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Case No: FC13C00021

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/08/2013

Before :

MRS JUSTICE PAUFFLEY

- -

Re IA (a Child)(Fact finding; Welfare; Single hearing; Experts reports)

- -

Julian Date for the London Borough of Croydon
Jane Rayson for the mother, CP
Sam King for the father, PA
Deborah Jacobs for the children's guardian, Michelle Dinall

Hearing dates: 29th July – 5th August 2013

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Judgment

This judgment consists of 115 paragraphs. The judge hereby gives leave for it to be reported.

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 name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

Mrs Justice Pauffley :

Introduction and issues

1. On 14th February 2013, the London Borough of Croydon began care proceedings in relation to an infant who had been born that day. The reasons given for the application were commendably brief and encapsulate most of the issues for decision at this hearing.

2. The summary relates that the parents' first born child had died in July 2011 aged 4 months. The cause of death was not identified but post mortem examination had revealed injuries to his leg and ribs which were considered to have been non accidental. It was also said that child's father has a conviction for assault upon his oldest son and no contact with him. In relation to the mother, it was suggested that she

was unable to safeguard her new baby because she was supporting the father. Police bail conditions arising out of the investigation into the injuries sustained by the child who had died did not allow either parent unsupervised contact with any child under the age of 18.

3. On 22nd February, the proceedings were transferred from the Family Proceedings Court to the County Court on the basis that all parties agreed there should be onward reassignment to the High Court. Judge Atkins duly transferred the case on 5th March and it was before me on 14th March. I listed it for a combined fact finding and welfare hearing on 29th July by which time the baby would be 24 weeks old.

4. The hearing itself has been really quite remarkable firstly because of the way in which the local authority and the children's guardian have radically altered their positions in relation to appropriate welfare orders and secondly because the exercise of making welfare decisions has been demonstrated to be comparatively simple when the individuals concerned provide oral evidence.

5. When the case was opened on Tuesday of last week, the London Borough of Croydon was inviting me to make a care order predicated on a care plan of adoption. It was said that even if the mother was not involved in causing the older child's injuries and did not know that he had suffered fractures it would nevertheless still not be safe to return the baby to her care. It did not bode well for the mother's ability to prioritise the child's needs over her own in the years to come, said Mr Date on behalf of the local authority, that it had taken her two years to come to a position of being able to make concessions in relation to failure to protect.

6. At the outset of the hearing, as her written report reflects, the guardian did not support the making of a care order. Ms Dinnall recommended there should be further assessment of the maternal grandmother as a possible Special Guardian. If the mother were to be exculpated in relation to causing the injuries but found to have 'failed to protect' then, said Ms Dinnall, it may have been appropriate to review the potential risks she posed and consider ongoing supervised contact.

7. I had always intended this would be the final part of the process, mindful of the child's urgent need to have permanent arrangements in place at the earliest opportunity. Thus, I was dismayed to find that the maternal grandmother did not feature at all upon the witness template. In response to my disquiet, all parties agreed there was a gap and she should give evidence. Arrangements were made for the grandmother to come to court on Thursday, as an observer, and to give evidence on Friday of last week.

8. At the conclusion of the grandmother's evidence, Mr Date announced that the local authority had been "hugely impressed" by her; and that he would no longer be asking me to endorse a care plan for adoption. There was agreement from the local authority that the child should be placed together with his mother in the grandmother's home. Over the weekend, that plan has crystallised to this – that a residence order should be made either to the maternal grandmother alone or jointly with the mother; and there should be a supervision order for 12 months in favour of a specified local authority in the West Midlands.

9. In similar vein, when Ms Dinnall went into the witness box on Friday, she relinquished her recommendation for further assessment, lending support to the suggestion that the child should be looked after by his grandmother and mother together under the auspices of a supervision order.

10. I have struggled to recall an instance where there have been quite such dramatic changes of position amongst the professionals; and whilst from the family's perspective (particularly the mother's and grandmother's) those shifts were so very welcome, it must also be said that in the weeks leading up to this hearing there have been serious errors of judgment in the care planning exercise.

11. By the time of final submissions, the issues in the case distilled to only these – (i) did the parents' older son sustain non accidental injury or are the origins of his fractures, as Miss King on the father's behalf contends, unknown? (ii) To what extent, if at all, did the mother fail to protect her first born son? (iii) Resulting from the way in which she has behaved since the discovery of that child's injuries, should she be viewed as an individual who presents a risk to a child? (iv) Against the background of the findings made at this hearing and on an overall consideration of the child's welfare needs, if there is to be direct contact between the child and his father what is the appropriate frequency and should it be supervised?

Essential background

12. The background essential to an understanding of the decisions to be made is this. The child at the centre of these proceedings is IA who is five and half months old. He has been living with foster parents since his discharge from hospital a few days after his birth. His mother is CP, aged 25, originally from the West Midlands. IA's father is PA who is 26 years old; he has lived predominantly in South London. He had a previous relationship which resulted in the birth of his first child, EA, in late January 2007.

