IMPORTANT NOTICE

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

Neutral Citation Number: [2025] EWFC 174 (B)

In the CENTRAL FAMILY COURT
In the matter of THE CHILDREN ACT 1989

And in the matter of D, E, and F (Children)

Between:

A local authority

Applicant

and

J

1st Respondent

and

K

2nd Respondent

and

D, E, and F (Children)
(through their Children's Guardian)

3rd to 5th Respondents

SAM WALLACE and SAMUEL PROUT appeared on behalf of the applicant
ANNA MCKENNA K.C. and Dr. MARTINA VAN DER LEIJ appeared on behalf of the first respondent
MARTIN KINGERLEY K.C. and CATHERINE PISKOLTI appeared on behalf of the second respondent
ANARKALI MUSGRAVE and KELLY WILD appeared on behalf of the children

Hearing dates 13, 14, 15, 20, 21, 22 January 2025
Judgment handed down with parties present on 3 March 2025

JUDGMENT
OF HER HONOUR JUDGE SAPNARA
3rd March 2025

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1. This judgment follows a fact-finding hearing within care proceedings. The subject children are D (a girl aged 8); E (a girl aged 4); and F (a boy aged 2). Care proceedings were instituted in respect of all three children by the applicant local authority, on 3rd November 2023.

2. Children's mother is J and their father is K. The parents are both now aged 29. The children are represented through their Children's Guardian.

3. The children were removed from their parents care on 28th October 2023. All three children were made the subject of interim care orders on 9th November 2023. F has remained in the mother's care in a mother and child foster placement. D and E have been placed together in the care of a paternal great aunt since August 2024. This aunt is a professional of a child protection social work background and is now a Children's Guardian.

4. Care proceedings were instituted as a result of all three children being infected with gonorrhoea. The local authority's case is that all three children contracted gonorrhoea from an adult or adults with whom they came into contact prior to 27th October 2023.

5. It is accepted between the parties that:
    a. on and around 16 October 2023, the mother was infected with gonorrhoea.
    b. on 28th October 2023 D and E had gonococcal infections in their throats, vaginas, and rectums.
    c. on 28th October 2023 F had a gonococcal infection in his throat.

THRESHOLD ALLEGATIONS

6. In its schedule of findings, which was amended on 20th January 2025 during the hearing before me, the local authority invites me to make the following findings:

    a. The results of vaginal swab tests taken from D and E on 19th October 2024, and repeated at the hospital on 28th October 2024 confirm that both children had been infected vaginally with gonorrhoea.

    b. Further rectal and throat swabs taken from D and E at the Hospital on 28th October 2024 confirm that both children had been infected with gonorrhoea in the throat and rectum.

    c. A swab test taken from F's throat at the hospital on 28th October 2024 confirmed that F had been infected with gonorrhoea in his throat.

    d. The vaginal infections of gonorrhoea found in D and E were likely to have been contracted in the period from the moment of sexual contact for mother – July to late August 2023 (i.e. up to 2 – 3 weeks before the mother first noticed that the children were displaying symptoms on 19th September 2023). That constitutes a period of 10 weeks or 70 days of intimate living connection between the mother and the children.

    e. On 13th October 2023 the mother attended a sexual health clinic for testing after experiencing symptoms (one week of a thick, offensive smelling vaginal discharge). The mother reported to the clinic that her last sexual contact had been around one month previously. Testing undertaken that day confirmed that the mother had contracted a vaginal infection of gonorrhoea.

    f. Whilst the rectal infections of gonorrhoea found in D and E could have occurred through passive transmission from vagina to anus, the most likely mode of transmission for the vaginal infections of gonorrhoea

found in D and E and the pharyngeal infections of gonorrhoea found in all three children is sexual.

g. On the balance of probabilities, each of the children were infected with gonorrhoea as a result of them being sexually abused by an adult perpetrator and the local authority identifies the following adults as being in the pool of possible perpetrators:
    i. The mother
    ii. The mother's casual sexual partner L (from whom the mother asserts that she contracted gonorrhoea).

h. As a consequence of being sexually abused each of the children has suffered significant sexual and emotional harm.

i. If the Court finds as a fact that the children were infected with gonorrhoea as a consequence of being sexually abused by L then it follows that the mother has failed to act protectively in respect of the children by providing a truthful account as to whether L was ever present within the family home at the same time as the children, and whether he therefore had the opportunity to cause the children significant sexual and emotional harm.

7. The evidence was properly tested on behalf of the Children's Guardian and in closing submissions, the Guardian does not seek positive findings against the mother.

8. On behalf of the mother, findings (a) – (d) are accepted. Finding (e) is partially accepted in that the mother disputes the accuracy of the record and states her last sexual contact was early August. She confirms that she did test positive for gonorrhoea on 13 October.

9. The mother does not accept findings (f) – (i). Her case is that all the children were infected with gonorrhoea by non-sexual transmission. The father supports the mother's case.

10. At the outset of the fact-finding hearing, the local authority's schedule of findings included a finding against the father in that he was included in the pool of perpetrators in respect of allegation (g).

11. The father has always denied ever sexually abusing his children or allowing anyone else to do so. Throughout the proceedings he asked for the children to be placed in his care. He continues to seek this outcome if findings are made against the mother. Following close of the local authority's case on Wednesday 15th January, the local authority amended its schedule of findings. It no longer sought any findings against the father and withdrew its case against him.

12. By that stage, there had been little if any positive case against the father put to witnesses, and I took the view that, on the evidence placed before me, it was an appropriate and responsible position for the local authority to adopt and I approved the removal of the father from the pool of potential perpetrators.

13. I note that the social work evidence in respect of the father is positive. He was assessed as being present for the children and playing an active role in their upbringing. He was described as a loving parent who has demonstrated that he is available to support his children, able to prioritise his involvement in their care and to advocate for their needs.

14. Upon being informed that the children had been infected with gonorrhoea, the father is recorded to have been present for hospital meetings, home visits, and contact sessions (which are overwhelmingly positive).

