he described it as an "odd" episode that could be fabricated or induced but it was not possible to be confident about this incident in isolation.

52. On the incident on 19 September 2020 to Z, Dr Samuels had looked for alternative causes, but again reached the conclusion that intentional suffocation was the most likely cause. Choking was suggested as a cause, but the Father had said that Z was shaking, which was not consistent with a choking incident.

53. Dr Samuels pointed to the fact that on the third episode on 23 September Z was found to have significantly raised blood sugar and a heart rate of 182, both of which indicate stress. The low oxygen levels found indicate inadequate breathing. Again, there was no evidence of an infection, and Z's oxygen levels in his blood had resolved much faster than would have been expected with an infection.

54. Drawing all the evidence together from the various events, the most likely cause was imposed upper airway obstruction.

Dr Yogarajah

55. Dr Mahinda Yogarajah is a Consultant Neurologist and Epileptologist at University College Hospital. A significant part of his work is seeing patients with epilepsy and seizures, and he sees in the region of 1000 patients a year. He has a subspecialist interest in epilepsy and functional seizures.

56. His view was that the Father suffers from functional seizures. This means that the seizures are genuine, i.e. the account is not fabricated, but they are not caused by any electrical malfunction or "storm" in the brain. Functional seizures are a form of somatic disorder.

57. The Father probably has underlying epilepsy which is in remission. His EEG shows abnormalities which are consistent with underlying epilepsy, such as an epilepsy syndrome that arose in childhood. Dr Yogarajah accepted that the medical evidence of the Father having epilepsy was open to some doubt as the test results did not definitively support the diagnosis, and the reason for him being placed on medication was not entirely clear.

58. However, he remained of the view that the Father probably did have underlying epilepsy. Dr Yogarajah said that he did not think the Father had fabricated his reports of seizures because the descriptions he gave would be hard to fabricate, for example of

dizziness and disassociation. The Father had also provided videos of his seizures, which would be less likely to be the case if they were fabricated.

59. Dr Yogarajah said that there was a continuum between functional seizures, exaggeration of symptoms and the feigning of seizures, rather than there being a binary choice between fabricated and functional seizures.

60. He said that he did not generally question a patient's account of their illness but took it at face value. This was partly simply good clinical practice but was also because no clinician in his position would have the time to test the accuracy of the patient's narrative.

Dr Walsh

61. Dr Walsh is a Consultant Cardiologist at Our Lady's Children's Hospital Dublin and The Mater Misericordiae Hospital Dublin. In relation to X he said that at post-mortem her heart was structurally sound. There was no evidence of any cardiomyopathy. In those circumstances her death was much more likely to be caused by SIDS or inflicted injury than by an electrical genetically inherited cardiac disorder.

62. Dr Saggar (the expert geneticist) had set out that Z had an inherited genetic variant which is associated with cardiomyopathy which X may also have inherited. Dr Walsh's view was that this was very unlikely to be contributory factor towards the death.

63. Z had been subject to an electrocardiogram which had indicated no cardiac arrhythmia. Dr Walsh's view was that it was again very unlikely that he was suffering from an inherited arrhythmia given the severity of his presentations and the fact he had had an ECG on each occasion, but no arrhythmia was found. Further, the fact that Z has suffered no incidents since he was removed from the parents' care points strongly against arrhythmia, it being a condition that it is virtually impossible for a child to grow out of.

Dr Robinson

64. Dr Robinson is a Consultant Paediatrician at Queen's University Hospital Romford. He specialises in cases of alleged Fabricated and Induced Illness ('FII'). He has published academic papers on FII and is a very experienced witness.

65. Dr Robinson carried out a detailed analysis of the medical histories of all the members of the family. He said that in FII cases the detailed medical chronology was critical. In his first report he advised that further investigations should be undertaken in order to exclude alternative possible diagnoses. All such further investigations have now been carried out.

66. His conclusion in his second report is that in respect of both Z and X the evidence suggested that there was upper airways obstruction, in other words suffocation.

67. In respect of Z, he pointed to three ALTEs in the space of seven days. He said that even if the first two were found to be exaggerated by the Father and therefore not genuine ALTEs, he would retain his conclusion simply on the basis of the third event. This was because of the heightened blood gas levels showing that there undoubtedly had been an ALTE, and which clearly indicated upper airways obstruction.

68. In respect of X, Dr Robinson pointed to the four incidents prior to her death, and said that episodes 2, 3 and 4 (31 December 2015, 10 January and 20 March 2016) had no explanation other than FII.

69. Mr Roche cross examined Dr Robinson, in part on the basis that some of the reports could be a product of the Father either exaggerating or misinterpreting the symptoms or fabricating them as a consequence of his anxiety. Dr Robinson accepted that this might be the case for some of the episodes, but for the incident concerning Z on 23 September 2020 there was clear clinical evidence in the blood gas results. Dr Robinson agreed with Dr Samuels that it was unlikely that the cause was an infection given Z's very rapid recovery.

70. I asked that Dr Robinson draw up a short addendum report addressing the ten key indicators of FII, which are set out in the Royal College of Paediatrics 2009 and 2013 Guidance. I find this is a useful framework in which to consider Dr Robinson's conclusions. I note that not all of the indicators are relevant in this case.

71. Indicator one is *"A carer reporting symptoms/signs not explained by any medical condition".* Dr Robinson pointed to the three occasions within five days when Z was presented between 19-23 September 2020, where for episodes 1 and 2 there were no abnormal signs on clinical examination.

72. X was presented for care from the age of 37 days to four months on three occasions with reported cessations of breathing. She then died at age of 8 months. The reported symptoms for these incidents have not been explained by any medical condition.

73. Indicator two is that *"Examination/investigations that do not explain the reported symptoms/signs".* Despite full investigations, in neither child has an explanation, other than suffocation, been found. I note at this point that Dr Robinson necessarily defers to the particular specialists, such as Dr Samuels, as to the results of investigations.

74. Indicator four is *"Acute symptoms are only observed by the carer".* Both Z and X were presented for care by the Father with symptoms that on a number of occasions were only observed by him. Dr Robinson also pointed to the fact that once Z was removed from the parents' care he ceased having these symptoms. Although his apnoea alarm went off on a number of occasions, this was considered to be a result of the monitor and not the indicator of any physical problem.

75. Indicator five is *"On resolution of a problem the carer reports new symptoms".* The relevance of this indicator appears to be the evidence that supports intentional suffocation of both children and the very frequent re-presentation of the children.

76. Indicator seven is *"Objective evidence of fabrication".* This case is somewhat complicated because it may be that there is a combination of fabricated illness and induced illness. Dr Robinson said that there was objective evidence of illness induction for both children.