13. In mid April 2007, when two and a half months old, EA sustained a broken arm – a spiral fracture of the humerus.

14. In late November 2007, His Honour Judge Meston QC found that the fracture had been caused by the father, who had been in sole charge of EA for several hours preceding his admission to hospital. The learned judge found the injury was inflicted as the result of "momentary loss of control through frustration or bad temper." He also found that the father, on occasions, had been unable to control his temper and violent aggression towards EA's mother; and he had, on at least one occasion, directed verbal abuse at EA.

15. In late April or early May 2010, the father pleaded guilty to an offence of causing actual bodily harm to EA and received a sentence of 30 weeks imprisonment, suspended for 18 months; a supervision order for 12 months and 200 hours of unpaid work.

16. At about the time the father was before the Crown Court in relation to the offence involving EA, he met and began his relationship with the mother.

17. Their first child, KA was born in March 2011. He died when almost four months old on 19th July 2011. Police inquiries in relation to his death and the injuries discovered

at post mortem examination have reached no conclusion. There has been no charging decision more than two years on. The mother has been told she is no longer on bail. That has been the situation, apparently, since about the end of February this year.

18. In the aftermath of KA's death, the parents went to stay with the maternal grandmother and her then husband in the West Midlands. In about August 2011, there was an ugly incident when the father punched the grandmother's husband causing him to lose his two front teeth. The father returned to live in London. The mother remained living with her mother but would travel to spend weekends with the father.

19. The parents began to live together again in London in July 2012. Soon thereafter the mother discovered she was pregnant. She referred herself to the local authority on 10th October 2012. There was a pre-birth assessment. The mother is recorded as saying that whilst it had been suggested she believed the father is innocent of allegations of having harmed EA and KA, "she did at some point doubt whether anything had happened in her absence which may have led to KA sustaining the injuries …. her defence of (the father) comes from the fact that she has never observed him to exhibit anger or agitation towards KA throughout their interactions." The mother stated that "if it came down to a choice between the father and her baby, she would choose the baby."

20. IA was born a little earlier than expected on 14th February 2013. Proceedings were begun that day.

21. On 10th April there was a case management conference at which I indicated to the parents in particular that I would be intent, at this hearing, upon making final welfare decisions for IA. I would be scrutinizing the parents' actions in the interim – whether they remained living together, whether they continued to be a couple. I would consider the social work and guardian's assessments; how the parents presented in the witness box, whether either of them could be viewed as adequately protective of their child and, thus, I would decide the long term arrangements for IA.

22. By that stage, as her statement signed on 10th April reveals, the mother had decided to separate from the father. She was inhibited in being able to move away from the property they shared until she had sufficient funds to rent a room close by to the venue where she has contact with IA. She moved out on 6th June but, as she and the father explained in evidence, their relationship was at an end when she decided to separate in April. There was no sexual involvement thereafter, they slept separately and lived separate lives.

23. During the relatively brief period since IA was born, there have been three allocated social workers. Most recently, since 12th June, Ms Jinela Kanii a Locum Advanced Practitioner has been responsible for the case particularly the assessments of the parents and grandparents leading to care planning.

The law – burden and standard of proof

24. Turning from the chronology to the law applicable when a court is conducting a fact finding exercise, I remind myself that it is for the local authority to establish its threshold case – in this instance that KA suffered non accidental injury, that the father rather than the mother was the perpetrator and that the mother failed to protect him

from injury. Neither the mother nor the father has to prove anything. The test to be applied to the identification of perpetrators as to any other factual issue in the case is the balance of probabilities, nothing more and nothing less.

25. It is also relevant in the current context, that I should not forget today's medical certainty may be discarded by the next generation of medical experts or that scientific research may throw light into corners that are at present dark. In similar vein, I must consider – of course – whether there is an evidential basis for concluding that the cause of KA's fractures is or may be unknown.

26. When considering issues of credibility, I remind myself that there are many reasons why a person in proceedings such as these might lie. They may do so for a whole host of motives. Not necessarily because they are culpable but, for example, to protect someone else; or in an attempt to bolster up a just cause, or out of shame or from a wish to conceal disgraceful behaviour from their family. The mere fact that a potential perpetrator lies is not in itself evidence of guilt. It would almost never in this situation be sufficient evidence of culpability to establish that someone had lied. It is an altogether more subtle and delicate process than that.

KA's injuries – non accidental or unknown cause? Required force, timing, mechanism

27. I turn to then to consider the several issues and take first the injuries suffered by KA, the fractures discovered at post mortem. He had two fractured ribs, two metaphyseal fractures of his right tibia (shin bone) and one metaphyseal fracture of his left tibia.

28. As Professor Malcolm, (consultant histopathologist) reports, non accidental rib fractures are almost the only cause of rib fractures in immobile infants. They require the application of significant force, way beyond rough handling. Gripping or squeezing the rib cage with significant and inappropriate force is, in Professor Malcolm's opinion, the most likely cause of KA's rib fractures.

