Neutral Citation Number: [2023] EWHC 748 (Fam)

Case No: BM22C50073

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/03/2023

Before :

MRS JUSTICE LIEVEN

- -

Between :

BIRMINGHAM CITY COUNCIL

Applicant

and

CD

First Respondent

and

SP

Second Respondent

and

FW

Third Respondent

and

X, Y & Z
(the Children, through their Children's Guardian)

Fourth to Sixth Respondents

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- -

Mr Nick Goodwin KC and Mr Matthew Brookes-Baker (instructed by **Birmingham City Council**) for the **Applicants**
Mr Andrew Bagchi KC and Ms Theresa Lim (instructed by **Osborne Solicitors**) for the **First Respondent**
Ms Yolanda Pemberton (instructed by **HRS Family Law**) for the **Second Respondent**
Ms Elisabeth Richards (instructed by **Duncan Lewis Solicitors**) for the **Third Respondent**
Mr Richard Hadley (instructed by **Cafcass**) for the **Fourth to Sixth Respondents**

Hearing dates: **27 February – 17 March 2023**

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Approved Judgment

This judgment was handed down remotely at 10.30am on 24 March 2023 by circulation to the parties or their representatives by e-mail.

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MRS JUSTICE LIEVEN

This judgment was handed down in private on 24 March 2023. It consists of 150 paragraphs. The judge gives leave for it to be reported in this anonymised form.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by his or her true name or actual location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

Mrs Justice Lieven DBE :

1. These are care proceedings concerning three boys, X aged 13, Y aged 12 and Z aged 4. The First Respondent ("CD") is the mother of all three children. The Second Respondent ("SP") is the father of the older two boys, and the Third Respondent ("FW") is the father of Z.

2. The Local Authority ("LA") were represented by Mr Goodwin KC and Mr Brookes-Baker. CD was represented by Mr Bagchi KC and Ms Lim, SP was represented by Ms Pemberton, FW was represented by Ms Richards and the Children's Guardian was represented by Mr Hadley. Ms Pemberton only attended those parts of the hearing which directly impacted on her client (a small portion). This was a wholly appropriate model that should be adopted in other cases where one parent has only a small role to play in the proceedings, for whatever reason.

3. The precipitating event for the proceedings was the death of CD's youngest child, B, aged 12 weeks on 2 March 2022. FW was B's father.

4. The LA's threshold covers three broad areas – the circumstances surrounding B's death and various injuries she had suffered in the days and weeks before her death; issues around neglect of the children by CD; and domestic abuse between FW and CD. This is a composite hearing to deal with both fact finding and welfare outcomes. The LA care plan at the start of the hearing was for X and Y to live with their father, SP, and for Z to remain in long-term foster care with the hope, but no certainty, that at some point in the future he might be able to return to the care of his mother or his father, FW.

5. At the present time Z is living in foster care. X and Y were living with SP. However, X had absconded on a number of occasions and did so some days before the start of the hearing. When he was recovered, X moved to live in a residential placement where he remains.

6. In terms of welfare outcomes there are now very limited disputes. It is accepted by all parties that X should be placed under a care order in a residential placement; Y should be under a supervision order with his father, SP, and Z should be under a care order in long term foster care. It is however proportionate and necessary for me to determine various disputed facts given that both CD and FW seek in the longer term for Z to be returned to their (separate) care, and FW has a number of other children, in relation to whom my findings may have some relevance.

Background

7. CD has four children, including K aged 18, by three different fathers. FW has nine children, by four different mothers. FW's children who are relevant to these proceedings are G aged 16 and N aged 3.

8. CD and her family have been known to Children's Services since 2009 when CD reported an assault by K's father to the police. There were then various periods when CD reached out to the LA for support referring to her mental health problems; difficulties setting boundaries for the children; and the lack of family support. There was a period in 2018 when the children were on a Child in Need Plan for a short period. Since 2020 there have been a number of times when X went missing from CD's home

and these were reported to the police and social services. On 6 September 2021 X was made subject to a Child Protection Plan and the younger children a Child in Need Plan. X was then placed in an out of area placement. X was at this placement at the time when B died.

9. Between 2010 and 2012 the mother of four of FW's children ("E") applied for and was granted a non-molestation order against FW, which was extended. They separated in 2012 with allegations of domestic abuse against FW. There are various references in Children's Services documentation concerning FW's care of the children, but no action was taken. In October 2013 FW was convicted of Actual Bodily Harm and received a 15 month suspended sentence.

10. In 2015 CD's first daughter, AA, was stillborn at 37 weeks. This was obviously a deeply distressing event for CD.

11. CD was convicted of drink driving in March 2017.

12. In 2017 CD and FW started a relationship. CD accepts that this was a deeply toxic relationship in which she became completely obsessed by FW, and intensely jealous about his other relationships. FW described the relationship as being only about sex, and suggested that he had never had any kind of serious or committed relationship with CD.

13. In May 2017 X (then aged 8) was found wandering in the street, and then shortly thereafter Y had said that CD was going out at night (to see FW) leaving K, X and Y alone. K would have been 13 at this point. In early 2018 CD was referred for a mental health assessment and was prescribed Quetiapine (an anti-psychotic). On 8 May 2018 there was an incident when CD went to FW's house; there was an altercation and the police were called, CD was 5 months pregnant. Z was born in September 2018. CD and FW had a break in their relationship, and it resumed when Z was about 9 months old. At that stage the relationship seems to have got even worse, partly because FW was having sex with at least one other woman.