15. The father has maintained his position in written and oral evidence, and in closing submissions, that he does not know what happened. He expressed an interest in finding out what it was that led the three children to being infected with gonorrhoea. His case has been consistent that he does not believe the mother has sexually abused the children nor does he believe that the mother would have allowed them to be sexually abused. He has known her since she was 13 years old and been in a relationship with her from the age of 15. He

points to the fact that the children have never made any allegations which could support the findings sought and he believes that D and E would have said something if anything untoward had taken place.

16. The parent's case is that they should both be exonerated from any findings; the interim care orders should be discharged in respect of all three children, and they should return to the care of the mother. Thereafter, it is agreed between the parents that the child arrangements in place, as at September 2023, which involved the children spending time with their father, should resume.

17. On any view this is a complex case. I am asked to decide whether the unchallenged fact that the three subject children of these proceedings have each contracted gonorrhoea in multiple sites is attributable to having been sexually abused or infected accidentally - either through contact with the mother directly, or from surfaces which she has infected and thereafter that they contracted it from each other.

18. I heard the case over 5 days, 13th - 15th and 20th - 21st January 2025. I have read the relevant documents in the eight trial bundles; further evidence as admitted during the hearing and heard the oral evidence of the following witnesses:

- Dr R (the GP to whom the mother brought D and E when they were showing signs of infection);
- Dr Ghaly (an expert genitourinary consultant);
- Professor Masterton (an expert medical microbiologist);
- The mother;
- The father.

19. I received written closing submissions filed by the parties on 22.01.25, and further submissions by way of responses on behalf of the mother and on behalf of the Guardian on 23.01.25.

THE LAW

20. The parties agreed a note of the law in a document dated 9 January 2025. Further case law was cited on behalf of the mother and the Guardian in written closing submissions. I have considered all those documents and will now set out the relevant applicable law.

The scope of the fact-finding exercise:

a. The court is considering whether s.31(2) Children Act 1989 is satisfied. That requires two conditions to be met:
    i. The "significant harm" condition (that (at the relevant time) the subject child was suffering or was likely to suffer significant harm); and
    ii. The "attributable" condition (that the harm was attributable to the care being given to the child not being what it would be reasonable to expect a parent to give).
    (As summarised by Peter Jackson LJ in Re B (Children: Uncertain Perpetrator) [2019] EWCA Civ 575))

b. The court is concerned at this hearing with establishing key facts on which it will ultimately reach a welfare decision: what happened, who did it, when, and how. The court is not obliged to place (or try to place) its findings within the criteria of any particular criminal offence (see A and B and C [2023] EWCA Civ 360, §§16-21).

c. Where children have suffered harm the court will endeavour to identify who is responsible. Per Wall J in Re K (Non-accidental injuries: perpetrator: new evidence) [2004] EWCA Civ 1181:

[55] As a general proposition we think that it is in the public interest for those who cause serious non-accidental injuries to children to be

identified, wherever such identification is possible. It is paradigmatic of such cases that the perpetrator denies responsibility and that those close to or emotionally engaged with the perpetrator likewise deny any knowledge of how the injuries occurred. Any process, which encourages or facilitates frankness, is, accordingly, in our view, to be welcomed in principle.

[56] As a second background proposition, we are also of the view that it is in the public interest that children have the right, as they grow into adulthood, to know the truth about who injured them when they were children, and why. Children who are removed from their parents as a result of non-accidental injuries have in due course to come to terms with the fact that one or both of their parents injured them. This is a heavy burden for any child to bear. In principle, children need to know the truth if the truth can be ascertained.

Standard and burden:

a. The burden of proof rests on the local authority throughout to prove the allegations contained in its threshold document. The burden of proof must not be reversed. It is not for either parent to prove or disprove the allegations.

b. The standard of proof is the simple balance of probabilities and the burden of proving any allegation falls on the party asserting it (Re B (Children) [2008] UKHL 35).

c. A fact alleged will either be found to be proved or not proved to the requisite standard (LB. Southwark v. A Family [2020] EWHC 3117), per Sir Mark Hedley:

[43] As ever, in the consideration of these issues one must start with Re B (Children) (Care Proceedings: Standard of Proof) [2008] UK HL 35. The sharpest analysis of the standard of proof is to be

found at paragraph 2 in the speech of Lord Hoffmann where he says this:

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

[44] That is clearly the law, although as everyone will immediately recognise, it does not accord exactly with the realities of human life as it is experienced, but it is perhaps inevitable if we are to have a system of law that we have a rule of that sort.

d. A failure to discharge that burden does not automatically justify a conclusion that the assertions have been invented or that the alleged events never took place (Re P (Sexual Abuse: Finding of Fact Hearing) [2019] EWFC 27), per MacDonald J:

[243] A failure to find a fact proved on the balance of probabilities does not equate, without more, to a finding that the allegation is false (see Re M (Children) [2013] EWCA Civ 388 at [17]). Having heard and considered the evidence it is open to the court to conclude that the evidence leaves it unsure whether it is more probable than not that the event occurred and, accordingly, that the party who has the burden of proving that the event occurred has failed to discharge that burden (see The Popi M, Rhesa Shipping Co SA v Edmunds, Rhesa Shipping Co SA v Fenton Insurance Co Ltd [1985] 1 WLR 948).

e. In *Re M (A Child)* [2012] EWCA Civ 1580 Ward LJ held that the judge had fallen into error in taking the view that *"absent a parental explanation, there was no satisfactory benign explanation, ergo there must be a malevolent explanation. And it is that leap which troubles me. It does not seem to me that the conclusion necessarily follows unless, wrongly, the burden of proof has been reversed, and the parents are being required to satisfy the court that this is not a non-accidental injury".*

f. Re U (A Child) (Serious Injury: Standard of Proof); Re B (A Child) (Serious Injury: Standard of Proof) -Case Law – VLEX 804424317 "*The responsibilities of local authorities under the Children Act 1989 had not been changed by the decision in R v Cannings. However, the following considerations emphasised by that judgment were of direct application in care proceedings: the cause of an injury or an episode that could not be explained scientifically remained equivocal; recurrence was not in itself probative; particular caution was necessary in any case where the medical experts disagreed, one opinion declining to exclude a reasonable possibility of natural cause; the court always had to be on guard against the over dogmatic expert, the expert whose reputation or amour propre was at stake, or the expert who had developed a scientific prejudice; and the judge in care proceedings should never forget that today's medical certainty might be discarded by the next generation of experts or that scientific research would throw light into corners that were at present dark….."*

g. The court is not limited to making only those findings sought by the applicant. It may make additional / alternative findings as long as such findings are securely supported by the evidence and do not undermine the fairness of the hearing (Re G and B (Fact-finding Hearing) [2009] EWCA Civ 10; Re B (a child) [2018] EWCA Civ 2127; Re A (No.2) (Children: Findings of Fact) [2019] EWCA Civ 1947, para.93-99).