29. The metaphyseal fractures appeared to Professor Malcolm to be of the same age and a little more recent than the rib injuries. They were about 3 to 4 days old whereas the rib fractures seemed to him to be between 4 and 8 days old. In evidence, Professor Malcolm explained that although he could not exclude the potential for overlap as to timing, his belief is that the rib fractures are older. There was no evidence of callus or bone repair in the metaphyseal fractures whereas there was bone callus in the rib fractures. Callus, he explained, "is a bit like scaffolding" and the extent of it provides an indication as to the length of the healing process.

30. Professor Malcolm considered and excluded the potential for various forms of metabolic bone disease, commenting that the histological assessment of bone for the three identified conditions "is much more sensitive and accurate than radiology." He concludes that KA's bones were "entirely normal apart from repair reaction to trauma." In evidence, he said he had read nothing to support the notion that there was an innocent explanation for KA's fractures. In addition, metaphyseal fractures are, as Professor Malcolm advises, "extremely rare outside of non accidental injury"

31. Dr Rylance, consultant paediatrician, instructed for two discrete purposes – to advise as to KA's likely symptoms in the aftermath of injury and also to interpret his blood test results – was asked by Miss King to comment upon KA's calcium levels. He said

that a high calcium level in life could be associated with greater propensity to fractures but here he believed the abnormal levels resulted from the death process.

32. The father's position in relation to the injuries is that he has not caused any injury to his son. He treated KA, he said "like gold." He was "not just (his) son but (his) second hope." Everything, said the father, had been "designed to perfection." The birth of KA had been "like a second chance" to prove himself. Later, the father said he knows that the mother "did not do it." He wants the baby to be placed with her. She is, he said, "the innocent party in this. She hasn't done nothing (*sic*) wrong. She is only in this by association." He had, he said, "put a different taste in her mouth as to who (he) was."

33. The father believes there "must be something else … another medical explanation."

34. Having reviewed the evidence, in all of its various forms across the wide canvas beginning at the time when EA sustained his fractured arm, I am in no doubt as to the origin of KA's injuries. They did not result from some obscure, medically inexplicable condition they were indeed inflicted. And notwithstanding all of those factors which might be said to militate against him having been the perpetrator, so ably highlighted within Miss King's impressive closing submissions, I conclusively conclude that the father, no one else, was responsible for causing the fractures.

35. Now I give my reasons for that decision and begin with the events involving EA in 2007. They are surely relevant and even although the father, notwithstanding an acceptance that he cannot seek to go behind his conviction, now denies he was in fact responsible for what befell EA. Miss King correctly suggests I should resist any temptation to utilise Judge Meston's findings and the father's plea of guilty in the criminal court as the 'foundation stone' or 'building block' for a conclusion that he was the perpetrator of KA's injuries.

36. But the fact of the findings as well as the conviction upon his plea of guilty together with the incriminating remarks made by the father when in discussion with Maria Hunter, a probation officer charged with preparing a Pre-Sentence Report, are surely very relevant when considering the potential for the father to have caused KA's injuries.

37. The father told Ms Hunter he accepted "full responsibility for causing physical harm to his baby but the injury was caused by a momentary lack of control." He expressed deep regret and remorse when in discussion with her believing that his "momentary and hasty actions caused harm yet this is in complete contrast to the love, pride and joy he feels for his child."

38. At this hearing the father said it wasn't true that he had accepted full responsibility but clearly he did. His attempts to deny he was culpable for EA's fracture were both disingenuous and incredible. He sought to do so, I am sure, because he realised the relevance of this part of his history in the fact finding exercise relating to KA.

39. It must also be relevant that there were two periods each of several hours duration during the medical timeframe for KA's rib fractures, namely 12th July 2011, when the father was alone with his son. The mother had gone out shopping with a friend, visited another during the morning and then went out in the afternoon for tea with a third friend. When she returned she did not notice anything amiss but on the following

day, 13th July, KA was "very unsettled, crying and was off his feeds." She had taken his temperature a few times during the course of that day and thought KA might have been teething. He had been, she said in evidence, "quite moaney, grizzly, drinking but not as much as usual." That had been the day when the father was "at probation." The mother remembered messaging him to say she did not know what the trouble was.

40. Throughout the course of the next two days, KA improved and was back to his usual self by the weekend, some three days after he had been on his own with his father on 12th July.

41. Correlating the likely symptoms when a baby's ribs are fractured (loud crying, possible screaming, in most cases for two or three minutes) it seems to me very likely indeed that, if present in the near vicinity, whichever parent did not perpetrate those injuries would have come running upon hearing KA's pain reaction. The mother is unable to describe any such event, almost certainly because she was not at home when the incident occurred.

42. I consider that in all probability, KA's ribs were broken on 12th July 2011 when the mother was out and the father alone was looking after him. KA's symptoms of being unsettled on 13th and 14th July are consistent with the advice as to likely presentation given by Dr Rylance – "he may have been more likely than usual to be irritable and to cry in the first few days following the rib fracture …"

43. As for the metaphyseal fractures, I consider it altogether likely they were caused at the time when the family was in London staying with the paternal family. They occurred, in all probability, when the father lost patience with KA, gripping and twisting his legs with such inappropriate force, perhaps when trying to change his nappy, that there was a shearing between the hard bone and the cartilage of the growth plate.