77. Dr Robinson placed considerable weight on the fact that once Z was removed from the parents, he had no further episodes. This is a very clear indicator of FII.

Dr Fear

78. Dr Fear is a consultant psychiatrist and a member of the expert reference group on FII. He had interviewed the Father and produced a detailed report. His view was that the Father suffers from a somatoform disorder, in other words he has genuine physical symptoms, but they have no physical or metabolic cause and must be psychologically induced. This accords with Dr Yogarajah's view that the Father suffers from functional seizures.

79. In many cases where FII is found, the "perpetrator" has a somatoform disorder. In a paper published by Dr Christopher Bass, the figure given is around 60%. However, a somatoform disorder is relatively common in the population as a whole, whereas FII is very rare. Therefore, it is critical to start with the consideration of whether the evidence supports a finding of FII, and not to use the existence of somatoform disorder as the determinative or even major factor.

80. He said the fact that the Father's mother took him to the doctor very frequently as a child may be relevant to the diagnosis.

81. Dr Fear accepted that it is difficult for a clinician to distinguish between a somatoform and feigned disorder, and clinicians are encouraged to believe the patient. If the symptoms don't "fit" then a conclusion might be reached that the condition is feigned. He also accepted that there is not necessarily a clear line between a factitious or feigned disorder and a somatoform disorder. A patient might have elements of both. This must be the case around the exaggeration of symptoms, which might be a combination of a genuine (but wrong) belief in the illness, and a deliberate exaggeration (perhaps to get medical attention).

82. With the Father Dr Fear pointed to the fact that often there was a trigger event which then led to the Father reporting various symptoms. One example was that his father had had angina and shortly thereafter the Father had started to report chest pains. He said that he could find no evidence in the records of illness that that was feigned, though there was evidence of clear exaggeration. He cited the example of the Father telling clinicians that he had not been able to pass urine for 12 hours, whereas the scan showed a nearly empty bladder. This would only be possible if the patient was severely dehydrated, and there was no evidence this was the case with the Father. Dr Fear thought there was evidence of the Father exaggerating symptoms in order to get medical attention.

Mr P – the social worker

83. Mr P has been the allocated social worker throughout this case. He has been a social worker for 30 years and struck me as being a highly professional, thoughtful and empathetic person. He has met the parents on numerous occasions and went to their house twice before they separated. He has seen them both together and apart.

84. He said that in all his interactions with them before March 2022 he had never had any suspicion that there was domestic abuse in the relationship.

The Parents

The Mother

85. I found the Mother an exceptionally difficult witness to reach conclusions about. She gave her evidence very calmly and relatively unemotionally, save for a couple of moments when she became upset around questions about X. She had a very poor recall of events around the children's call outs to emergency services, with her virtually saying she had no memory of the individual events. She said that she had a very poor memory for dates. However, when it came to questions about the Father's two alleged infidelities, she had a very detailed recall. She suggested, when I asked her about this, that she was so upset about what had happened to X that she had blanked it from her mind. However, she did not appear in the witness box to be very upset.

86. She said that she had not really thought about the enormous number of call outs to emergency services and visits to hospital, both for herself, the Father, and the children, because she had become normalised to the situation. This is very surprising given that she had not had frequent severe allergic reactions before she met the Father, and the number of call outs was highly unusual. I found it very surprising that she was not more concerned about the call outs for Y and Z given that X had died, apparently from SIDS.

87. She presented in the witness box as being highly passive and completely uncurious or questioning about what had been happening to the children at the time. She suggested that she never doubted the Father's descriptions of X and Z's frequent very serious episodes, either in terms of his account of them or the causes.

88. Although she suggested in the witness box that she was deeply traumatised by X's death, her subsequent response to Z's three serious episodes in September 2020 stands in contrast to that. On 21 September 2020, when the Father called her downstairs because Z was said not to be responding, she came downstairs still drying her hair with the hairdryer. In circumstances where the first baby had died, and Z had been taken to hospital in an ambulance two days earlier, her response on 21 September is beyond "odd".

89. In her two statements after 8 March 2022, she set out detailed allegations in respect of domestic abuse by the Father. She has exhibited to those statements photographs that show an injury to her eye (a cut and a bruised eye) and bruising on her leg. She says that the abuse started when she was pregnant with X and has regularly occurred during arguments since then. She says there was one occasion when the Father pulled the door shut in anger and knocked her unconscious. Shortly after X's funeral, the Father twisted her thumb and tore a tendon. She went to hospital but lied about the cause both to the hospital and her family.

90. On 6 September 2019 she alleges she was holding Y when the Father hit her, she went to hospital and said she had tripped over a toy. She took a photograph of the injury. She refers to a number of occasions when the Father tried to strangle and put his hands over her mouth, and once put a pillow over her face. She says that she did once tell his mother, and his mother had said that he had a "wire" loose. She says it was a consistent feature that he would lie about something until absolutely forced to accept the truth, which is why she took the photographs of the syringe and the chocolate.

91. She said he would also be verbally abusive and demeaning to her, telling her that she was stupid and unattractive and would not find another partner.

92. She also describes in some detail an occasion when they were having sex and she asked the Father to stop, and he refused. She said she was screaming at him to stop but he paid no attention.

93. She says that she did not speak about the abuse earlier because she is a very private person and she likes to keep things in, and to herself. In her statement she says he had undermined her self-confidence and felt she deserved what he was doing. He would apologise and say he would change. When asked why she did not tell her mother or grandmother, she again said she was very private, and she did not want them asking lots of questions.

94. She could not give any very coherent answer as to why she had suddenly decided in early March 2022 to tell the social worker and then the police about the abuse. She just said she had got to a point where she decided to speak about it after an argument with the Father. However, there was no suggestion this was a particularly serious argument.

95. She says that in September 2021, when she was searching for the Father's glasses case, she found a syringe full of blood in his glasses case. She challenged the Father about it, showing him the photo that she had taken of it, and he said he knew nothing about it.

96. She then searched on top of the kitchen cupboards, which she could not reach without climbing on a chair, and she found two chocolate bars (a snickers and a bounty) which had been chopped into small slices with a sharp knife and she took a photo. She produced the photo of this, with clear signs that the bars had been cut with the knife. She said she found this "suspicious" but could not explain what she was suspicious of. She raised this with the Father, but when he simply denied knowing anything about it, she took no further action.

The Father

97. The Father was wholly unemotional and very deadpan giving his evidence. I reached the conclusion that he was consistently untruthful, and only accepting various matters when the documentation gave him absolutely no alternative but to do so.