The evidence:

a. Findings of fact must be based on evidence not speculation. Munby LJ observed in Re A (Fact Finding: Disputed findings) [2011] 1 FLR 1817 (para 26) "*it is an elementary position that findings of fact must be based on evidence, including inferences that can be properly drawn from evidence and not suspicion or speculation*".

b. In that task the court should survey the "*broadest canvas*" of evidence before it. Hayden J in Lancashire County Council v M, F, and J [2023] EWHC 3097 (Fam):

> *[44] … section 31(2) of the Children Act 1989 requires the Court to focus not only on the significant harm sustained by the child but on its attributability. Inevitably, within the home environment, there are unlikely to be witnesses. The investigative process must track down ascertainable facts from the broadest canvas available and, where possible, draw such inferences as those facts will support. It is frequently a difficult task, but it is not one that can be shirked. The danger in failing to confront it is that an innocent individual may be tainted by a finding that has a direct impact, both on her and on the child. A finding which leaves a parent in a pool of perpetrators is likely to adversely influence the nature and extent of the contact arrangements or indeed, on where and with whom the child will live in the future. Of course, the imperative of child protection must not generate a reason to burden unsatisfactory evidence with a greater weight than it can legitimately support. That would create an injustice to all, not least the subject children, but neither does it absolve the Judge of the responsibility to confront the findings that the evidence properly establishes. The same obligation for forensic rigour applies to the lawyers.*

c. Reviewing the broadest canvas of evidence before it does not mean that the court requires all conceivable evidence or "*perfect*" evidence to make a finding. Baker LJ in J, P, and Q (Care Proceedings) [2024] EWCA Civ 22 said:

> *[72] … the fact that at one stage there had been, or might have been, other evidence relevant to the allegations did not prevent the judge proceeding to make findings on the evidence put before her. In almost every case there will be potentially relevant evidence that for one reason or another is not adduced at the hearing. One other example in this case was that neither J nor Y gave oral evidence. Had they done so, it is possible that the judge may have reached a different conclusion on J's allegations. The fact that material evidence is "missing" does not preclude a judge reaching a decision on the basis of what is available. Mr Twomey is, of course, right to say that the judge has to consider the wider canvas. There may, of course, be cases where the available evidence is so thin – where substantial parts of the canvas are empty or obscure – that, applying the burden and standard of proof, a finding cannot fairly or properly be made. But that was plainly not the case here.*

d. When approaching allegations of sexual abuse the court should ask first whether there is evidence of sexual abuse and then whether there is evidence of the identity of the perpetrator (AS v TH (Fake Allegations of Abuse) [2016] EWHC 532 Fam, para.31). All of the evidence the court has read or heard should be considered in context. Per MacDonald J in AS v TH:

> *[24] The decision on whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and should have regard to the wide context of social, emotional, ethical and moral factors (A County Council v A Mother, A Father and X, Y and Z [2005] EWHC 31 (Fam)). Where the*

evidence of a child stands only as hearsay, the court weighing up that evidence has to take into account the fact that it was not subject to cross-examination (Re W (Children)(Abuse: Oral Evidence) [2010] 1 FLR 1485).

[…]

[26] The court must not evaluate and assess the available evidence in separate compartments. Rather, regard must be had to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward has been made out on the balance of probabilities (Re T [2004] 2 FLR 838 at [33]).

e. Hearsay evidence is admissible in proceedings concerning children (Children (Admissibility of Hearsay Evidence) Order 1993 / SI 1993 No.621) and the court retains broad powers to control evidence under Part 22 FPR.

f. The proper approach to an individual witness' evidence was described by King LJ in Re A (A Child) (Fact Finding) [2020] EWCA Civ 1230, [2021] 1 FLR 815:

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

[41] The court must, however, be mindful of the fallibility of memory and the pressures of giving evidence. The relative significance of

oral and contemporaneous evidence will vary from case to case. What is important, as was highlighted in Kogan, is that the court assesses all the evidence in a manner suited to the case before it and does not inappropriately elevate one kind of evidence over another.

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

Lies and witness credibility:

a. Just because a person has lied in one aspect of a case does not mean they have lied about everything. A finding that a person has lied about one issue does not, in and of itself, confirm the truth of any allegation(s) against them. It does not - necessarily - undermine the truth of other areas of their evidence (Re H-C (Children) [2016] EWCA Civ 136, para.97-100).

b. A "*Lucas direction*" may assist the court with the general credibility of a witness (or witnesses), although per Re A, B, C (Children) [2021] EWCA Civ 451:

[57] To be clear, and as I indicate above, a 'Lucas direction' will not be called for in every family case in which a party or intervenor is challenging the factual case alleged against them and, in my opinion, should not be included in the judgment as a tick box exercise. If the issue for the tribunal to decide is whether to believe A or B on the central issue/s, and the evidence is clearly one way then there will be no need to address credibility in general.

However, if the tribunal looks to find support for their view, it must caution itself against treating what it finds to be an established propensity to dishonesty as determinative of guilt for the reasons the Recorder gave in [40]. Conversely, an established propensity to honesty will not always equate with the witness's reliability of recall on a particular issue.