14. In February 2020, N was born. His mother, H, has a history of social services involvement, with two previous children having been adopted.

15. Throughout 2020 there are frequent references in the records to CD's mental health and to incidents between CD and FW.

16. On 20 January 2020 CD's neighbour TB had a birthday party. CD attended that party and FW came to pick her up. There was some form of altercation on the way home. The next day TB saw CD with considerable facial injuries.

17. In early 2021 G reported an assault by his father, FW. G had bruising to his face. He then moved to reside with his mother so no further action was taken.

18. Throughout 2021 there are very frequent reports of X going missing, and him being involved with children who are being criminally exploited. He was reported to be in possession of a knife and had a prolonged period out of education. In July 2021 the police attended the house and found Y and Z home alone. Z was 2 ½ at the time. In

September 2021 X was placed on a Child Protection Plan and Y and Z on a Child in Need plan.

19. Throughout this period CD accepts that she was obsessively jealous of a woman, OM, who FW was reportedly having a relationship with. In November 2021 CD informed the LA that she was having a mental health crisis and she then had extensive engagement with the Community Psychiatric Nurse ("CPN"). There was a home visit on 29 November and the CPN is recorded as considering that CD was prioritising the children's wellbeing. On 10 December it was decided that the children should remain under a Child in Need plan.

20. B was born on 14 December, one month premature. She and CD were discharged home on 21 December with daily visits, but no concerns identified.

21. On 9 January 2022 CD attended at hospital with B saying that she had fallen downstairs whilst carrying the baby and she was concerned she might have banged the baby's head. This happened at the house of CD's friend, RN. B was examined and no signs of any injury were found.

22. On 14 January there was an incident where CD says FW came to her house and woke her by touching her genitals. FW says he went to the house to see B and Z, but CD was awake. He left but CD rang him to tell him to return with her keys. There is then a further incident where CD says he punched her in the face, but FW denies this.

23. CD then regularly attended perinatal mental health appointments up until B's death.

24. The factual position in relation to the hours before B's death is not particularly clear. CD says she spent the morning with a friend. She drove Y, Z and B to RNs' house at about 3pm. She then spent the afternoon there doing RN's daughter's hair. She, RN and the children then went shopping to buy an outfit for World Book Day. She returned briefly to RN's house and drove home with the children, arriving home at about 9pm.

25. The next time which is clear is that CD called 999 at 3.02 am on 2 March, the ambulance arrived very shortly thereafter, and B was declared dead at 4.08 am.

26. As set out below, CD says she has very limited memory of that evening and night and has no memory of driving home or of what happened when she got home. Y did not give a police interview and has not given any statement as to what happened. CD says that Y told her when she woke up just before 3 am that B had woken at about 1am crying and CD had not woken up. He had also said to his mother that she was drunk when driving home and that the car had crashed.

27. FW says that Y said something similar to him when he spoke to Y a few days after B's death. It is extremely difficult to establish precisely what Y said to whom and when, given that it was not written down and his account seems to have varied somewhat in different accounts. However, there is a consistent account of Y saying that CD was drunk, and that B had woken in the night crying, but CD had not woken, or had only woken briefly.

The evidence

28. A number of people gave evidence of what had been said to them about the events surrounding B's death. With the exception of RN, all these accounts are hearsay, and necessarily carry limited weight.

29. PJ was an acquaintance of CD's friend, RN. RN had spoken to her on the day after B's death. PJ had never met or spoken to CD. RN had told her that the day before B's death, CD and B had been at RN's house. They had been drinking vodka, although RN referred to CD having had two glasses but might have had more. I put no weight on this evidence, it is hearsay and it impossible to tell how reliable it is.

30. MS was a friend of CD's neighbour, TB. She had known CD before B's birth but had not seen her since B was born. She had met CD she thought 7-8 times, although I am not confident as to how accurate this is. I think MS was an essentially truthful witness although she was clearly evasive about who she had spoken to after B's death. MS rang the police after B's death to give them information. What she said was entered into the log, but there are various parts of that log which she disputes. In my view, when the log is in direct quotes it is very likely that it is an accurate recording of what MS said.

31. MS's evidence fell into two parts. Her direct knowledge of CD's parenting before B's death, and various social media exchanges in the immediate aftermath of the death. In respect of the parenting, MS recounted two incidents. One where she, CD and various other people were outside on the grass in front of the houses in CD's street. CD left the baby, who must have been Z when a young baby, on the grass and simply left, getting into a car. MS was not sure where she went or for how long, but she said no one was left in charge of the baby.

32. The second incident was when she was in CD's house. She had been inside the house on a number of occasions and said the house was in disarray – unkempt and untidy. One time she went upstairs and apparently none of the children's beds were made, and the sheets were in packets obviously unused. She made the beds for the children. She said one of the children, probably Y, said to her that his mother did not love him. She said she comforted him and then went back downstairs and said nothing to CD.

33. After B's death, there was a great deal of "chatter" or gossip on social media. I place no weight on this part of MS's evidence.

34. K is CD's older son. He said at the time of B's death he had been living with his older half-brother. He did not see CD and B the day before she died and did not see CD afterwards for a few days. He did speak to CD when she was shopping for a shirt, but he thought that was a few days earlier.

35. He said that Y had said to him that he had tried to wake his mother during the night. However, K said that Y was not a reliable witness, frequently changed the story and might well have been lying. Y had also said something to him about a car accident on the way home, perhaps skimming a kerb. Y subsequently said that there was no car accident. K said most of the damage to the car, which is shown in the photographs taken by the police, had happened much earlier when CD was taking the children to school.