44. The likely symptoms, according to Dr Rylance would have been of crying, and crying loudly, but relatively briefly. It is comparatively easy to contemplate circumstances in which the metaphyseal fractures occurred within the paternal grandmother's home whilst the father and KA were alone in a particular room, so that no one saw what had happened, and whatever cries ensued could have been ascribed to any number of causes.

45. It is also very significant, when considering the attribution of responsibility for KA's injuries, that the father has a very extensive history of dishonesty about matters of real importance. He was deceitful in his explanations to the mother about what had occurred in relation to EA, as he himself accepts. He said in evidence, he had "kept it very sweet." He said, "I was telling the story; I was the narrator. She (the mother) knew all I wanted her to know. I told her EA's Mum had injured the son."

46. The father did not tell the mother, very obviously, that there had been proceedings in the family court about EA. He did not reveal that adverse findings had been made against him by Judge Meston QC. Nor did he disclose that a forensic psychiatric assessment by Dr Van Velsen in January 2008 had resulted in advice that he would remain a risk to those with whom he becomes intimate unless he sought out assessment and treatment for his anger management difficulties.

47. Moreover, the father practiced a very significant deception upon his probation officer when he concealed KA's existence from him, closing the bedroom door so that the baby's paraphernalia was not in view when the officer made a home visit and somehow arranging for the mother to be absent from the home. The father said in evidence that his probation officer hadn't been "a smart chap at all". He had been trying to protect his family so had "probably told the mother to go shopping or something" on the day of the visit. The father agrees he was not honest but did not seem to me to consider that at all serious or relevant in the current context, as self evidently it is.

48. The father did not impress me at all as a witness. He will say whatever he believes will cause him the fewest problems with the authorities. He volunteered in evidence, somewhat alarmingly, that he "is used to controlling situations; making people see things through (his) eyes; and every time (he has) done that, something has gone bad …. Because of all that manipulation."

49. So there is a level of insight but the persistent problem remains. The father is unable to face up to the scale of his wrongdoing in relation to both EA and now KA. In relation to KA, he must fear renewed police involvement and the potential for further charges to be laid against him.

50. The father has been unable, probably because he is too proud to admit to any weaknesses, to contemplate taking the advice of Dr Van Velsen that he should avail himself of cognitive behavioural therapy. Worryingly, he said at one point in evidence that there are a "few things (he needs) to bury" whereas in reality and very obviously, there is a pressing requirement for him to do the exact opposite – to confront his demons, deal with his anger management problems, seek out treatment for himself to address his difficulties.

51. Finally in relation to KA' injuries, it is to the father's credit that he has not, at any time, sought to blame the mother. He holds her in high regard, credits her with bringing about positive changes in him so that he no longer "walked with certain friends, and (so he contends) became a gentle giant." Everyone, said the father, liked the mother and saw the good she brought out in him. He has never accused her of any wrongdoing, as so often occurs in this situation; and for that he deserves some recognition.

Failure to protect

52. Next I turn to consider the extent to which, if at all, the mother should be seen as having failed to protect KA from harm.

53. 'Failure to protect' arises in various forms and, where established, is always a matter of degree. Cases where such shortcomings are found are as many as they are variable. They are intensely fact specific and call for detailed scrutiny as to what was known, or ought to have been known, as well as the reasons why, if it be the case, certain facts were unavailable to a non perpetrator parent.

54. At one end of the spectrum, there may be serious failure to protect where incidents have occurred whilst the non abusing parent was present, therefore had actual knowledge but nonetheless failed to intervene to protect the child. Other examples of

severe failures would be where there had been a determined attempt to conceal the circumstances in which a child had suffered harm, or enduring collusion of some kind with the perpetrator. At the lower end of the spectrum, a non perpetrator may choose to ignore relatively trivial child protection issues, of which others may be all too conscious, perhaps because wise judgment has become clouded by affection for the other parent. The possibilities are endless.

55. The circumstances prevailing at the time of and leading up to the period when injury is inflicted are all important. It would be manifestly unjust and inappropriate to look back, with the benefit of hindsight, so as to conclude that a parent had failed to protect because of information which became available him / her after key events occurred.

56. Thus, in the current context, it becomes crucial to consider what this mother knew or ought to have known by the time that KA came to be injured. There is, in fact, no dispute. She knew only what the father and his loyal family had told her about events involving EA. The mother was led to believe that the father was essentially innocent of wrongdoing, that the broken arm had been caused by EA's mother and that the father had only pleaded guilty so as to avoid being sent to prison – he'd received advice that imprisonment was altogether more likely if he was convicted after a trial.