Where it is unclear who has harmed a child or how:

a. Re B (Children: Uncertain Perpetrator) [2019] EWCA Civ 575 offers a structure for the court's decision where an allegation cannot be proved to the civil standard against a single, identified individual:

[49] The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: Re D (Children) [2009] EWCA Civ 472 at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'.

b. Each step in the route described in Re B (Children: Uncertain Perpetrator) - the "*proper approach*" according to King LJ in Re A (Children) (Pool of Perpetrators) [2022] EWCA Civ 1348 - ought to be reflected in the court's judgment if a pool finding is reached.

c. The court must take into account, to the extent that it considers to be appropriate in any given case, the possibility of an unknown cause (see R v. Henderson and Butler and Others [2010] EWCA Crim 126 and Re R (Care Proceedings: Causation) [2011] EWHC 1715 (Fam), para.10).

d. The court will approach with caution the inherent probability or improbability of any particular cause or event but consider each case on its own evidence. Per MacDonald J in A Local Authority v W and Others [2020] EWFC 68:

[78] […] In particular, the authorities make clear that in every court case of this type, the answer is not to be found in the inherent probabilities per se but in the evidence, and that it is when analysing the evidence in a specific case that the court takes account of the inherent probabilities as appropriate (see Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35, [2009] 1 AC 11, [2008] 2 FLR 141 and Re BR (Proof of Facts) [2015] EWFC 41 (unreported) 11 May 2015). Thus, in the context of the general population it is less likely that a child presenting with S's symptoms will have been smothered or overlaid than it is that he will have been the victim of a natural event. However, in the context of the evidence in this case, the inherent probability of smothering or overlaying as against being victim of a poorly understood natural event will necessarily be different because inherent probability is sensitive to context.

[79] In the circumstances, the proposition that an organic cause of respiratory arrest or suppression in a child is inherently more probable than deliberate or accidental suffocation is generally true for the population at large. However, the validity of that proposition becomes increasingly strained where the context that falls to be considered having regard to the evidence in this specific case is not that of the general population at large but rather that of a child living in a chaotic household in which domestic abuse and drug and alcohol abuse was prevalent, where S's parents were the subject of significant stressors in the form of a lack of finances, exhaustion, lack of support and social isolation, where there had already been a drunken incident causing S to fall to the floor, where the parents had put in place unsafe sleeping arrangements for their children, including co-sleeping, where on one parent's evidence S was found

face down in a pillow and where the parents claim to have awoken at just the right time to resuscitate S.

Findings that a parent has failed to protect their children:

a. The court should be cautious not to make a finding that any parent failed to protect their child simply as a bolt-on to a finding that the child suffered harm. There must be a causative link to show that the parent who has failed to protect was aware (or ought to have been aware) of the harm the children were suffering or were likely to suffer. In Re L-W Children [2019] EWCA Civ 159, [2019] 2 FLR 278 King LJ observed:

> *[64] Any court conducting a finding of fact hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J (A Child) [2015] EWCA Civ 222, [2015] All ER (D) 229 (Mar), 'nearly all parents will be imperfect in some way or another'. Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that, for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm.*

Cases considering similar circumstances to the present case:

a. Re A, B, and C (children) (fact finding: gonorrhoea) [2023] EWCA Civ 437, [2023] 2 FLR 683:

i. The case related to the attribution of significant harm arising from an established gonorrhoeal infection in children.
ii. In Re A, B, and C the judge at first instance had been wrong to appear to conclude that the mere presence of infection in a child was determinative in the question of whether the child has experienced ill-treatment. The presence of infection is a piece of evidence to be weighed against all other substantial evidence.
iii. In such cases the court should not consider the identity of a perpetrator separately from the question of whether the child has been ill-treated, as each enquiry could be relevant to the other and should be part of the overall assessment of the evidence including the absence of positive evidence of physical sexual abuse, expert evidence as to modes of transmission.
iv. While the court may reach findings other than those contained in the local authority's pleading, part of ensuring that conclusion is securely founded in the evidence is allowing the point to be fairly put to the respondents and dealt with by counsel in submissions.

b. Some of the risks of procedural error illustrated in Re A, B, and C can be avoided by following the court's guidance in Re B (Uncertain Perpetrator), a case in which the court was also considering a gonorrhoeal infection in children (per Peter Jackson LJ at para.52 of Re B):

> *as part of the court's normal case-management responsibilities it should at the outset of proceedings of this kind ensure (i) that a list of possible perpetrators is created, and (ii) that directions are given for the local authority to gather (either itself or through other agencies) all relevant information about and from those individuals, and (iii) that those against whom allegations are made are given the opportunity to be heard. By these means some of the complications that can arise in these difficult cases may be avoided.*

Recent Family Court cases in which judges have considered cases of gonorrhoeal infection in children:

d. Liverpool City Council v M and others [2024] EWFC 318 (B). In which His Honour Judge Greensmith, following Re A, B, and C (above) that the infection of a child's eye with gonorrhoea was not itself determinative of sexual abuse. The evidence in that case did however support the transmission of that infection due to the conditions of the home environment and unhygienic actions of one of the alleged perpetrators. The judge found that the child had suffered significant harm, perpetrated by her uncle, because that man had known that he was carrying the infection when he frequented the home, continuing with low standards of personal hygiene (including leaving infected towels and bedding available to the children), and had known or should have known that his infection could be transmitted to others.

e. Wiltshire Council v M [2021] 6 WLUK 107. A local authority sought permission to withdraw care proceedings as the evidence available did not readily identify whether a child's gonorrhoeal infection had been the result of sexual abuse or by transmission from another infected child at nursery school. The width of the pool of perpetrators made a fact-finding investigation disproportionate and unwieldy without likelihood of a meaningful outcome.

THE BACKGROUND

1. The parents met and commenced a relationship in 2010. In 2017, after D was born, the mother and child moved to the family home. From this point until May 2023 the father shared his time between the mother's home and his great grandmother's home. They separated in 2023, because of the father's infidelities. In 2020, he had a one-night stand with an individual whose name he does not recall and another one-night stand with another individual in May 2023.