36. He said that he hadn't asked CD what had happened to B as he didn't like discussing such things.

37. RN is a close friend of CD. She came to court very unwillingly and was angry and argumentative in the witness box. I do not think she was truthful about what she could or could not remember and what happened the night before B died. In particular I do not think that she was truthful about her and CD's drug and alcohol consumption. She allegedly had almost no memory of various events but was adamant that CD had only had 1-2 glasses of vodka. I put no weight on her evidence in this respect.

38. She said that on the day before B's death CD had come round with the three youngest children at about 3pm, she subsequently changed this to later in the day. She said CD had had 1-2 drinks but had not taken any cocaine. Her cousin L had come round, who was an alcoholic, and he had been drinking. She said she did not remember whether she had taken cocaine. She later, when prompted by Mr Bagchi, agreed that CD hadn't taken any cannabis that day because she was plaiting RN's daughter's hair.

39. CD had driven to the first shop, and then RN had driven because CD was breastfeeding B. She was highly evasive about the damage to the car and what state the car was in. She said they had driven home and then RN had lent CD a car seat for Z. She said that neither she nor CD were drunk.

40. She said CD rang her in the night when B wasn't breathing, and she spoke to her a number of times during that day. However, she said that she and CD had never spoken about what had happened to B.

41. She said that she did remember when CD and B had fallen down the stairs, and CD had hurt her elbow.

42. TB was CD's next door neighbour and friend at the time of B's death. She was at home the night of B's death but had no direct knowledge of the circumstances of her death. TB's important evidence related to an incident between CD and FW.

43. This incident occurred at TB's 28th birthday party, which was on 20 January 2020. CD was at the party and FW came to collect her. TB said FW was rude and dismissive to CD. After CD left the party with FW, TB and others were concerned about TB and rang her. She was very distressed on the phone but would not explain what had happened. It seemed that FW had driven into a barrier in the car park, which TB then had to pay for. She saw CD the next day and she had cuts and bruises on her face, including round her eye. CD told TB that FW had hit her, but she didn't go into detail. CD was very upset.

44. In my view TB was an honest witness who was telling the truth about what she heard and saw. She was by far the least evasive of the witnesses of fact and I could see no reason for her to lie about the events in January 2020.

45. PC Gemma Griffiths attended the house shortly after PC Cleaver. She described the house as being chaotic, and similarly to MS, being in disarray. She stood close to CD and clearly smelled stale alcohol. She saw a bag of cannabis on the table.

46. PC Griffiths reported that Y came into the kitchen and said to CD that he had tried to wake her when the baby was crying but she hadn't woken. CD said "what do you mean

I didn't wake" and was very distressed. She went upstairs to CD's bedroom, where she was told B slept. The Moses basket was piled with clothes and plainly unused.

47. PC Allen attended at the hospital when B was taken there and remained in the room after she was declared deceased. CD and Y were allowed into the room to be with B. He recorded CD saying the following:

> *"I had been out with [RN] for a few drinks. I got home around 9pm and fell asleep. I was supposed to take Quetiapine but don't as I don't want to not wake up when [B] cries. [Y] told me, he tried to wake me up around 1.30am but I told him to leave me alone and I put [B] on my chest. I think I woke up around 2.30am and felt [B] who was warm and then woke again around 3am and realised I could not wake her. [B] at this point was on the other side of the bed. I tried to shake her to get a response but there was nothing. I went and got [Y] to try but he didn't believe me because I'm always making jokes like that but I told him to go and try so he tried to shake her as well."*

48. He said in evidence that these sentences were not all said consecutively, but he had written down a number of things CD had said, which he had checked from his body worn footage.

49. LC was the Ward Manager in the Unit where CD was detained under the MHA after B's death. CD was in a very volatile state, sometimes very distressed. She had said at one point that she had been very drunk when she was in charge of the children. But it seemed from LC's evidence that CD did not herself recall what had happened and was, herself, trying to understand.

Medical Evidence

50. B had the following injuries at the post mortem. Both the injuries and the timings are not in dispute.

    (a) Acute bilateral rib fractures inflicted between 1-4 hours before death;

    (b) Older posterior right rib fractures inflicted 2-5 days before death;

    (c) Older posterior left rib fractures inflicted 2-5 days before death;

    (d) An older anterior left rib fracture inflicted 'several days' before death;

    (e) A metaphyseal fracture to the proximal left tibia inflicted 2-5 days before death;

    (f) A metaphyseal fracture to the proximal right tibia inflicted less than 12 hours prior to death.

51. There is no history of accidental injury within the 2-5 day timeframe that might explain those fractures falling within that bracket. As referred to briefly below, there was a large

amount of medical evidence, none of which was subject to any substantive challenge. Mr Jayamohan, Professor Arthurs, and Professor Mangham all gave oral evidence.

52. Professor Al-Sarraj (Consultant Neuro-Pathologist), who did not give oral evidence, identified a subdural haemorrhage ("SDH"), but no evidence of any damage to the brain itself. The SDH was consistent with an old, healed haematoma of several weeks or months.

53. Mr Jayamohan is a Consultant Paediatric Neurosurgeon. He referred to the potential causes of the SDH. The only explanation advanced by CD was that it was birth related. Mr Jayamohan said that in cases of vaginal delivery there is a high incident of SDHs which then heal. However, B was born by elective caesarean, with no complications, and the research papers show that it is extremely unusual for a baby to be born with an SDH in these circumstances.