98. He denied that he had ever caused harm to any of the children. He denied all the allegations of domestic abuse. He denied that he had intentionally exaggerated or fabricated any of the symptoms that he had described in respect of both himself and the children. He denied deliberately inducing allergic reactions in the Mother. I will take the various matters in chronological order.

99. He absolutely denied exaggerating his symptoms. The record of the contact supervisor Ms Q states that he told her that he had not attended two sessions of contact because he had had a seizure and had been unconscious for 40 minutes. However, when the records were examined for that period, he had told the paramedic that he had been unconscious for about one minute. He said he had no memory of telling the contact supervisor it was 40 minutes, but her statement is clear and she has no reason to lie and necessarily knows the importance of accuracy. I have no doubt that he very significantly exaggerated, beyond all scale of possible innocent exaggeration, the severity of whatever occurred.

100. There was an incident in March 2019 when he attended at hospital with a suspected fractured hand. He told the hospital that he had injured his hand on a car bonnet. However, in his statement and oral evidence he said that he injured his hand by hitting it on the kitchen hob, and he said he had subsequently made an insurance claim for the hob. The Mother said this was an incident when he had been arguing with her and tried to hit her but actually hit his hand on the hob. I have no doubt the Mother's version is true. The reason for lying to the hospital was because he would inevitably have been asked why he hit his hand on the hob so hard he injured it, and the domestic abuse might have been revealed. He said in court that he did not remember telling the hospital about the car bonnet. But again, the record is clear. Notably, in oral evidence he accepted that he and the Mother were having an argument, having previously denied that they argued. He said this is the only occasion they shouted at each other, which is simply unbelievable. This is a good example of the way the Father's evidence came out. There was effectively irrefutable evidence that there had been an argument, but he then said this was only once.

101. He accepted that he had become angry with his mother over money in December 2021 and had smashed a bottle. But he said he had not lost his temper and the bottle breaking was an accident. However, he said he had not asked his mother to confirm this. He had no coherent explanation for why he had not asked her to confirm his story.

102. In respect of the syringe episode in September 2021, he accepted that the Mother had said she had found a syringe with blood in it in his glasses case and had shown him the photo. He said that he knew nothing about it and when he looked in the glasses case there was no syringe. He said he had ordered a first aid kit and when it arrived it was full of syringes which he said he put in the safe. His story was not believable. Firstly, he told the police he had bought the kit off eBay and he would check his eBay account. However, he told the court he had done so and could find no trace of the purchase, whether on eBay or Amazon. If he bought the kit on the internet, then he would be able to trace and prove the purchase. However, he did not do so and gave no explanation for why not. Secondly, there is no reason he would have put the syringes in the safe. Thirdly, he said he did not know where to dispose of the syringes, but the Mother regularly disposed of her EpiPens so it would have been easy to ask her how to dispose of them. Fourthly, he could give no explanation as to why the Mother would have planted the syringe in his glasses case. Fifthly, he claimed he did not really think or challenge her about the issue. This is extraordinary in the circumstances of the case.

103. His explanation in respect of the chocolate bar on top of the cupboard was equally unconvincing. He simply said he had no idea why it was there together with the kitchen knife which had plainly been used to cut it into pieces. He suggested again that the Mother might have sought to frame him but could give no reason why she should do this months before she left him. He suggested perhaps the Mother's cousin C put it there, but he did not raise this with the Police and he had not asked C even though he saw him only two weeks ago.

104. In closing, Mr Roche again reverted to the possibility of C having placed the chocolate bar there and having chopped it up. There is no evidence to support this thesis. I understand that sometimes in these cases, parties may advance possibilities for which there is no evidence, but which logically might have happened. However, even in the context of child care law, I think the courts should be slow to allow parties to advance theories for which they could have sought to obtain supporting evidence, but did not do

so. The Father did not try to obtain a witness statement from C even though he lives close to the Father and they saw each other so recently. In those circumstances I dismiss the suggestion that C was responsible for the chocolate bar.

105. In respect to the abusive phone call in March 2022, the Father told the police that he remembered the call but that it had been an appropriate discussion about dividing possessions, including photos and items of X. He denied being drunk. When asked about the phone call in court, after the Court had listened to the call, he initially denied having any recollection of it. He then said that he had been to the pub and was very drunk and that is why he did not remember it. But that was wholly inconsistent with what he had told the police. He said he had never been abusive to the Mother, but that is plainly not true in the light of the recording. Again, he now has to accept the one event, but claims it was a one-off when he was drunk.

106. In respect of each of the medical incidents concerning the three children, he claimed that his report to the emergency services and the doctors had been accurate. He denied any exaggeration in his accounts. He also denied having any responsibility for inducing any of their symptoms, and of doing anything which led to X's death. For most of the events, he had very limited recall. He recalled more of the events surrounding X's death and the third incident concerning Z.

The law

107. The law relevant to this case is not controversial, and the summary set out below is based on an agreed document from the parties. The approach the Court should take is set out in the judgments of Baker J (as he then was) in the cases of *Re JS* [2012] EWHC 1370 (Fam), *Re L and M* [2013] EWHC 1569 (Fam), repeated in *Re IB and EB* [2014] EWHC 369. First and second, he deals with the burden and standard of proof:

> *"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)."*

108. The parents do not have to prove that they are not responsible for any injuries, and they are not obliged to come up with alternative or accidental explanations for the injuries; *Lancashire v R* [2013] EWHC 3064 (Fam), paragraph 8. *In Re M (fact-finding hearing: burden of proof)* [2012] EWCA Civ 1580, the Court of Appeal warned against the dangers of inferring that because the parents had not given an explanation for an injury, the real explanation must be a sinister one.

109. The standard of proof does not shift according to the seriousness of the allegation, nor the inherent probability or improbability of an event occurring, see Baroness Hale in *Re B (Children)(Fc)* [2008] UKHL 35:

> *"70. My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold ... 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."*

110. And per Peter Jackson LJ in *BR (Proof of Facts)* [2015] EWFC 41:

> *"'(3) The court takes account of any inherent probability or improbability of an event having occurred as part of a natural process of reasoning. But the fact that an event is a very common one does not lower the standard of probability to which it must be proved. Nor does the fact that an event is very uncommon raise the standard of proof that must be satisfied before it can be said to have occurred.*
>
> *(4) Similarly, the frequency or infrequency with which an event generally occurs cannot divert attention from the question of whether it actually occurred. As Mr Rowley QC and Ms Bannon felicitously observe:*
>
> *"Improbable events occur all the time. Probability itself is a weak prognosticator of occurrence in any given case. Unlikely, even highly unlikely things, do happen. Somebody wins the lottery most weeks; children are struck by lightning. The individual probability of any given person enjoying or suffering either fate is extremely low."*
>
> *I agree. It is exceptionally unusual for a baby to sustain so many fractures, but this baby did. The inherent improbability of a devoted parent inflicting such widespread, serious injuries is high, but then so is the inherent improbability of this being the first example of an as yet undiscovered medical condition. Clearly, in this and every case, the answer is not to be found in the inherent probabilities but in the evidence, and it is when analysing the evidence that the court takes account of the probabilities.'"*

111. In *Re IB and EB* Baker J continues:

> *"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 (Serious 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." Later in the same judgment, Charles J added at paragraph 49, "In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non-accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof ... The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury or human agency and the clinical observations of the child, although consistent with non-accidental injury or human agency, are the type asserted is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that, on the balance of probability there has been a non-accidental injury or human agency as asserted and the threshold is established."