57. The mother described within her written evidence how her relationship with the father began, developed and became secure. He came across as extremely genuine; he respected and treated her well. She relates that in the months leading up to KA's death, they had laughed a lot; she felt they had a great relationship and thought she had found her 'soul mate'. She was never shown any violence or aggression. Even when they argued, he did not frighten or worry her. Nor did he ever 'raise a hand' to her. The only occasion upon which the mother witnessed the father as aggressive was when, after KA's death, the father punched her former step father. At that time, as she said, "everything felt very raw."

58. Those who knew the father best, namely his family, maintained his version of history. The paternal grandmother struck the mother as someone who would not stand by if she "felt something was not right and would speak her mind." And yet, when the mother asked her and the father's sister about his previous relationship with EA's mother, they supported him, saying it had been turbulent. The mother believed neither the grandmother nor the father's sister would have been supportive of him if they believed he had done anything wrong.

59. I do not believe she could be criticised for that which seems to me to be an altogether reasonable assumption, particularly given that the father's sister has children of her own.

60. No one opened the mother's eyes to the realities in relation to EA. She had no access to any of the court papers from the 2007 care proceedings. Nor, indeed, did she know of their existence; and that continued to be the position until the interval between her first and second police interviews in 2011 when there was a conversation with the father in which he had told her about EA's family proceedings. She had no contact with the probation service because the father's deliberate ploy was to keep her away from his probation officer. There was no ongoing local authority involvement with the father after the conclusion of the care proceedings in early 2008; and thus no opportunity for the mother to discover the actuality.

61. It is also relevant that the mother was 21 years old when she met the father and only 22 when KA was born. Should she have asked more questions? I don't believe it is fair or reasonable to conclude she should. On behalf of the local authority, Mr Date suggests that at the time of KA's death, the mother's failure was that she did not recognise the warning signals and too readily accepted the father's version of past events. I cannot agree, on a dispassionate analysis of the evidence, that those suggestions are apt. There were no warning signals. She was young and very much in love, entitled to trust what she was told by her partner particularly when his behaviour mirrored the notion that he was anything other than a danger to children.

62. It should be said that the mother, both in her written and oral evidence, has been all too ready to acknowledge that she failed to protect KA. She said that by choosing to get into a relationship with the father, trusting and having a child with him, her son has come to harm. If she had not got into that relationship KA would not have been harmed; and therefore, she said, she has failed her child. As a mother she wanted to do everything she could to protect him so she feels she let her first son down.

63. I have no doubt as to the mother's sincerity. She was an extraordinarily impressive, transparently honest witness, revealing the depth of her sorrow time and time again throughout her evidence.

64. That said, I do not believe she should be as hard on herself as she has been. Standing back as I do, weighing information from all sides, there is in truth nothing to substantiate the claims that the mother should have acted differently, has failed to respond to a developing situation in which the child was placed at risk or otherwise should be seen as blameworthy for what happened to KA. Put shortly and more simply, the mother did nothing wrong. She is not to be viewed as a parent who has failed to protect her son. She is blameless in relation to him.

Events following KA's death – should the mother have behaved differently?

65. Next, I turn to consider whether in the events which have occurred since KA's death, the mother's actions are questionable and sufficient to give rise to a finding that she should be viewed as a parent who cannot be trusted to protect her child.

66. Again with the benefit of hindsight and a good deal of after-acquired knowledge, it is all too easy to criticise the mother for failing to separate from the father, failing to discover the dark secrets from his past and make choices accordingly. It is worthwhile to recall events as they unfolded in the years since KA's death. There were no proceedings in this or any other family court until IA was born, 5 months ago.

67. The police inquiry, so far as anyone is able to judge, has been inordinately slow. No documentation of any kind emerged from that investigation until orders for disclosure were made during the early weeks of these proceedings. No information has been supplied to the mother, notwithstanding her repeated requests of the police. There has been no charging decision.

68. The only documentary material available to the mother has been that disclosed in dribs and drabs as the result of these proceedings.

69. It is said by Mr Date that this bright and articulate young mother should have remained separate from the father after her second interview with the police on 18th August 2011 when she was alerted to the fact that KA's injuries were non accidental and recent. It is also suggested that she should have listened to her family members who were advising her to part from the father and that witnessing the assault upon her stepfather should have warned the mother of the father's potential for losing control. Mr Date also contends that the mother, once pregnant with IA and knowing he would in all likelihood be removed into care, should have prioritized the baby over her relationship with the father and separated from him rather than having their relationship blessed during a ceremony on 18th November.

70. All in all, submits Mr Date, the mother's separation has come very late in the day though the precise time may not be very significant; and her reluctance until recently to accept the father's culpability is both puzzling and worrying.

71. It is often and wisely said that the enlightenment process for the non abusing parent, particularly those who are not found responsible in any way for what occurred, should properly be seen as 'a journey.' It is expecting far too much, indeed it borders on the surreal, to suggest that more or less immediately in the aftermath of whatever defining incident, the innocent and truly ignorant parent should shun the other, depart the relationship and make definitive judgments for herself as to what has occurred.