54. Mr Bagchi suggested that CD's fall down the stairs could have caused the SDH. Mr Jayamohan said this was extremely unlikely given the description of the fall. There was no evidence in the hospital notes of any swelling, and there was no suggestion that B had acted differently after the fall. He thought that the SDH was even less likely to have been caused by this fall than by the elective caesarean.

55. Professor Arthurs is a Consultant Paediatric Radiologist at Great Ormond Street Hospital. He referred to the existence, causation and timing of the various fractures found at post-mortem. In respect of the existence and timing of the fractures, he said he would defer to Professor Mangham's histopathology evidence.

56. He said that the anterior rib fractures could have been caused by the attempts at resuscitation, subject to Professor Mangham's evidence. However, this is not a likely explanation for the posterior rib fractures. He was clear that quite separately from any issue of timing, CPR was not a viable explanation for such fractures. There was no clinical or observational evidence to support such a mechanism. Such injuries require an encircling of the ribs, which would not happen with CPR.

57. Equally, co-sleeping, with the parent rolling on top of the baby, was not a viable mechanism for these fractures.

58. B had corner metaphyseal fractures, also known as classical metaphyseal lesions ("CML"), to her tibiae, which the medical literature shows are strongly associated with non-accidental injuries. Professor Arthurs said that CML was almost exclusively seen in cases of abuse, other than very specific medical situations (e.g. an emergency C-section). Again, neither CPR nor co-sleeping is a viable mechanism.

59. B's bones were mildly osteopenic (lacking bone density) and there is evidence of periosteal bone development in B's x-rays, however this is irrelevant to the causation of the fractures. There was no evidence of rickets on the x-rays. He pointed to research that established that in the vast majority of cases (over 95%) a radiologist could differentiate between CMLs and rickets. The fact that B had mild bone abnormality would not change the causation of her fractures. He was absolutely clear that B's fractures could not be attributed to bone disease, or from any combination of appropriate handling and bone disease. He was also clear that her very slight prematurity (5/6 weeks) would not give any predisposition to fractures.

60. Professor Mangham is a Consultant Histopathologist, now working at the Royal Marsden Hospital. He said there was no evidence of any bone disease in respect of the tibiae, and no reason to believe that they had been weakened. Therefore, the explanation for the CMLs had to be excessive force.

61. The posterior rib fractures were likely to have occurred 2-5 days before B's death. Again, there was no evidence of any bone disease.

62. In respect of the older rib fractures, these were either healing fractures or an early manifestation of vitamin D insufficiency. Professor Mangham was clear that only if rickets was fully established would it increase the propensity of a bone to fracture. The evidence of B's anterior ribs did not give rise to such a propensity.

63. The timing of the anterior rib fractures was 1-4 hours prior to death. The distribution of the fractures was consistent with CPR. However, these were haemorrhagic fractures indicating that there had been blood pressure at that time they occurred. If B was dead by the time CPR took place, then there would have been no blood pressure. Dr Kolar's report referred to frontal hypostasis to the face and chest, indicating that she had been face down before being discovered. This would indicate that she had died before the CPR took place, and therefore the fractures had already occurred.

64. Dr C is a Consultant Psychiatrist who was appointed to assess CD, he did not give oral evidence. CD had been diagnosed with a mood disorder (bipolar affective disorder) in 2018. After B's death she was admitted under s.2 Mental Health Act 1983 ("MHA") to the unit where Dr C works. He met her on 8 March when he said she was largely calm and controlled and showing appropriate behaviour. She told him that she rarely took her medication and had not had any suicidal thoughts after B's death. She told him she had been functioning well after B's birth, managing her responsibilities with the children.

65. Dr C met CD again on 14 March when she was more hostile and less co-operative, apparently because she was focused on being discharged. She was discharged on that day.

66. Dr C referred to the diagnosis in 2018 but he had seen no evidence of mental disorder whilst CD was in hospital.

The evidence of CD and FW's drug use

67. Both CD and FW have been subject to multiple hair strand testing. Ms Muldoon from Lextox gave oral evidence and was cross examined.

68. CD accepts that she frequently takes cannabis, and the hair strand testing entirely supports that. She says that she is now trying to stop her drug use because she very much wants to be in a position to care for Z in the future.

69. CD denies cocaine use both at the time of B's death and subsequently. CD was tested for cocaine for the period November 2021 to March 2022 by taking the relevant hair sample for that period and tested negative. For the period March to September 2022, she tested positive for a metabolite of cocaine and the test results were "more likely to

be the result of active use than of exposure". Her results were only marginally above the cut-off point, implying either low use or high exposure.

70. On 11 January 2022 CD had WhatsApp'd FW saying *"Took a bloody line never again … Coke. I took a line."* Her explanation that she somehow wanted to trap FW into saying whether he was taking cocaine because that would tell her whether he was seeing OM makes very little sense.

71. On balance I think CD probably was taking a low level of cocaine at around the time of B's death. I note that she spent a lot of time at RN's house, and RN was plainly a frequent cocaine user.

72. FW has tested positive for cocaine on a number of occasions. He adamantly rejects such a finding and says that he has not used cocaine since February 2022. However, he tested positive for the period January to April 2022, and it was "very unlikely" to be the consequence of only using cocaine on 3-4 occasions. For the period ending August 2022 and onwards, the tests showed a very significant reduction in the amount of cocaine consumed, however each of those tests was still more likely to be the consequence of consumption rather than exposure alone.