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).”

112. The need to be balanced in assessing oral evidence is discussed by King LJ at paragraphs 29 to 42 of Re A (A Child) [2020] EWCA Civ 1230, concluding at paragraph 40 as follows:

“I do not seek in any way to undermine the importance of oral evidence in family cases, or the long-held view that judges at first instance have a significant advantage over the judges on appeal in having seen and heard the witnesses give evidence and be subjected to cross-examination (Piglowska v Piglowski [1999] WL 477307, [1999] 2 FLR 763 at 784). As Baker J said in in Gloucestershire CC v RH and others at [42], it is essential that the judge forms a view as to the credibility of each of the witnesses, to which end oral evidence will be of great importance in enabling the court to discover what occurred, and in assessing the reliability of the witness.

The court must, however, be mindful of the fallibility of memory and the pressures of giving evidence. The relative significance of oral and contemporaneous evidence will vary from case to case. What is important, as was highlighted in Kogan, is that the court assesses all the evidence in a manner suited to the case before it and does not inappropriately elevate one kind of evidence over another.

In the present case, the mother was giving evidence about an incident which had lasted only a few seconds seven years before, in circumstances where her recollection was taking place in the aftermath of unimaginably traumatic events. Those features alone would highlight the need for this critical evidence to be assessed in its proper place, alongside contemporaneous documentary evidence, and any evidence upon which undoubted, or probable, reliance could be placed.”

113. Continuing with Baker J’s list:

“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).”*

Non-accidental injury

114. The term ‘non-accidental’ does not necessarily mean that an injury must have been deliberately or intentionally inflicted in order for there to be an element of wrong that satisfies the s.31 threshold criteria, see Ryder LJ in *S (A Child)* [2014] EWCA Civ 25:

> *“The term "non-accidental" injury may be a term of art used by clinicians as a shorthand and I make no criticism of its use but it is a "catch-all" for everything that is not an accident. It is also a tautology: the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from, say, negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy*

the significant harm, attributability and the objective standard of care elements of section 31(2)'"

Expert evidence

115. In *Re U (Serious Injury: Standard of Proof): Re B* [2004] 2 FLR 263 at paragraph 23. Butler-Sloss P said:

> *"'...there is a broad measure of agreement as to some of the considerations emphasised by the judgment in R v Cannings that are of direct application in care proceedings. We adopt the following...*
>
> *The cause of an injury or an episode that cannot be explained scientifically remains equivocal.*
>
> *Recurrence is not in itself probative.*
>
> *Caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.*
>
> *The court must always be on guard against the over-dogmatic expert, the expert whose reputation or amour propre is at stake, or the expert who has developed a scientific prejudice.'*
>
> *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 will throw light into corners that are at present dark.'"*

116. The Court is entitled to depart from the opinion of a medical expert, but must have a sound evidential basis upon which to do so; *M-W (A Child) (2010)* [2010] EWCA Civ 12 per Wall LJ:

> *"39. I regard the following as trite propositions of law:-*
>
> *Experts do not decide cases. Judges do. The expert's function is to advise the judge;*
>
> *The judge is fully entitled to accept or reject expert opinion;*
>
> *If the judge decides to reject an expert's advice, he or she; (a) must have a sound basis upon which to do so; and (b) must explain why the advice is being rejected.*
>
> *Similar considerations arise when a judge prefers one expert's evidence to that of another. Judges must explain why they prefer the evidence of A to that of B."*

117. In cases including *Re L (Care: Assessment: Fair Trial)* [2002] 2 FLR 730, and *Lancashire CC v R & W* [2013] EWHC 3064 (Fam), the Court is reminded to carry out a full and thorough examination of the environment in which the child was injured and a careful consideration of alternative causes, remembering that a Court cannot and

should not conclude, in the cases of a series of improbable causes, that the least improbable is nonetheless the cause of the event.

118. However, in determining whether an injury is non-accidental on the balance of probabilities, fanciful speculation and speculative theories are not an appropriate method of inquiry; *Re B (Threshold Criteria: Fabricated Illness)* [2004] 2 FLR 200:

> *"[24] It is undoubtedly true that the frontiers of medical science are constantly being pushed back and that the state of knowledge is increasing all the time. That is why, when presented with a speculative theory based on an unlikely hypothetical base, an expert will rarely discount it and will, in effect, never say never. Fanciful speculation is not an appropriate method of inquiry. What is needed and what the experts have endeavoured to achieve in this case is to piece together all the available information and look at the differential diagnosis. Some of the experts in this case specialise within a particular and very narrow field, and by reason of being experts of referral at centres of excellence, they acquire special knowledge and skill. However, concentration on a very narrow area of expertise can sometimes render it difficult for the expert to see the whole picture. It is for that reason that I find Dr S is best placed to view the overall picture. The judge has the duty of sifting the evidence from the experts, who form their assessments within their particular area of expertise, and the judge has to decide the case by reference to the identified issues. Although the medical evidence is of very great importance, it is not the only evidence in the case. Explanations given by carers and the credibility of those involved with the child concerned are of great significance. All the evidence, both medical and non-medical, has to be considered in assessing whether the pieces of the jigsaw form into a clear convincing picture of what happened.'"*

119. The medical evidence does not stand alone. The court is under a duty to evaluate the totality of the evidence – Butler-Sloss P, *Re T (Abuse: Standard of Proof)* [2004] 2 FLR 838 at paragraph 33 and Bracewell J, *Re B (Threshold Criteria: Fabricated Illness)* [2004] 2 FLR 200 at paragraph 24 (above).