2. No party disputes that this is a “single-issue” case. However, it is to be noted that although not relevant to the fact-finding exercise, there were some historical concerns relating to the parent’s care of the children which are mentioned in the agreed chronology. On 24 June 2020 Midwifery referred the family to the London Borough of Brent, raising concern that the mother was using cannabis during her pregnancy with E. A while after the birth of E, on 14 December 2021 the father was convicted of drugs offences (possession with intent to supply on 13 July 2019). He was sentenced to eight months in prison, suspended for 24 months. After F’s birth, Probation Services referred the family to the local authority on 7th June 2022 for a safeguarding check (arising from the father’s conviction for possession with intent to supply class A drugs.) This check was unsuccessful as the children could not be identified / located from information given by Probation. On 10 October 2022 D’s school contacted the GP as D had been burned accidentally on the cheek by her aunt’s cigarette the previous day.

3. Following their separation in May 2023, the parents acknowledge that they argued throughout the summer months of 2023, but they highlight that they nonetheless continued to co-parent the children. There is no evidence to suggest that the children were exposed to, or otherwise adversely impacted by their parents’ relationship post separation. Both adults maintained the children's stable and regular routines and activities.

4. The father moved out of the family home in May 2023 and thereafter returned to stay with the family regularly most nights of the week. He otherwise stayed with his grandmother with whom he now lives full time. The father maintained regular contact with the children and had them stay overnight and alternate weekends with him. He was seeing them on almost a daily basis and sharing school and runs and facilitating the children’s social activities with the mother.

5. Prior to the children contracting gonorrhoea, each parent tested positive for sexually transmitted infections. On 31st May the mother tested positive for infection with chlamydia and was prescribed antibiotics.

6. The children spent regular time with the father including consecutive overnight stays from May to October. On 5th June the father underwent sexual health screening. He tested positive for infection with chlamydia and was prescribed antibiotics. He tested negative for gonorrhoea.

7. He reported having had three sexual partners in the preceding three months and believes he contracted chlamydia from the one-night stand in May 2023. Thereafter the father spent time in hospital with a urinary tract infection and on 28 June he again tested negative for gonorrhoea.

8. The evidence indicates that D and E began experiencing vaginal discharge by no later the 19th September. The father observed vaginal discharge in D between the 14th to 16th September 2023 which is a period during which the children were spending the weekend with their father. The father noticed that D had experienced some discharge after toileting and during bathtime. The father told his aunt (the carer for the two girls) about this, and he also spoke to the mother about it. But the agreed chronology records that the mother herself noticed discharge in D and E's underwear on 19th September. It is noted in the chronology that the father recalls that the mother told him that she was aware and was sorry she had not mentioned it and told him she would be seeking medical advice.

9. On 23 September 2023 the mother called NHS 111. Dr P returned the mother's call. The mother described first noticing a yellowish-brown discharge in E's underwear on 21 September 2023. E and D were prescribed topical antifungal cream (clotrimazole) and paracetamol as required.

10. There is no dispute that the mother had contracted gonorrhoea around the time that the children contracted the same. There is no dispute that when the GP, Dr R, administered the swab test on 4 October 2023, the results established that the children had contracted gonorrhoea. The local authority's case is that the most likely explanation for the children's infections, and in particular the vaginal infections identified in D and E is that one or more child has been sexually abused. In closing submissions, the local authority states that thereafter, it is

possible that inadvertent, nonsexual transmission has taken place between the children and between sites on each child (this appears to be a submission based on the opinion of Professor Masterton, as it emerged in oral evidence, and it is not how the local authority case is pleaded in the threshold document.)

11. In written closing submissions, the local authority asserts that it is highly unlikely that all three children coincidentally contracted gonorrhoea from environmental factors unless their mother's hygienic practises were so poor as to be unreasonable (this is not specifically pleaded as an alternative in the threshold document).

12. The local authority contends that the mother withheld information about her sexual relationships and asserts that these omissions suggest she is hiding something because she either knows how the children became infected in the first place or she is trying to conceal her own culpability.

13. In late July / early August 2023 the mother had a one-night stand with an individual she met online, L, in late July / early August 2023. She believes she contracted gonorrhoea from this encounter. He is the person referred to as "L" in the threshold document.

14. The mother was diagnosed with gonorrhoea on 16 October 2023. Once the mother herself was diagnosed she notified Dr Q, a GP at the practice the mother and children were registered with, immediately on the 16th of October 2023 it was the mother who called and asked for the girls to be tested. The social worker noted that the mother called 111 immediately after she spotted symptoms in E on the night of Friday 22nd of October after a bath. The mother relies on these matters as evidence in support of her case that she had been seeking clarity about the children's symptoms and chasing the surgery for results.

15. D was attending school in September 2023. Prior to the diagnosis of gonorrhoea, and other than the matters I have referred to contained in the agreed chronology, there has never been any concerns expressed by the

school, GP, social care any other individual or statutory agency about any aspect of the care of the children. Children services noted that the children were meeting their developmental milestones.

16. Each parent has been noted to have interacted with the children in a warm, spontaneous and caring way, even when they were undergoing intimate examination at hospital by Dr S, the consultant clinical lead from the local SARC service on the 29th October 2023.

17. As the Guardian notes, there has been an exceptionally high level of commitment and support to both the parents and children from members of the wider family, and as a result all three children have continued to thrive.

18. No party disputes the general view in cases such as this a finding of gonorrhoea in children is both rare and most commonly as a result of sexual abuse. It is after all, commonly classified as a sexually transmitted disease. However, the medical profession does recognise that non-sexual transmission can occur.

19. Although a diagnosis that a child clinically presents with gonorrhoea cannot be presumptive of sexual abuse, it is obvious that the index of suspicion would be raised in such circumstances. The Royal College of Paediatrics and Child Health's guidance in respect of sexual abuse ("Purple Book") is clear on this *" the presence of suspicious ano genital signs or the diagnosis of an STI cannot be used in isolation to establish whether or not a child has been sexually abused"*

20. Established case law requires that in reaching my conclusion, I must take into account the wide canvas of evidence available to me. This means that the clinical presentation cannot be viewed in isolation and must be considered in the context of evidence relating to wider social and environmental factors. The children's lived experience is an important factor to weigh in my considerations.

21. This approach is also embedded in the clinical approach to such a diagnosis as set out in the Purple Book at chapter 1.