73. Ms Richards cross examined Ms Muldoon on the line that there are a number of stages of the Lextox hair strand testing process in which mistakes could be made, and errors could enter the process. Ms Muldoon accepted that this is possible. However, I note that Lextox are frequently relied upon by the courts for evidence as to drug use through hair strand testing. Ms Richards did not put any case before me where a court had found that the Lextox work was not reliable, or the conclusions had been in error. Further, Ms Richards could not point to any evidence of a mistake in the process being made in relation to FW's tests.

74. I have no reason to doubt the reliability of the Lextox results. They clearly show a high probability of FW using cocaine through the relevant period, albeit that it has significantly reduced since mid-2022.

75. Dr Cirimele, from the laboratory which had tested B's hair, confirmed that the cocaine traces in the "wash" of B's hair were "very low" suggesting that her overall positive cocaine result was not caused simply by passive exposure. She had ingested cocaine, either directly or through breast feeding. The presence of metabolites of cocaine indicated ingestion, although it was possible that the cocaine had transferred from the sweat of an adult to the child. I accept that ingestion from handling is less likely than some form of oral ingestion.

76. However, I do consider that how the cocaine became present in B's hair is rather beside the point. It is possible that CD's limited consumption entered B's system through breast milk. It is possible that it was through handling, either by CD or more likely by RN. In either case CD was grossly neglectful in exposing a small baby to cocaine, whether by her own consumption or by spending large amounts of time with RN when she was using cocaine. Equally, if the exposure was from FW, then CD clearly believed FW was consuming cocaine, but did not prevent him from handling B.

77. However B got cocaine into her system, ultimately CD is responsible for failing to protect her from such exposure.

CD's evidence

78. It was very clear that CD loved B enormously and was devastated by her death. CD had very much wanted a daughter, and within her own perceptions she felt she had acted to protect B and was a good parent. I do not doubt that she genuinely believed that. I also do not doubt that she is now trying to change and put herself in a position to care for Z.

79. Her evidence fell into two parts – that relating to the circumstances of B's death, and her relationship with FW. I will set them out separately.

80. She said that she had very little memory of the evening and night of B's death, up to her waking up in psychiatric hospital on 2 March. She recalls seeing a friend on the morning of 1 March and then driving with B, Z and Y to RN's house in the late afternoon. RN was there with a number of her children, and her cousin L, who is apparently an alcoholic. CD had gone to plait one of RN's daughter's hair. She said that whilst plaiting the hair she had had one drink of vodka. RN had a 'sky juice' with a takeaway, and she had put some vodka in it. CD thought she might have had some of that drink. She said she knew she wasn't drunk because her head wasn't spinning. She denied having taken any cannabis or cocaine with RN or at any other point during the day.

81. From this point on, it appears that CD's recollection is largely based on what she has been told, either by RN or by Y.

82. I note that CD's evidence is very inconsistent. On the one hand she said that she had virtually no recollection of the evening or night. However, when anything was put to her which might place responsibility on her, she was quick to say it did not happen. So she said she had taken no drugs and that she had not drunk more than two alcoholic drinks, but it was very unclear to me how she was confident on these points given her general lack of memory. She said that there had been no incident driving home (Y spoke about there having been some form of accident or hitting the kerb) but she said that she had no memory of the drive.

83. She accepted that she had gone out with RN, B and Z to three shops, she said to buy an outfit for one of the children for World Book Day. She said that she had driven to the first shop, but then she had fed B whilst RN drove to the other shops. It may seem a minor point in the context of this case, but I note that the car was in a very poor state. CD described this as aesthetic damage, but when I asked her whether the left headlight worked (it had a large hole), she accepted she did not know. Further, it was clear that she fed B with no seatbelt on, and that RN was not insured for the car.

84. They then went to RN's house, where RN lent CD a car seat for Z, and CD then drove home – a drive of 30-45 minutes. CD said she had no recollection of getting home or she or B going to bed, save that she changed her sanitary towel. She said she did not think that she had anything to drink when she got home because the car seat was upstairs. There was an open bottle of Baileys in the sitting room, but CD says her friend had drunk some in the morning. I note that CD had not before giving her oral evidence made this suggestion.

85. The next thing CD remembers is waking at 3am and realising that B was not breathing. She has no recollection of Y waking her in the night and saying that B was crying and

her putting B on her chest. CD said she was a very light sleeper. She chose not to take her Quetiapine because it made her sleep heavily and then she might not wake for B. She did however, later in her evidence, say that when she stayed the night at RN's sometimes, she did take her Quetiapine because then she would get a good night's sleep. I found her evidence in this regard both inconsistent and self-serving.

86. It was CD's evidence that she always co-slept with B, usually on the sofa downstairs. She said she had co-slept with all her babies and she thought it was the right thing to do.

87. It is clear from all the evidence that when CD woke up and realised B was not breathing she became extremely distressed, which is wholly understandable. She was asking Y then, and later, to tell her what had happened. She said in evidence that she did not believe Y's account because he frequently changed the story and he was an attention seeker who frequently made things up. Y said that morning that CD was drunk and the baby had woken crying in the night, but CD hadn't initially woken up. CD said that Y now said she was not drunk, so she does not know what to believe.