Identification of a perpetrator

120. Where a Court is satisfied injuries are non-accidental, it should in the first instance identify a perpetrator of injuries if it can do so. If the Court is unable to do this then the Court will move to consider which of the adults with care of the child in the relevant timeframe should fall within a pool of possible perpetrators. Per Peter Jackson LJ in *B (A Child)* [2018] EWCA Civ 2127 at paragraph 21:

> *"In what Mr Geekie described as a simple binary case like the present one, the identification of one person as the perpetrator on the balance of probabilities carries the logical corollary that the second person must be excluded. However, the correct legal approach is to survey the evidence as a whole as it relates to each individual in order to arrive at a conclusion about whether the allegation has been made out in relation to one or other on a balance of probability. Evidentially, this will involve considering the individuals separately and together, and no doubt comparing the*

> *probabilities in respect of each of them. However, in the end the court must still ask itself the right question, which is not "who is the more likely?" but "does the evidence establish that this individual probably caused this injury?" In a case where there are more than two possible perpetrators, there are clear dangers in identifying an individual simply because they are the likeliest candidate, as this could lead to an identification on evidence that fell short of a probability. Although the danger does not arise in this form where there are only two possible perpetrators, the correct question is the same, if only to avoid the risk of an incorrect identification being made by a linear process of exclusion".*

121. Whilst the Court should not hesitate to make a finding identifying the perpetrator of an injury if the evidence is sufficient to support such a finding, the court is not obliged to make a finding identifying the perpetrator at all costs – Wall LJ, *Re D (Care Proceedings: Preliminary Hearings)* [2009] 2 FLR 668:

> *"[12] … Nothing in Re B, in our judgment, requires the court to identify an individual as the perpetrator of non-accidental injuries to a child, simply because the standard of proof for such an identification is the balance of probabilities. If such an identification is not possible – because, for example, a judge remains genuinely uncertain at the end of a fact finding hearing, and cannot find on the balance of probabilities that A rather than B caused the injuries to the child, but that neither A nor B can be excluded as a perpetrator - it is the duty of the judge to state that as his or her conclusion. To put the matter another way, judges should not, as a result of the decision in Re B, and the fact that it supersedes Re H, strain to identify the perpetrator of non-accidental injuries to children. If an individual perpetrator can be properly identified on the balance of probabilities, then for the reasons given in Re K it is the judge's duty to identify him or her. But the judge should not start from the premise that it will only be in an exceptional case that it will not be possible to make such an identification. There will inevitably be cases - of which this, in our judgment, is one – where the only conclusion which the court can properly reach is that one of the two parents – or both - must have inflicted the injuries, and that neither can be excluded."*

122. *Rhesa Shipping Co SA v Edmond and Another, the Popi M* [1985] 1 WLR 948 and *R v Henderson and Butler, and Others* [2010] EWCA Crim 26) reminds the Court that it 'must resist the temptation identified by the Court of Appeal in *R v Henderson and Others* [2010] EWCA Crim 1219 to believe that it is always possible to identify the cause of injury to the child.' (Per Baker J in *Re JS* [2012] EWHC 1370 (Fam), at paragraph 44.

123. If the court is not able to identify the perpetrator, on the balance of probabilities, then the court must consider who falls within the pool of possible perpetrators. The approach of the court should be to ask itself 'Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?', *North Yorkshire County Council v SA* [2003] EWCA Civ 839 at paragraph 26.

Discrepancies/Lies

124. The Court must remember a *Lucas* direction as regards any lie, or alleged lies, told by a witness; lies do not themselves indicate guilt. Other explanations for why an individual has lied should be considered.

125. Where a witness/party lies about a material issue, the court may consider what conclusions should be drawn from that; *A Council v LG and others* [2014] EWHC 1325 Keehan J at paragraph 64:

> *"I, of course, give myself a modified Lucas direction. In so far as the mother has been found to have lied about a material issue, I must ask myself whether there is any reasonable explanation for her untruthfulness or whether there is no such explanation and the only conclusion the court can draw is that she has lied because she is responsible for the injuries sustained by GS and/or LS or she otherwise knows the truth about how these injuries were sustained and has not revealed the same."*

126. More recently, in *Re H-C (Children)* [2016] EWCA Civ 136, McFarlane LJ considered the *Lucas* direction further, in particular that a lie of itself, must never be taken as proof of guilt. At paragraphs 97 to 100 he said:

> *"97. Within that list of factors, although the judge does not expressly prioritise them, the finding that Mr C lied about the quietness in his flat that night is given the greatest prominence in this section of the judge's analysis. A family court, in common with a criminal court, can rely upon a finding that a witness has lied as evidence in support of a primary positive allegation. The well-known authority is the case of R v Lucas (R) [1981] QB 720 in which the Court of Appeal Criminal Division, after stressing that people sometimes tell lies for reasons other than a belief that the lie is necessary to conceal guilt, held that four conditions must be satisfied before a defendant's lie could be seen as supporting the prosecution case as explained in the judgment of the court given by Lord Lane CJ:*
>
> *"To be capable of amounting to corroboration the lie told out of court must first of all be deliberate. Secondly it must relate to a material issue. Thirdly the motive for the lie must be a realisation of guilt and a fear of the truth. The jury should in appropriate cases be reminded that people sometimes lie, for example, in an attempt to bolster up a just cause, or out of shame or out of a wish to conceal disgraceful behaviour from their family. Fourthly the statement must be clearly shown to be a lie by evidence other than that of the accomplice who is to be corroborated, that is to say by admission or by evidence from an independent witness."*
>
> *98. The decision in R v Lucas has been the subject of a number of further decisions of the Court of Appeal Criminal Division over the years, however the core conditions set out by Lord Lane remain authoritative. The approach in R v Lucas is not confined, as it was on the facts of Lucas itself, to a statement made out of court and can apply to a "lie" made in*

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

127. The Court should consider how much weight to attach to discrepancies in accounts between witnesses or from one witness at different times. Per Mostyn J in <u>*Lancashire v R*</u> [2013] EWHC 3064 (Fam):

> *"[8]…*
>
> *(xi) The assessment of credibility generally involves wider problems than mere "demeanour" which is mostly concerned with whether the witness appears to be telling the truth as he now believes it to be. With every day that passes the memory becomes fainter and the imagination becomes more active. The human capacity for honestly believing something which bears no relation to what actually happened is unlimited."*

128. See also Peter Jackson J (as he then was) in <u>*LCC v The Children*</u> (2014) EWHC 3 (Fam) about the notion of 'story creep':

> *"[9] To these matters I would only add that in cases where repeated accounts are given of events surrounding injury and death the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy not fully appreciated, or there may be inaccuracy or mistake in the record keeping or recollection of the person hearing and relaying the account. The possible effects of delay and questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles*

may not be unnatural – a process which might inelegantly described as "story creep" – may occur without any inference of bad faith."