72. Here, as the mother movingly relates, it is very difficult to describe what it is like to lose a child. It was for her an "extremely lonely and alienating experience." "Everyone around her had known her child had died but no one knew what to say." She had "felt angry and upset that (her own) and KA's privacy had been invaded when everyone came to watch the air ambulance landing in the local school so that he could be taken to hospital." People, said the mother, "had not felt able to ask her how she was or how she was feeling." She became aware she "was making people feel awkward just by being there and being sad." She had stopped wanting to go out, wore sunglasses if she did to avoid eye contact and "pretended she was invisible."

73. The mother explained that she felt the father was really the only one who understood how she was feeling as he was going through the same thing. It had made her unite with him more and she was in no emotional state to start contemplating that he could have been the one who hurt KA.

74. She goes on to describe how, after KA's funeral in September 2011, the intensity of the police investigation died down as did her conversations with the father about what had happened to their son. She knew there "remained a huge question mark which (she) would have to confront. However the weeks and months drifted on and (they) continued in a state of limbo." No one had been asking her to think about what had happened to KA and she "supposed it was easier for (her) to cope with trying to grieve if she did not ask those questions" herself. For about a year the mother, was taking anti depressants and "just about coping."

75. When soon after July 2012, she discovered she was pregnant, the mother had mixed feelings, knowing there was every likelihood she would not be given the chance to care for another baby whilst KA's death was being investigated. She said in evidence she had contemplated an abortion. She had not wanted to bring a child into the world in such unsettled circumstances but she "could not do it – lose one child and then get

rid of another." But she had been "very, very scared." She added she had "brought her second son into the world, he had been separated from her which was not the normal way." She feels guilty about letting her first son down and that "will never go away."

76. I cannot find the mother culpable or deficient in relation to what she has done or omitted to do since KA died. Reading her statements, listening to her evidence, I was profoundly impressed by her ability to describe her feelings. Nothing she described seemed to me to be anything other than the entirely understandable reactions of a bereaved and grieving mother. Her reactions to a rapidly developing situation after proceedings were begun in February this year, to my mind, were entirely reasonable. I find it impossible to be critical of her responses and choices living through events, as they have unfolded, since KA's death.

77. It is noteworthy that, hitherto, most parents in this mother's situation, have had the opportunity to participate at a two-stage care process – fact-finding followed some weeks, even months, later by welfare determination. Because from the child's perspective it was vital so to do, those who were found to have failed to protect have been afforded the opportunity for reflection upon the judgment. There was then the potential for establishing whether there were signs of acknowledgment, sufficient to embark upon a process of rehabilitation. In this instance, there has been no such relaxed opportunity – responses were required in advance of fact finding in order to prepare welfare plans.

78. The impact of the consolidated hearing is that this mother, according to the way in which the local authority puts its case, has been expected to work out causation for herself in advance of the evidence being given, respond accordingly and defend her conduct as far back as August 2011. She is castigated for failing to separate from the father immediately after IA's birth. Those expectations, to my mind, are profoundly unjust. They elevate what might be expected of a parent into the realms of professional reaction; a professional moreover seized of all relevant information.

79. All the signs are that the mother is not only capable of protecting IA, she is alert to the reality which is that she finds herself now in more or less the same situation as a first time mother. She described how KA's death had left her anxious as does the fact that hitherto she has not been IA's main carer. So she is worried about him settling and grateful to know that the support of her own mother will be right there.

80. Finally, in relation to this aspect of the case, I pay tribute to the mother and her Solicitor, Emma Sherrington, for two superbly well drafted, powerful and poignant statements, explaining amongst other things, how the mother's thought processes have developed over time. She explained in evidence how the statements came into being. She spoke to her Solicitor who made notes and then a typed version was prepared. The statements, the mother confirmed, were "100% her input."

81. Read in combination with the mother's evidence, they provide the clearest picture possible of a young woman's struggle to come to terms with the enormity of what has occurred not only to her elder son but also to EA. It is her immense credit that she has been able to work out as much as she has without the benefit of a judgment on the facts.

82. Her responsiveness to her child cannot be in doubt nor her ability, especially when assisted by the maternal grandmother as she will be, to protect IA from harm of whatever kind. I have no doubt at all but that for her he is the most precious thing in the entire world. As she said in evidence, he is beautiful, happy, content, placid, smiley, healthy and "just a real joy."

83. The order which is most appropriate to govern IA's living arrangements, without question, is a joint residence order in favour of the mother and grandmother. The mother's confidence will be enhanced by the making of such an order and it will reflect the actual situation in the maternal grandmother's home. They will look after IA together. The mother will look to the grandmother for wise guidance.

84. The depth of their affection for one another and their ability to strive together to achieve the very best for IA was never better demonstrated than when, after the local authority had announced its dramatically altered position, the mother who had been holding hands with the grandmother at the back of the court, gently laid her head on the grandmother's shoulder. They were in perfect harmony, united in their immense relief that IA would be restored to them and, so it seemed to me, at peace.

The father's desire for contact

85. Lastly as to the issues, I turn to consider the father's desire to have contact with IA, whether there should be provision for any at all, if so at what level and under what conditions.