88. CD says that she has no explanation for the other injuries found on B by the clinical experts. Although other people sometimes held B for periods, and occasionally for a few minutes when CD went shopping, she does not suggest any other person would have inflicted the injuries. She says there were no times when the baby was with someone else, and she returned to find her distressed.

89. She said RN frequently took cocaine. CD spent a number of days, and some nights with B at RN's home. RN would often hold B. Therefore, CD accepted this might be how B had traces of cocaine in her system.

90. CD freely admitted that her relationship with FW was "toxic". She was extremely jealous of his other relationships, particularly with OM, and at times this led her to be out of control. She felt that she had been used by FW, not just for sex, but also to get money. Much of the detail of their relationship has little relevance to the issues in this case, but CD accepted that there were times when she had been very angry with FW and on one occasion (January 2022) had been physically aggressive towards him. However, in the main, he was the aggressor, particularly when she challenged him about his infidelities and he would lose his temper.

91. She said that FW exercised coercive control over her by preying on her vulnerabilities, both in terms of her mental health, but also her desire to have a relationship with him. She said that this was a pattern in his relationships with women.

92. She accepted that the children had been damaged by their exposure to domestic abuse between her and FW.

93. She denied taking cocaine and I have dealt with this matter by reference to the drug testing experts.

FW's evidence

94. FW was hardly a satisfactory witness. Although he accepted that the children had been exposed to domestic abuse, he rejected any responsibility for that abuse. He said that CD was extremely aggressive and antagonistic, particularly concerning his other relationships, and OM especially. She would come round to his house and become angry and on at least two occasions she attacked OM.

95. He made it clear that he considered the relationship with CD to only be about sex and to be a wholly uncommitted one from his point of view. His evidence was to the effect that he did not know why CD, or indeed other women, became obsessed by him and acted in the way they did. He took absolutely no responsibility for their actions.

96. He denied ever assaulting or being violent to CD and said whenever there had been a physical fight CD had always been the instigator and the aggressor, and he had only ever acted in self-defence.

97. He denied that he had sex with CD when both his daughters were in the room.

98. He also denied assaulting G on 16 March 2021. He said that he had been trying to restrain G when he got hit in the face, but he had not caused any injury to his eye, and he was only acting to calm G down.

99. Quite apart from the fact that FW took no responsibility for his actions, I do not think that he was a truthful witness. The evidence that he assaulted CD on the night of TB's party is overwhelming. Similarly, the evidence that he was the person who caused G's injuries, and it was much more than restraint is clear.

100. I think that FW lied in the witness box about his behaviour to CD and to other women. He very significantly lacks empathy towards the women he has had relationships with, and my view was that he would have little concern if he had been violent towards them. I do not accept his evidence about how he has behaved towards those women.

Welfare witnesses

101. The welfare outcomes were agreed by the end of the hearing, so I can deal with the evidence relatively briefly.

102. Madeline Jones is an independent social worker instructed to undertake a parenting assessment of FW. The bulk of her work had been undertaken in May-June 2022, with an interim report on CD undertaken in early 2023.

103. Ms Jones had conducted two sessions with FW totalling about 6 hours. She had not observed any contact between FW and Z. This was for a variety of reasons and Ms Jones accepted that it was unfortunate because such an observation would have helped her in understanding Z's attachment issues. She accepted that it was difficult to form a proper view without observing contact. However, she did also say that such an observation would necessarily be a snapshot of a snapshot.

104. Her conclusions were that FW could provide a good level of basic care for Z and he showed a high level of commitment to being involved in his children's lives and to looking after Z. He had looked after his son, G, since he was 2 years old and had recently

had his son, N aged 2, placed in his care by Dudley Council. However, he had limited understanding of the impact on the child of neglectful parenting and of Z's likely needs in the light of his experiences.

105. Key points that emerged from her evidence were concerns about how FW would cope with caring for both N and Z, particularly given the concern that Z had been exposed to neglectful, inconsistent and frightening parenting. Ms Jones noted that FW had described N as having some particular needs, following him from room to room to be sure where he was at all times.

106. Ms Jones recommended that FW undertake a course of therapeutic parenting with her. Such a course would normally last 8-12 sessions, but she said it would generally be clear by about session 6 whether the parent was willing and able to make the type of changes necessary to allow them to properly care for their child. She also recommended that he undertook grief counselling. If findings of domestic abuse were made in respect of FW then she said he should undertake some form of perpetrator's programme. All this work should be undertaken before Z could be placed in his care.

107. Ms Smith has been the allocated social worker since 30 September 2022. The vast majority of her proposed Care Plan is agreed. There is an issue about the level of contact that Z has with his parents. Ms Smith's view was that this should be limited to once every two weeks for each parent, and then indirect contact on the other week. It is important to ensure that he remains well settled with his foster carer, who he is doing very well with, and his routine is not too disrupted by going to contact. He can remain with the current foster carer long term. She was also going to ensure that there was some sibling contact, though this is more difficult with X at the moment.

108. She was clear that the Care Plan was not for foster care with planned rehabilitation to the parents, although it is hoped that might be achieved in the longer term. This will depend on the progress that each parent makes in the work that they are undertaking.

109. She informed the Court that N had been removed from FW the previous week because of poor home conditions, although the intention was to return him back to FW's care. I note that FW had not informed Ms Smith or the Court of this fact.

110. Ms Smith said that CD did show insight into the situation of the children and had engaged very well with her and was child focused.