"*It is important to consider all physical findings together with other important clinical information including the history, the context, the child's or young person's behaviour and demeanour, and statements made by the child to professionals, in order to make the diagnosis. The medical assessment will contribute to the whole picture which includes multi agency assessment.*"

22. There are features of this case which are unusual. These are three high functioning children, who were living in a single household and receiving care from their single mother. The entire household became infected with gonorrhoea. In the experts meeting which took place between expert Professor Masterton and Dr Ghaly on 13 May 2024, Professor Masterton expressed the opinion that *"this is an extremely unusual case, I have never come across a case like this in my clinical practice".* Dr Ghaly agreed.

23. On behalf of each parent, in closing written submissions, it is submitted (and I accept) that a number of common risk factors associated with cases of child abuse, for example as contained in the NSPCC common assessment framework, do not feature in this case. It is asserted that they are conspicuous by their absence. They are:

    a. *Physical or mental disability in children that may increase caregiver burden*
    b. *Social isolation of families*
    c. *Parents' lack of understanding of children's needs and child development*
    d. *Parents' history of domestic abuse*
    e. *History of physical or sexual abuse (as a child)*
    f. *Past physical or sexual abuse of a child*
    g. *Poverty and other socioeconomic disadvantage*
    h. *Family disorganisation, dissolution, and violence, including intimate partner violence*
    i. *Lack of family cohesion*

j. *Substance abuse in family*
k. *Parental immaturity*
l. *Single or non-biological parents*
m. *Poor parent-child relationships and negative interactions*
n. *Parental thoughts and emotions supporting maltreatment behaviours*
o. *Parental stress and distress, including depression or other mental health conditions*
p. *Community violence*

Additionally, I note that the children were not hidden away from professionals and the community. They were registered with their local GP and fully vaccinated. D regularly attended school and D attended a number of extracurricular activities including gymnastics, football, jujitsu, learning circus skills and also attending a music club. It appears that she flourished in these activities and was awarded a couple of scholarships as a result.

24. Furthermore, it is submitted (and I accept) that there are a number of recognised protective factors in respect of these children and their family. These are:
    a. *family environment. The children live within an extended maternal and paternal family network which has been supportive of the children and both parents throughout these proceedings. Many members on both sides engaged with the family group conference. Some of these family members have attended contact and been prepared to be assessed by social services as potential carers for the children. Both sides of the family remained loyal to the mother, and she has been well known to the father and his family since she was 15 years old. She is now 28. As I have mentioned the paternal great aunt is a social worker and children's guardian.*
    b. *Nurturing parenting skills*
    c. *Stable family relationships*
    d. *Household rules and monitoring of the child*
    e. *Adequate parental finances*
    f. *Adequate housing*

g. *Access to health care and social services*
h. *Caring adults who can serve as role models or mentors*
i. *Community support*

25. Other than the expert opinion evidence, there are a number of other relevant factors to take into account in my analysis of the evidence and I will set those out now.

26. The social work evidence is that these children have received good care from the parents. The mother has been the primary carer. In terms of their development, Dr T the paediatric consultant at The hospital and Dr S, consultant clinical lead from a local SARC service described D, at the age of 7 when they saw her, as being articulate for her age.

27. The social worker's observation was that E was meeting her developmental milestones and developing particularly well in her self-care and her communication skills.

28. There is no evidence of any infected male carer or visitor who has come into contact with the children.

29. There is no evidence of any physical indicators of sexual abuse in any of the children. D and E have been seen, examined physically and questioned on a number of occasions. There has been nothing seen or heard that would raise concern that they may have been sexually abused.

30. I take into account that the absence of a specific allegation of sexual abuse and/ or the absence of clinical findings of sexual abuse in a physical examination do not refute that sexual transmission has occurred. My attention is drawn on behalf of the local authority to the decision of the Court of Appeal in Re A, B, and C (children) (fact finding: gonorrhoea) [2023] EWCA Civ 437, [2023] 2 FLR 683. The seven-year old child who was the subject of those proceedings and who had tested positive for gonorrhoea, made no allegation of abuse and when questioned directly by professionals had emphatically

denied that any form of sexual abuse had occurred. Nonetheless having been remitted by the Court of Appeal and by the time it was reheard, the child then aged 8 went on to make a specific allegation that she had been sexually abused by her mother's partner.

31. E was seen by Dr. R on 4th of October when she was examined and swabbed and there were no signs of sexual abuse reported. No allegation was made by the child. When D and E were seen by Dr. R on 19th October, they were examined and swabbed but there was no report of any physical signs of sexual abuse nor anything either child said which would have given rise to the possibility of sexual abuse.

32. On 28th of October 2023, Dr. T examined and swabbed all three children in the knowledge that concerns about sexual abuse were live. He reported that the mother attended when the children were medically reviewed by him. The children underwent full examinations including external genital area and a repeat of the swabs that the mother had previously taken at home. His conclusion in respect of D was that there were no concerns raised by this examination, there was no bruising or trauma. He recommended that a further examination would be needed to be done. No child said anything that would give rise to concern about sexual abuse.

33. Dr S from the local SARC service conducted a sexual health medical and reported on the 29th of October. She had seen and examined both D and E. There were no signs of sexual abuse seen and no allegation made by either child. In respect of D the doctor recorded that the child was healthy, fully immunised and that all milestones were normal. There was no bruising, the hymen was normal. There was no discharge or dry skin on labia majora. This was a 7-year-old with normal development physically and normal ano genital anatomy. Similarly in respect of the child E, who was upset during the examination and had to be held by the mother, her hymen was normal. More swabs were taken. The conclusion was that the child's milestones were all normal and she was developing appropriately. It was noted by the doctor that

the child attended nursery and spoke clearly and interacted warmly with both her parents.

34. F was examined on the 14th of November 2023 by Dr. U who reported on 22nd November 2023 that there were no genital injuries. Examination was normal and there were no signs of sexual abuse seen.