Propensity

129. See the judgment of Peter Jackson LJ in the case of *R v P (Children: Similar Fact Evidence)* [2020] EWCA Civ 1088, and particularly at paragraphs 25 to 26. In cases where evidence of an alleged pattern of behaviour is relied upon to assert that the core allegation is more likely to be true because of the character of the person accused, the Court must be satisfied on the basis of proven facts that propensity has been proven.

What constitutes a threshold finding?

130. It is for the local authority to prove that there is a link between the facts upon which it relies and its case on threshold. The local authority must demonstrate why certain facts, if proved, lead to the conclusion that 'the child has suffered or is at the risk of suffering significant harm' of the type asserted by the local authority.

131. A threshold finding must be unusual, at least something more than commonplace human failure or inadequacy. Per Baroness Hale in *In the matter of B (A Child) (FC)* [2013] UKSC 33 at paragraphs 179 to 182.

Failure to protect

132. In *Re L-W (children)* [2019] EWCA Civ 159 the Court of Appeal overturned a finding of failure to protect, where it had not been shown that on the particular facts of that case, the mother should have identified a risk to the child. The Court of Appeal found the evidence of the perpetrator's behaviour in the home and his two past incidents of aggression did not go anywhere near to supporting a causative link such that the mother ought to have known he presented a risk of physical abuse either to L or her other children. At paragraph 62 of the leading judgment Lady Justice King said:

"62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.

63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries.

64. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central

> *issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm. This professional and realistic approach allowed the Court to focus on what was, in reality, the only live issue, namely; was GL's history of violence sufficient to lead to a finding of failure to protect upon the mother's part?'"*

133. In *G-L-T (children)* [2019] EWCA Civ 717, Lady Justice King again gave the leading judgment, granting an appeal against a finding that a father had failed to protect his son in circumstances where findings had been made that a mother had fabricated or directly caused many of a child's significant illnesses and injuries. Identifying the judge as having fallen into the trap of making this very serious finding as a 'bolt on' to the substantive issues in the case, Lady Justice King said, at paragraphs 72 to 74:

> *"'I repeat my exhortation for courts and Local Authorities to approach allegations of 'failure to protect' with assiduous care and to keep to the forefront of their collective minds that this is a threshold finding that may have important consequences for subsequent assessments and decisions.*
>
> *Unhappily, the courts will inevitably have before them numerous cases where there has undoubtedly been a failure to protect and there will be, as a consequence, complex welfare issues to consider. There is, however, a danger that significant welfare issues, which need to be teased out and analysed by assessment, are inappropriately elevated to findings of failure to protect capable of satisfying the section 31 criteria.*
>
> *It should not be thought that the absence of a finding of failure to protect against a non-perpetrating parent creates some sort of a presumption or starting point that the child/children in question can or should be returned to the care of the non-perpetrating parent. At the welfare stage, the court's absolute focus (subject to the Convention rights of the parents) is in relation to the welfare interests of the child or children.'"*

134. The Court must not make an assumption that a parent living in a household where significant harm to a child occurred must have been able to foresee the risk. Even if a risk is identifiable, it does not follow that the parent could or should have taken steps to protect the child. Even if there is a failure to protect, that failure must be, in the words of section 31, 'not what it would be reasonable to expect' from a parent.

135. The Court must be careful to avoid hindsight or outcome bias. This was explained by Mrs Justice Theis in *Surrey CC v E* [2013] EWHC Fam 2400, at paragraph 75:

> *"I should guard against 'Hindsight Bias' and 'Outcome Bias' which is described in The Department of Education's Guidance on 'Improving the Quality of Serious Case Review' published in June 2013 as follows:*
>
> *'Hindsight bias occurs when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident. Outcome bias occurs when the outcome of the incident influences the way it is analysed. For example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. If people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair.'"*

The parties' submissions

136. The LA sought to uphold the entirety of its amended threshold document, save that it accepted in the light of the oral evidence that the Mother was not the perpetrator of any injuries upon the children. The LA did not therefore seek any pool of perpetrators findings. The LA submissions followed from the evidence set out above, and largely align with my conclusions.

137. The Guardian agreed with the LA that the Father had intentionally suffocated both X and Z on a number of occasions. The Guardian expressly accepted that the Mother was not present on any of these occasions and therefore did not witness them. The only material difference between the LA and the Guardian's cases is that the Guardian is marginally more sympathetic to the Mother's failure to report the domestic abuse than is the LA. However, both parties argue that the Mother failed to protect the children and needs to be subject to psychological assessment before any conclusions can be reached in respect of the welfare outcome for the children.

138. Mr Samuels, on behalf of the Mother, emphasises the fact that she has always been considered by professionals to be a good and caring mother, and that she feels deeply guilty for not leaving the Father much earlier, and thus protecting the children. He says that much of the evidence is also positive about the Father's parenting, and that the Father is a manipulative and dishonest liar who deceived the Mother as well as all others concerned.

139. He accepts that the Mother failed to protect by leaving the children exposed to domestic abuse, and that psychological assessment is required. However, he argues that the Court should be slow to criticise the Mother, given the domestic abuse, and should "calibrate" its findings accordingly. He argues that the failure to protect the children from domestic abuse should not in itself lead to threshold findings given that there is little evidence that the domestic abuse itself led to harm to the children, see *Re L-W* [2019] EWCA Civ 159. He says the Mother felt trapped and did not know where to turn, which led to her not telling her family about the abuse.

140. In terms of the reasons to believe the Mother in respect of the domestic abuse, he points to many of the factors I have already set out.

141. He argues that there is no evidence to support a finding that the Mother exaggerated the Father's symptoms. The one incident where the Father was unconscious for a short period and the Mother was asked in evidence how long the Father had been unconscious for, the Mother initially said: *"I am not sure, a couple of minutes".* It was only when the court put to her 40 minutes that she said: *"I don't think it was that long, maybe 10-15 minutes, I can't be 100% sure. I didn't see it."* I accept that this may have been no more that the Mother misremembering the incident.

142. Mr Roche, on behalf of the Father, rightly submits that the evidence of the Father harming the children is circumstantial in the sense that nobody has seen him doing harm and there is no DNA or other objective evidence of harm. He also argues that the Father is "by no means a consistently reliable historian", has a low threshold for seeking medical attention and is suggestible.

143. He points to Dr Fear and Dr Yogarajah's view that the Father suffers from a genuine somatoform disorder, of which one aspect is the functional seizures. Neither doctor considered that the Father deliberately fabricated his symptoms.