86. The father's hope is that he might be permitted to see IA though he understands it would be "infrequent and supervised contact, of course." Later, he said he "personally feels contact should be at least once a month and ideally in London but it is what's easier for IA that matters." If it were to be at a contact centre then the father would agree to pay towards the cost.

87. The mother's as well as the grandmother's natural reaction to the notion of continuing contact is that there should be none. They do not believe the father should be anywhere near children but accept that IA will need to know his father. They would comply, I'm quite sure, with whatever arrangements were put in place at the end of this hearing.

88. The local authority suggests the father should see IA on two occasions each year at a contact centre in the West Midlands. Flexibility and negotiation would not be encouraged. Contact between the father and the maternal family should be minimal and there should not be, it is suggested, any contact direct or indirect between the mother and father.

89. Ms Dinall recommends there should be not be any more than two or three occasions of contact per year so that IA should know who his father is and for the purposes of establishing his identity.

90. IA's welfare is paramount when considering the contact question. A number of factors in combination persuade me that contact on two occasions each year, supervised, and in the West Midlands is appropriate.

91. First and most significant, the mother and grandmother are strongly antipathetic to the father and understandably so. For them confronting and preparing IA as he grows older for more regular occasions of contact would be well nigh intolerable. They are likely to need assistance from the supervising social worker in order to manage even two visits a year. Endeavouring to explain to IA why it is that he sees his father in such artificial surroundings and so infrequently, is a matter which will require the most careful handling.

92. Contact at monthly or even quarterly intervals would simply be too much and even although, thus far, the father's interaction with IA has been of uniformly good quality. This hearing has been a watershed. The father has been found to have been responsible for injuring KA. That is the background for consideration of the contact question. Unless and until he confronts his wrongdoing, expresses sincere remorse and undertakes assessment and treatment for anger management there is every reason to be cautious and prescriptive about contact.

93. I agree with the local authority that for the foreseeable future there should be certainty and no opportunity for increase.

94. Contact as between IA and his wider paternal family is and should be a matter for the mother and maternal grandmother. I apprehend no difficulty. There is no ill will and a ready acceptance that it would be to IA's advantage to keep in touch with his paternal grandmother, aunts and cousins. There is no need for any order in that regard.

Case handling by the local authority

95. Turning from the issues for decision to other matters, I cannot leave this case without commenting upon the way in which it has been handled by the local authority.

96. I take account, of course, of the considerable difficulties drawn to my attention by Mr Date in his final submissions – that the social services department is "an unhappy place;" that Ms Kanii, who had no handover from the previous worker has only been in post for six weeks; that there has been a change of team manager during that time and changes of personnel as well within the legal department. Mr Date accepts that the work of assessment undertaken by Ms Kanii was not as thorough as it should have been and the conclusions reached were incorrect.

97. All of that said, I should have been in the position of being able to place reliance upon the social work assessment so as to reach proper welfare determinations for IA. I should have had fair, balanced and proportionate advice resulting from a thorough inquiry undertaken over the five months or so since the proceedings were begun in February. I should have been able to view the social workers as experts in relation to the child's welfare and to repose trust in their decision making.

98. As it is, I am bound to say that Ms Kanii's work was of poor quality, superficial and, most worryingly of all, did not reflect the key principles which underpin the workings of the family justice system. I mention just three – first that wherever possible, consistent with their welfare needs, children deserve an upbringing within their natural families (*Re KD [1988] AC 806; Re W [1993] 2FLR 625)*; second, that the local authority's duty should be to support and eventually reunite the family unless the risks are so high that the child's welfare requires alternative provision (*Re C and B*

(Care Order; Future Harm) [2001] 1FLR 611); and third that orders ratifying a care plan for adoption are "very extreme" only made when "necessary" for the protection of the children's interests, which means "when nothing else will do", "when all else fails." Adoption "should only be contemplated as a last resort" (*Re B [2013] UKSC 33; Re P (a child) EWCA Civ 963; Re G (a child) EWCA Civ 965*).

99. The mother's second statement refers to the difficulty she encountered in speaking with Ms Kanii. She said she found her "quite intimidating" and she gained the "impression she had formed her opinions before really speaking with (her)".

100. I found Ms Kanii to be quite extraordinarily uncompromising. Interested only in repeating her own view and seemingly unwilling to countenance she may have misjudged anyone. Overall, I would have to say she was quite arrogant. She delivered her evidence at breakneck pace and could not be persuaded to slow down notwithstanding several reminders. She referred to the mother throughout as "Mom" which seemed to me somewhat disrespectful. But the most important matter of all is that on any objective analysis, Ms Kanii simply made significant errors of judgment in her appraisal of the mother as well as the maternal grandmother.

101. In relation to the mother, Ms Kanii said it is "her view that she cannot care for IA. She lacks insight into significant harm. She would fail to protect the baby. She would not be able to prioritise his needs over her own." Ms Kanii went on to say that the mother would "struggle to prioritise the child's needs because fundamentally she does not grasp the significance of harm and how that would impact a child."