35. Despite being questioned a number of times by professionals in both formal and informal settings, none of the children have alleged or reported even the possibility of sexual abuse. There were no behaviours of concern witnessed by anyone. Nor have the children made any allegations to the father. Despite being seen by a range of professionals at school, the GP, doctors, social workers, foster carers, contact supervisors there is nothing that any child has said that would indicate that they have been sexually abused by the mother or anyone else. It is recorded in the social worker's statement dated 6th of November 2023 that the father had asked D if anyone had stayed at their house, and she had said nobody had. Indeed, a decision was made by the police on 15th November 2023 not to video record interview D as she had been questioned already by multiple professionals. It is notable that no allegations have been made by these children despite having been placed in eight different foster care placements since October 2023.

36. At the time the children were received into care the social workers evidence is that the designated safeguarding lead teacher at the school expressed no concerns in respect of D and E. It is also significant that no allegations have been made by D in the context of her being engaged in age appropriate dialogue around safe touch on the 6th of November 2023 by the social worker SW1 in which the child confirmed that *"she does understand everything under pants is the private area of her body and nobody is allowed to touch her there"*. When asked if anybody had touched her there, D said "no".

37. On 28th October 2023 at the hospital, Detective Constable A and the social worker SW2 spoke to both D and E. D immediately told them about staying over at her father's home and that they shared a bed when the children stayed

over. E was too young to have a conversation but neither child said anything which could amount to “disclosures” of abuse or inappropriate sexual experiences, and the social worker recorded that there were no safeguarding concerns raised. Both children appeared happy.

38. When Detective Constables A and B together with the social worker SW1 spoke to D and E separately on the 9th of November, no allegations were made. The professionals spoke to E about bed and bath time and about pants. It is recorded by the professionals that no safeguarding concerns were raised during this conversation. D was willing to talk about the reason for attending hospital for medicine, and private parts and also about bath time and bedtime. Similarly, she made no allegations

39. When repeat tested at the hospital on the 29th of November 2023 and seen by the GP Dr R again on 15th December 2023 when he examined and swabbed D and E, no allegations were made.

40. It is notable the child protection professionals, including the medical profession, police and social workers have all recorded the high level of love and warmth between the children and each parent. The parents have been cooperative with professionals. The mother agreed to section 20 accommodation at the outset of proceedings and her interactions with the local authority have been positive. She is recorded as having taken steps to ensure that the foster carers had sufficient information about the children when the two younger children were removed from her care and placed in foster care, so that they were settled in their placement, and she recognised that they should feel safe and have stability. The police records confirm that on 29th October, for example, the mother readily permitted the social worker and DC A speak with the children alone.

41. Neither the father nor the extended family network holds any belief in the allegations

42. So that is a summary of the social and environmental context of this case.

THE EVIDENCE OF THE WITNESSES

Dr R

43. Dr R is a GP at the practice the children and mother were registered with. The local authority in closing submissions says that little turns on Dr R evidence. It is correct to say that the evidence of the doctor does not go to the heart of how the children may have contracted gonorrhoea, but I consider it is relevant to my assessment of the credibility of the mother.

44. Doctor R is clearly a very busy and a committed doctor. In my judgment he was well intentioned and tried his best to assist me. Unfortunately, his written evidence as well as his oral evidence was confusing and flawed, in a number of respects. The first statement he submitted, contained a number of inaccuracies, and in his oral evidence it transpired that it was not even written by him. He then attempted to clarify matters (unsuccessfully) by producing a second statement. He told me his understanding was that this second statement would replace the original. Overall, his oral evidence like his record keeping, was rather chaotic in content at times.

45. The entry in his written record that in summer 2023, the mother was behaving in a way to "get back at the father" was challenged as inaccurate on behalf of the mother. Dr R's evidence is that the mother informed him she had an affair and deliberately became pregnant as an act of spite against the father because of his infidelity. On behalf of the mother, it is submitted that such a claim is in itself *"preposterous"* and furthermore, the fact that Dr R did not record this anywhere undermines the credibility of his evidence on this issue. The mother denies ever having made such a comment or being motivated in this way to become pregnant.

46. In fact, the doctor's evidence was broadly consistent with the mother's own evidence. In light of this and matters I set out below, and despite the shortcomings of his evidence, I find that this entry made by Dr R on this issue is likely to have been accurate.

47. There is no dispute that the mother did have a sexual encounter which resulted in her becoming pregnant and undergoing a termination. The fact of the pregnancy was only revealed when the medical records were made available in these proceedings.

48. What Dr R says on this disputed issue is reflected in the minutes of the strategy meeting where it is recorded that he informed the meeting that the mother got her own back, became pregnant by someone else and had a termination. This information was taken by a minute taker at the strategy meeting and attributed to Dr R rather than contained in the GP's own notes. The mother's case is that she did not tell the father until 19th October about her one-night stand and that was the day she sent the photo of a man in her bed; that she never told father about the pregnancy or the termination; and that the pregnancy was only revealed when the medical records were disclosed. In my judgment, those facts do not operate to dislodge the reliability of what was recorded by the note taker. The mother cannot be criticised for not having informed the father of the pregnancy and subsequent termination, but the mother's own evidence confirms that her interactions with the father at the time in summer 2023 were spiteful and targeted, for example sending him the photo of another man in her bed. Her oral evidence confirmed this - she told me that she was going to send the photograph to the father to say *"look there's another man in your bed"*. On the balance of probabilities, I'm inclined to prefer the evidence of Dr R over that of the mother on this issue.

49. It is clear that some mistakes were made in what the mother is recorded to have said and done since the involvement of social services. The index of suspicion against the mother would inevitably have been heightened and gained momentum, through a series of errors made by professionals in the early stages of their involvement.

50. The social worker’s statement refers to the mother providing differing accounts of family members who had access to the children. The social worker records the mother wrongly stating that only the father and the paternal grandmother lived at the father's home because the social worker's own case notes record that the mother had informed her four days before that the father’s sister and his brother stay overnight.

51. Furthermore, the social worker asserted in her written statement dated 6 November 2023 that the mother informed her that the children do not have sleepovers, which conflicted with the account the father had given when he informed the social worker that the mother and children had indeed stayed overnight with a female friend. It appears that in the social workers own notes, made four days earlier on the 2nd of November 2023, she recorded that the mother had told her that the children stayed overnight with her at her friend’s home.