144. Mr Roche analysed the various incidents to X and Z and said that they could have been instances of the Father exaggerating and/or misinterpreting what he saw. There were a number of other potential causes for the incidents where the child had a genuine medical problem which cannot be fully discounted, such as viral infection, undiagnosed inherited heart condition or, in the choking incidents, choking on milk. Essentially Mr Roche's argument was that there could be a combination of the Father exaggerating some of the events, and undiagnosed issues such as infection. The Court should be very slow to assume intentional suffocation, an extremely rare event, without direct evidence.

145. In respect of the alleged induced allergic reactions, Mr Roche argues the increase in the number of allergic reactions after the Mother met the Father may be a result of her pregnancies. There is no clear evidence that the Father was always present when the Mother had these reactions, or that the trigger was something he could possibly have caused.

146. On the domestic abuse allegations, Mr Roche points to the fact that the Mother was close to her highly supportive family to whom she could have turned. She was not socially isolated, and the Father did not try to keep her away from her family. Further, none of the large number of professionals involved with this family ever spotted any sign of domestic abuse. Nor did the Mother's family despite the fact they knew the Father well and saw him and the Mother together very regularly. He says that it does not make sense that the Mother would have moved in with the Father after the incident when he forced her to continue with intercourse against her will. The evidence strongly suggested that the Mother was not afraid of the Father nor under his control.

147. Mr Roche also submits that the recording of the parents shows that the Mother was much more articulate than came across during her oral evidence. She also had very good recall about conversations she had had with her friend, D, about the Father's alleged infidelity. Finally, her allegations have come forward very late, with no corroboration and no clear explanation as to why she has waited so long to report them.

Conclusions

148. I have reached the conclusion that the Father killed X through suffocation and induced the three episodes when Z received emergency medical treatment. The evidence of induction is less clear in respect of Y. I accept Dr Samuels' view that it is not possible to reach a finding of induced illness in respect of Y.

149. The Father's psychological motivations for these actions is not a matter I intend to speculate upon. Equally, whether the suffocation of X was an attempt to induce illness and then medical attention which went wrong is impossible to know. These matters may be of great interest to a psychologist, but they are not necessary for me to determine.

150. My starting point is the medical evidence. During and after the three episodes in September 2020 Z was subject to a barrage of tests and subsequent expert consideration. All possible causes of the three episodes have been extensively considered, and ultimately excluded, save for suffocation. It is possible that the first two episodes were instances of either exaggeration or fabrication of symptoms by the Father. However, on the third episode the blood gas readings indicate very clearly that there was a lack of oxygen in his blood. Mr Roche suggests this might have been caused by an infection, but there are absolutely no indicators of infection. Probably most importantly the issue resolved far more quickly than would be expected with an infection. Both the treating clinicians and the experts consider infection highly unlikely in these circumstances.

151. X was subject to a post-mortem. There was nothing to indicate any medical disorder that would explain her death. Importantly, in respect of any suggestion that she may have had a genetic heart condition, there was no evidence from X's post-mortem of any such condition. X suffered three events prior to her sudden death. The medical evidence is that it is more likely that there was one unifying cause rather than a number of coincidental incidents. I accept however that it is right to be cautious about assuming a unifying diagnosis and then fitting the facts to that one cause.

152. Dr Saggar raised the possibility of genetic heart condition playing a role in respect of Z's presentations. However, all the tests on Z showed no heart arrhythmia or other heart condition. Dr Walsh did not consider any underlying heart condition leading to Z's presentation as being at all likely.

153. When considering the medical evidence, both Dr Robinson and Dr Samuels emphasised the importance in these cases in taking a holistic view and not merely examining the individual events as Mr Roche urged. I accept that it is necessary not to fall into the trap of thinking that a series of unlikely or unexplained events necessarily leads to a conclusion of FII. The caselaw shows that unlikely events do happen. However, in this case we have the large number of unexplained events, primarily to X and Z, combined with the lack of any supporting evidence for a medical diagnosis other than airway obstruction. Combined with this is the medical evidence that Z has suffered no similar incidents since he was removed from his parents' care, a factor which Dr Robinson places very considerable weight upon.

154. Taking that holistic view, the medical evidence points in favour of deliberate airway obstruction.

155. The second factor supporting the findings is the coincidence of the timings when the children became seriously unwell. On each occasion it was the Father who found them or was with them, and the Mother was either not in the room or asleep. When X was alive the Father was not living in the house full time, often being away during the week for work. Therefore, the coincidence of the timing becomes more important. Further, when Y was born the Mother said (and the Father agreed) that the Father was not left alone with him because of the onset of the Father's seizures. Therefore, the opportunity for the Father to inflict injury upon Y when he was a baby was much more limited than upon either X or Z.

156. When Z was born there were two young children in the household and inevitably the Father had much more time alone with Z than he had had with Y, and the opportunity reappeared.

157. The third, and important factor, is the Father's undoubted lies. The Father has undoubtedly lied to the Court on a number of matters. I have set these out above, but they include lying about the abusive phone call, lying to the supervisor about being unconscious for 40 minutes, lying to the hospital about the car bonnet and lying about the syringes. It is important that the Father is prepared to tell clear "bald faced" lies with complete composure and no outward sign he is telling a lie. The Mother's assessment appears to me to be correct, the Father will tell a lie until he is confronted with absolutely unequivocal evidence to the contrary. He then says he either does not recall the event or thinks of another lie to avoid the conclusion that is contrary to his case. This case is a good example of the analysis in ***Gestmin***, it would be very difficult to tell the Father was telling a lie except where there is clear third party evidence.

158. I fully take into account the principles in ***Lucas*** that the fact someone tells a lie about one thing does not mean that other parts of their evidence are not true, and the fact of a lie does not prove "guilt". However, I have reached the view that the Father is fundamentally untruthful. The motivation for his lies may vary, but he appears to have no regard for the truth, and he tells deliberate lies to deceive for his advantage.

159. Fourthly, there is a clear pattern of the Father seeking medical attention when there is no evidence of any objective cause. There are, as set out above and in detail in the CLINCO report, a truly extraordinary number of medical presentations for the Father with very little, if any, evidence of underlying medical causes. The psychological reasons behind this presentation is unfathomable, and ultimately not my task to determine. It seems likely that it is some form of medical attention seeking, but the degree of conscious or unconscious motivation is unknowable. However, according to Dr Robinson and Dr Fear there can be some correlation between such behaviour and FII. On a fairly basic level, if the Father is constantly seeking medical attention for himself because of some underlying psychological need, then that may well give rise to the same pattern of behaviour with the children. It might be, in some cases, that this would be an instance of extreme anxiety leading to exaggeration. However, here the Father's lies and the fact that the incidents only occur when he is alone with the children points strongly to induced rather than exaggerated disorders.