111. There was a period when Z appeared to be unsettled and upset prior to contact with FW but that does now seem to have passed. The contact notes of FW's contact with Z are entirely positive

112. The Guardian (Ms Murray) had the same position as the LA.

The Law

113. There is no dispute between the parties on the legal principles and the case law that should be applied in this case. The following represents an agreed distillation of those principles and the considerable volume of applicable case law. I consider that the summary set out below is an appropriate analysis of the relevant caselaw, and it is not necessary to set out the various cases that lie behind this summary

114. The burden of proof is on the Local Authority. There is no obligation on the parents to provide explanations for injuries or 'memorable events' although the court is entitled to weigh the absence of such explanation alongside all the other evidence in the case. The civil standard of proof applies, namely the balance of probabilities. If the Local Authority proves that it is more probable than not that a disputed event occurred, then it becomes an established fact for the purposes of these proceedings. If the event in question is not proved, it is treated as having not occurred. That is the binary system that operates in the Family Court.

115. The court must reach decisions in relation to disputed allegations on evidence, not speculation or rumour. It may, however, draw logical inferences from evidence that it has accepted.

116. The court must reach a conclusion in respect of each separate allegation but must also take care not to compartmentalise its analysis – the entire canvas of evidence must be surveyed and each piece of evidence must be considered in the context of the other evidence.

117. The role of the judge and the expert are very different. The responsibility for making decisions always rests with the judge and not the expert - the expert advises, and the court decides. It is important that the expert evidence in this case is considered as part of the overall evidence in the case and not analysed in isolation.

118. When considering the expert evidence, the court must keep the following firmly in mind.

119. The answer to the issues or an allegation in this case cannot be provided by the expert opinion alone. The expert medical evidence must always be combined with the factual evidence before a proper conclusion can be reached by the court and inevitably the parents' accounts will be an important part of its analysis.

120. The court should recognise that medical science, knowledge and understanding are always developing. Things which are routinely advanced as a matter of accepted medical understanding today may be shown, in subsequent years, to be unfounded or inaccurate.

121. It is important that each expert keeps withing the bounds of their own expertise and defers, where appropriate, to the expertise of others.

122. Recurrence of injury is not in itself probative.

123. If the court disagrees with an expert's conclusions or recommendations an explanation from the court is always required.

124. The evidence of CD and FW is very important. The court will assess their credibility and their accounts carefully. The court will factor in the difficulties and stresses inherent in giving oral evidence and the highly distressing and traumatic nature of the evidence regarding B's death. The court will also be mindful of the fallibility of memory. The court will acknowledge the dangers of inferring that because a parent has not explained how an injury was caused, the real explanation must be a sinister one.

125. The LA alleges that CD and FW have not always told the truth. Where it is alleged that a person has lied the court must approach this allegation with considerable care, as highlighted in ***R v Lucas*** [1981] QB 720. First, having identified the alleged lie in issue, it must ask itself whether the LA has proved, on the simple balance of probabilities, that the alleged lie has been told. The court must accordingly seek to distinguish a lie from, for example, "story creep", mistake, confusion, memory failure or distortion arising from impairment.

126. Once the court has undertaken that analysis it will move to the second stage, by which it will consider why the proven lie has been told. This is important because people may lie for many different reasons - embarrassment, a sense of shame for having caused an injury accidentally, a desire to hide some other wrong-doing or a mistaken belief that lying might improve their position.

127. If a lie is proven, then the relevance of the lie to the court's enquiry must always be carefully considered. Some lies, irrespective of how unpalatable they may be, will have absolutely nothing to do with the ultimate facts in issue of the case, save perhaps assisting the court with an analysis of the person's general credibility.

128. Finally, it is also imperative that the court reminds itself that just because a person lies about one issue, it does not automatically follow that they have lied about everything.

Conclusions

129. CD accepts some elements of neglectful parenting, in particular around the state of the home, but in the main denies responsibility for the vast majority of the matters asserted in the Threshold.

130. CD accepts that she was obsessed by FW and their relationship and that led to her frequently being out of control. In my view, she routinely prioritised that relationship over any proper care of the children. The evidence is overwhelming that she left the children alone on a large number of occasions when they were far too young for that to be appropriate. This follows from the evidence of the police finding Y and Z alone on 23 July 2021, X being found out on the streets alone, and evidence of CD simply leaving Z when a baby on the grass. There are numerous other references where CD left the children to go to FW's house, either to have sex or to check whether there was another woman with him, and leaving the children at home.

131. Although CD considers herself to have been a protective parent, I find that this was not the case. She routinely co-slept with B, despite having been expressly warned by the nurse on 20 December 2021 not to do so. This is particularly troubling given that they were usually sleeping on the sofa, where the risk of CD lying on top of B and her being suffocated was even greater than in the bed. This risk was even further exacerbated by the fact that CD continued to consume cannabis, on her own admission, before B died.

132. On the evening before B died, I find that CD consumed more alcohol than she or RN were prepared to admit. I find that she drove the car home, with three children, when she was drunk, and may have consumed drugs. I base my finding that CD was drunk on Y's account, both to CD and later to FW. This is necessarily hearsay, and I take into account that CD, FW and K have described Y as being something of a fantasist. However, he was very consistent on this point about CD being drunk. I did not think

RN was a reliable witness in respect of how much alcohol CD had consumed. Her aggression and dysregulation in the witness box may well have been a method of obscuring the fact that she was not telling the truth.