102. As for the maternal grandmother, Ms Kanii's overall position was that although the grandmother "came across as quite willing, she was not able to prioritise the needs of the child over those of her daughter."

103. Challenged in cross examination by Miss Rayson and Miss King, and very properly so, Ms Kanii was essentially unmoved. Her only concession was that in the event the father was found to be the perpetrator then she favoured some further assessment of the maternal family. Although Ms Kanii denied she had "put the boot in" whenever the opportunity to do so had arisen, I'm impelled to say that Miss Rayson's suggestion was both apt and justified.

104. Ms Kanii's written statement and addendum viability assessments, it has to be said, were perfunctory, lacking in balance and indefensibly critical of the mother and grandmother. I was left bemused that such adverse judgments had been made of the mother in particular when the content of her written statements had given me such cause for optimism. My sense was that Ms Kanii could not have read and assimilated the mother's statements and yet she said she had. More bewildering still was the thought that the mother must have presented very similarly in discussion with Ms Kanii to the way in which she reacted in the witness box. And yet, such harsh judgments were made. It seems to me that Ms Kanii was operating in a parallel universe, intent on securing a placement order whatever the strengths within the natural family.

105. Finally, in relation to this, two things should be said. First, I strongly believe – though cannot know – that Mr Date as the head of the local authority's team intervened during the course of last week so as to retrieve an increasingly hopeless situation. If I

am right about that, then I would wish to express my gratitude to him or to whichever individual it was who reconfigured the local authority's position.

106. Secondly, I would wish to emphasise that the mother as well as the maternal grandmother was a very impressive witness. Great store was put upon the impact of the maternal grandmother's evidence both by the local authority as well as Ms Dinnall. Their rationale for shifting positions was that her testimony had provided such a level of reassurance that other options were put to one side.

107. My view of the mother is as favourable as the altogether positive impression created by the grandmother. The mother is still very young. In the last two years, she has experienced unspeakably traumatic events. The ordeal of the last five months and the inherent anxiety leading up to this hearing should not be underestimated. She has the incalculable advantage of a loving, nurturing and wise mother who is not only willing but strongly enthusiastic about the plan for IA to be looked after by them both.

Dr Rylance's report

108. The very last matter for comment arises from Dr Rylance's report. When I sanctioned his instruction in February, it was on the basis that he should "provide a short report on KA's clinical presentation following the injuries sustained and …interpret blood test results." Ms Jacobs letter of instruction explicitly referred to the President's very recent Practice Direction in relation to Experts. She attached a copy to her letter. Although there is no mention of it with the correspondence, Ms Jacobs informs me that Dr Rylance was requested to confine his report within 10 to 12 pages. He apparently said he was content to do so.

109. When he gave evidence, Dr Rylance confirmed he was aware of the reforms to the way in which experts are now required to report, that they should be succinct, focused and analytical and should avoid recitals of too much history and factual narrative.

110. Dr Rylance's report was 35 pages long. There was a reasonably lengthy section comprising the relevant background information (5 pages) extrapolating material from reports of other doctors and the medical records. Dr Rylance then dealt with the following issues – Timeframe for fractures; Possible / likely mechanism/ causation of rib fractures; Possible / likely mechanism / causation of right tibia metaphyseal fractures; Force to cause the fractures of the 4th and 5th ribs laterally; Force to cause metaphyseal fractures. He devoted about 5 pages to the issues of likely reaction at the time of and in the aftermath of injury and to whether or not a non perpetrator would have had awareness. Over the course of 5 pages, he provided advice upon the potential for there to have been a medical explanation for the rib fractures. Dr Rylance then tackled the explanations given by the parents and gave an opinion on plausibility before turning to consider (on page 25) the post mortem blood test results and their significance. He also provided an opinion as to the likely cause of the rib fractures.

111. None of the foregoing was requested. Those matters did not form any part of his instruction and for the obvious reason that Professor Malcolm had already reported in relation to them.

112. On page 27 of his report, Dr Rylance turned to consider and answer the specific questions asked of him, referring as he did so to many of his earlier paragraphs, as relevant, and repeating their content.

113. In the 1980s and 1990s before it became the norm for experts (particularly paediatricians and psychologists) to produce absurdly lengthy reports, courts were routinely confronted with, for example, radiological reports in the form of letters which extended to about a page and a half. Professor Christine Hall at Great Ormond Street Hospitals was masterly in her ability to distil essential information and opinion within an impressively succinct report.

114. Her contributions to cases of this kind, and she was but one example of the then general trend in radiology, contained all the judge needed to know about the nature of the injury, mechanism, force required, likely acute and sequential symptoms, whether a proffered explanation was consistent with the injury as revealed or not.

115. Reports of that kind were singularly helpful. The modern way exemplified by Dr Rylance's over-inclusive and doubtless expensive report is no longer acceptable. Experts must conform to the specifics of what is asked of them rather than, as here, provide something akin to a 'paediatric overview.' I struggle to recall a single instance when such expansive and all inclusive analysis has been of real utility in a case of this kind.