160. Fifthly, and closely related, is the history of the Father's seizures and other disorders. Dr Yogarajah's view is that these were functional seizures, and Dr Fear considers that the Father suffers from a somatoform disorder. I have very real doubts about this, although of course I am not a clinician. Both Dr Yogarajah and Dr Fear made clear that

they did not investigate the veracity of the Father's account. Dr Yogarajah said it was simply not possible for him to do so with his patients, and Dr Fear said clinicians generally accept their patient's account. The Judge however is in a different position. I have heard the Father give evidence for a day, have heard the Mother's evidence, and have examined a wide range of written records. Having undertaken this exercise I have reached the conclusion that the Father has been deliberately inaccurate, or lied, in a number of respects, including exaggerating and lying about his condition on at least two occasions.

161. I have also reached the view that the only rational explanation for the chopped up chocolate bar is that the Father was inducing serious allergic reactions in the Mother. The Mother has undoubtedly had a great many serious allergic reactions since she has been in a relationship with the Father. It is noteworthy that she had her allergies under control until she met him. It is simply not possible to decide what proportion of the allergic reactions were induced by the Father. It may be that she became more susceptible for a period after the children were born. However, 19 such reactions in a five year period for someone who was very careful is a surprisingly high number. Added to that is the coincidence of timing, that the reactions only came on after she met the Father. Critically, there is simply no other rational explanation for the chocolate bar incident, bizarre though it is.

162. These conclusions cast real doubt on whether the Father has lied to the clinicians rather than merely exaggerating symptoms. Dr Yogarajah said that the Father's description of his seizures rang true and would be difficult for a lay person to make up. However, the Father was in my view quite capable of reading symptoms on the internet. Whether he had genuine seizures as a child and then this tied into his adult presentation goes beyond my role or expertise.

163. I accept the Mother's evidence as to the domestic abuse. It is correct that there is very little corroborative evidence, but that is often the case with domestic abuse. The most surprising aspect of this issue is that no professional spotted any signs of domestic abuse, neither Mr P nor the health visitor, nor any of the various midwives and doctors who saw the Mother through the relevant periods. Further, it appears that the Mother's own family were wholly unaware. It is also somewhat surprising that the Mother at no point confided in her family, even though they live close by and she has a warm and apparently supportive relationship with them.

164. The Mother's presentation I can only describe as odd. She appeared both incurious and highly passive in the witness box, but that is not the way she came across in the March phone call, nor the way the family support worker described her, and also not the way Mr P had perceived her. I also note that she had an element of planning, and perhaps even guile, which were not apparent in her oral evidence. She took photos of her injuries years before she told anyone. She sent a photo to make the Father think she had gone to the cinema when she had not done so. She took photos of the syringe and the chocolate bar even though she did not at that stage plan to leave the Father.

165. However, despite these factors I accept her evidence for the following reasons. Firstly, she has given a very detailed account, in particular of the incident when she says the Father forced her to continue with sex against her will. I do not think the Mother has the imagination or the self-confidence to make up such a detailed account. Mr Roche suggests that she had a long time to concoct the story, and the detail may have come

out of effectively leading questions from the police. But there is no evidence to support this, and the detail is very unlikely to be something the Mother was led into by the police.

166. Secondly, there is some supporting evidence in the photos both of the bruising on her leg and the eye injury. The Father's account of the eye injury, with the Mother falling over a toy and then hitting her face in such a way as to knock the TV off the stand, seems unlikely.

167. Thirdly, there is clear evidence that the Father loses his temper and is abusive. This comes from the recorded phone call when he was highly abusive to the Mother, but also the fact that he now accepts he lost his temper when he hurt his hand on the cooker, and with his mother at Christmas 2021. He had previously made no admission about losing his temper. It seems that the Father, even on his own narrative, has not given an honest account of the relationship.

168. Fourthly, and importantly, the Mother's account fits into a fairly classic pattern of domestic abuse. The Father diminished her self-confidence and told her than no-one else would want her. The fact he called her a "retard" on the recorded phone call strongly supports this analysis. Many such relationships are characterised by the abusive partner saying that they will change, but also undermining the victim. I continue to find it odd that the Mother did not tell her family. This is not a situation where the Mother was socially isolated, or that the Father kept her away from her family and friends. But I accept Mr Samuels' submission that the Mother knew her family liked the Father, and she may have felt there was a risk that they would not have believed her.

169. Fifthly, the Mother's explanation that she is a private person and did not want to share details with her family is not inherently implausible. There is potential shame and embarrassment about admitting that she was in an abusive relationship. The contents of the phone call certainly suggest that the Father undermined the Mother's confidence in a very broad way.

170. I do, however, find that the Mother has failed to protect the children, not merely to the degree accepted by Mr Samuels in her remaining in abusive relationship. I take into account the need to be careful about "hindsight bias" and not expect the Mother to have understood events she did not see. However, she was fully aware that the Father was not just aggressive and violent to her, but also that he was a persistent and determined liar. He was presenting himself as a loving partner when he was violently abusing her. On one occasion she says he tried to hit her when Y was in her arms. Despite X's death and the younger children being taken into care after an ALTE to Z, she still waited another 17 months before informing the professionals about the abuse.

171. At the lowest, the Mother failed to protect the children because she was in a highly abusive household, and she seems to have taken no steps to protect the children from the emotional abuse that was going on, and on at least one occasion the physical abuse which could have impacted on Y.

172. However, beyond that, the Mother was living in a house with the Father when he was calling the emergency services on a truly extraordinary number of occasions, either for himself or the children. Her reaction to this is impossible to understand. Perhaps, as she

suggested, she had become completely normalised to it, but in a situation where one child had died, her complete lack of curiosity or questioning about what was happening, is in my view itself a failure to protect. This is the distinction from some of the other cases. The Mother knew X had died when the Mother was asleep. Her failure to question the Father when similar incidents started with Z is in my view a failure to protect.

173. Her failure to properly investigate or question the Father about the chocolate and the syringes again indicates a lack of curiosity and passivity that gives no confidence in her ability to protect the children. Albeit, by the time of those episodes the children had been removed from her care.

174. Mr Samuels says that the Father was a determined and manipulative liar and he had managed to hide his behaviour from all the professionals. But the key point in my view is that the Mother knew that he was manipulative and untruthful and therefore was not in the same position as the professionals. In the light of that knowledge, her failure to apparently ask any questions of the Father about what was happening to the children or raise her knowledge of the Father's conduct with the professionals is in my view a failure to protect the children.

175. For these reasons I make the findings sought by the Local Authority other than there being no finding in respect of Y and no finding against the Mother that she exaggerated the father's medical symptoms under para 3(h); the matter will proceed to a welfare hearing.