133. I place very little weight on what CD says about the night B died. She says she has very little memory, but I note that whatever she did remember was entirely self-serving. I place no weight on her saying she was not drunk because she was not dizzy. It is her evidence that she does not remember coming into the house and going to bed. I do not know whether she had more to drink when she got home, although that is a possibility.

134. It is important to note that CD's behaviour by drinking, and very possibly taking drugs, and then driving home with three children was not just very dangerous for the children, but also incredibly unfair on Y, who in effect then had to take responsibility for his younger siblings. This is an impact which is likely to affect him for the rest of his life.

135. In respect of B's injuries, CD does not suggest anyone else could be responsible for them. No accident or other event has been referred to which could give rise to these injuries. The medical evidence is clear that, with the possible exception of the newer anterior rib fractures, there is no realistic cause other than inflicted injuries by forceful handling. It is highly likely that B would have been distressed when the injuries were caused, but CD chose to ignore that distress.

136. CD's co-sleeping with B undoubtedly put her at risk but would not have caused the injuries which are recorded from the post-mortem and referred to by Professor Arthurs and Professor Mangham. I therefore find that the most likely cause of those injuries is that they were inflicted by CD. There is no evidence that she injured B intentionally, but potentially through a combination of the effect of alcohol and drugs the injuries were inflicted. I note that there is reference to CD being very tired at times, and to B crying a lot. It is not difficult to see that this combination of factors led to CD handling B in a wholly inappropriate way that led to the injuries.

137. In respect of the recent anterior rib fractures, the balance of the evidence is that they too were inflicted injuries rather than the consequence of CPR because of the timing as set out in Professor Mangham's evidence. The evidence on these injuries is less clear cut than on the other injuries because both Professors Arthurs and Mangham accepted that in principle this type of fracture could be a consequence of CPR. However, given the evidence of Professor Mangham I find on the balance of probabilities that they too were inflicted injuries.

138. Similarly, in respect of the SDH the expert evidence suggests that there is no plausible cause other than an inflicted injury, albeit without necessarily any intent to injure. In the light of CD's description of the fall at RN's house it seems highly unlikely that this caused the SDH. I therefore find on the balance of probabilities that this injury was caused by CD.

139. CD accepts that X was beyond parental control.

140. The position in respect of domestic abuse is complex. CD was extremely jealous of FW's other relationships, and at times became completely out of control. I accept that she could be both angry and aggressive and was very intimidating to OM. I accept that on at least one occasion she instigated physical violence on FW.

141. However, the backdrop to CD's conduct is FW's own actions. FW described his relationship with CD as being only about sex. It appears that he has had concurrent relationships with a number of women, many of whom have their own vulnerabilities. He seems to have no interest or insight into the impact of his conduct, either on the women concerned or the children. He has had nine children by four different women and was brazen about the fact that he made no financial contribution towards any of those children who did not live with him.

142. As Mr Bagchi put it, FW's attitude towards women could be described as an exemplar of "toxic masculinity". However, it is important that the court does not set itself up as a moral arbiter, and the court needs to be prepared to accept very different standards of parenting and people with attitudes that the court may itself deprecate.

143. FW views himself as being the victim in these situations because he considers that the women he has had sex with then make false allegations against him. However, in my view he simply fails to take any responsibility for his own actions and choices, and for the effect that has on his multiple children and their mothers. His attitude to those women, including CD, has had the direct consequence of the children being exposed to domestic abuse, including physical abuse. I do not accept that FW has always been the victim of physical assaults and has only acted to defend himself. The situation here, as with so many cases of domestic abuse, is that most of it has happened in private and there is no independent third party evidence. However, in this case there is the evidence of TB, who saw FW being verbally abusive and demeaning to CD, then spoke to CD when she was very distressed in the presence of FW, and then saw CD the next day when she had a number of facial injuries. I have no doubt these were inflicted by FW.

144. Further there is evidence of the neighbour about the incident when CD was pregnant with Z, when FW may not have kicked CD in the stomach, but I do not believe that he was simply defending himself.

145. It is not necessary for me to make findings on each occasion of alleged domestic abuse and who instigated it. I accept that CD is capable of being aggressive and her animosity towards OM led her to assault OM on at least two occasions. It also led her to provoke FW. However, I accept that FW has been the principal physical aggressor, and on the balance of probabilities I find that he did put his hands round her neck, choking her on a number of occasions. They were both responsible for serious incidents of domestic abuse taking place in front of the children. Neither party has much or any insight into the harm they have inflicted on the children through this behaviour, although CD appears to have at least some appreciation of the impact, whereas FW takes no responsibility and appears to have no insight.

146. I accept that FW and CD had sex in the bed whilst FW's daughters were also in the bed. CD made this allegation in a text message to FW and it seems inexplicable that she would have made up this allegation at a point where there was no benefit to her in doing so. Taking the evidence as a whole it is a believable allegation, which I accept.

147. I also find that FW assaulted G on or about 16 March 2021 and caused him bruising and swelling to his left eye. FW accepts that there was some form of altercation with G and the injuries are clearly recorded in the police record. I find it overwhelmingly likely that G's injuries were inflicted by FW.

148. In terms of welfare outcomes, the position is now entirely agreed. Z will be subject to a Care Order with long term foster care at his current placement. The contact will be fortnightly with each parent, and one remote contact fortnightly. Although it is hoped that Z might be able to ultimately return to one of his parents that is not the current plan.

149. X will also be under a Care Order, with contact with CD to be reviewed during his current and future placement.

150. Y will be under a Supervision Order living with his father, SP.