52. The mother takes issue with Dr R's evidence in terms of the accuracy of his records and the negative impact of these in the approach professionals took towards her and that it also placed the father under suspicion. The impression gained from Dr R's recordings was of a mother who had delayed in taking the vaginal swabs that had been given to her to administer at home and also in delivering them to the surgery for testing. The mother was diagnosed with gonorrhoea and she reported this fact to Dr Q on the same day - 16th of October 2024. I accept the submission on her behalf that the record clearly demonstrates that she did so without hesitation and purposefully. Dr R erroneously recorded that the mother first reported her diagnosis to him on the 19th of October. That error was repeated in a later statement in respect of E. Contrary to Dr R's repeated assertion in his written evidence, it was not the case that the mother was uncontactable by Dr Q.

53. During the course of cross examination of Dr R, it emerged that the local authority’s contention that the mother delayed in administering the swabs and returning them was incorrect. Doctor R's evidence was that the hospital

only received the swabs on the 25th of October. However, the laboratory records demonstrate that the results were recorded and available from 4:00 PM the day before on the 24th of October. His evidence was that when a patient delivers swabs to the surgery for testing, they are told to call back for results after four to five days. Given that the results were available from the 24th of October, it follows that the mother must have delivered the swabs four to five days earlier, and therefore she delivered them promptly. It is likely that she did so on the 20th of October, and this is what the mother told the GP as it is recorded as having been done on the 20th of October 2023

54. Thereafter, the surgery evidently chased the mother to deliver the swabs on the 23rd and 24th of October in error. Because it is likely that the swabs were already in the laboratory and being processed by 4:00 PM on the 25th of October.

55. Doctor R saw the results, he told me, late at night on Thursday the 26th of October. He recorded that the mother admitted to him that she had contracted gonorrhoea from her partner who had an extramarital affair. That is at odds with what he recorded a week earlier on the 19th of October. The doctor recorded *"this is a different discussion to four weeks ago - but a full discussion was not had at that time with mum".* What is contained in the GP records of 31st of October 2023 is a reference at 17.44 PM to the doctor calling the mother and the mother reporting that she had gonorrhoea, but that the father did not. The error was repeated in medical records on the morning of 27th October that the mother was known to have shared with her GP Dr R that both she and her ex-husband had gonorrhoea following an affair that he had before and had caught the STI as a result.

56. The strategy meeting on 3rd November 2023 refers to the conversation which took place between the mother and a police officer. The mother informed the police that she had tested positive for chlamydia in June following the father's affair which led to their split. It also referred to the mother having another sexual partner who did not meet the children at the address and that this partner had given the mother gonorrhoea. They clarified that the mother had not been with

the children's father sexually since their split. The police were then intending to interview the mother under police caution.

57. On 28th October, the social worker took a history from the mother. That account is consistent with what the mother told the police and told me in oral evidence, following her having been made aware of wrongly recorded entries of Dr R.

58. It is submitted on behalf of the mother, and I accept in general, the more reliable note taking is seen from social services and the police and that these are consistent with the accounts given by the mother.

59. Dr R attended the strategy meetings in relation to the family. There is a clear error relating to Dr R recording that the father was only the father of E and F but not D. This error was incorporated into the social worker case notes and repeated by the doctor's colleague Dr V at the strategy meeting dated 27 October 2023. Dr R recorded that when he made a call to the mother on the 7th of November 2023, the mother corrected the error. Dr R asserted that the mother had admitted to not using the vaginal cream properly in his statement of 27 December 2023. But the entries in the patient case notes do not record this. Neither is this to be found in the entries of the doctor's associate, MK on 13 October 2023.

60. In his first written statement he says that the mother called the practice to say that she did not want to use the cream prescribed. However, the GP records demonstrate that it was the surgery who called the mother (nothing turns on who called whom) and that the mother explained in that call that she was concerned about using the cream due to poor prior reaction.

61. Doctor R is clearly a very busy General Practitioner. I have no doubt that he is a dedicated and conscientious GP. I do not consider that there was any bad faith in him recording these errors, nor any bias towards the mother (not that such criticisms were advanced on behalf of the mother). In fact, I note that at the strategy meeting on 27 October he is recorded to have stated that *"he has*

no suspicion of [the mother] but appreciates this may not be enough to reassure professionals". However, his rather chaotic and inaccurate record keeping, difficulties in him interpreting them in a coherent way and his ability to explain how the electronic noting system recorded information, together with his at times inaccurate notes (not always having been contemporaneously recorded) and his contradictory evidence, significantly limits the reliance I can place upon his evidence. At points during his oral evidence, it was clear that he could not recall and struggled to articulate events accurately, particularly in respect of any interactions he had with the mother; this difficulty was no doubt compounded by the passage of time.

62. Unfortunately, the number and range of inaccurate entries within Dr R's records, coupled with multiple corrected versions of his statements, is likely to have negatively influenced other professionals, including the police. The police records for the 6th of December 2023 demonstrate that the entries made by Dr R had been taken into account as part of their investigation and it was not until then that the police took the view that the documentation of those conversations with the mother were not detailed and did not offer any clear information on what exactly was discussed or said by anyone during those consultations.

63. Findings are not sought against the father, but in relation to him also, the doctor recorded an entirely inaccurate account when he stated that the mother had contracted gonorrhoea from the father or another. There is no dispute that the father had a relationship with another person. When questioned about this in evidence Dr R conceded *"there is room for there to have been a misunderstanding or the individual communicated it in a way which was picked up in that way"*. Clearly, if relied upon this could have had a negative impact in respect of the father and his role in the children acquiring the infection.

64. It is likely that the sequence of events originating with the factually incorrect/ inaccurate entries about the mother's conduct had contributed to the impression that she was being inconsistent and evasive, the subtext being that she had something to hide. Furthermore, it was the doctor's incorrect recording

that the father had been the one to contract gonorrhoea and passed it on to the mother which put him under suspicion and landed him in the pool of perpetrators. The incorrect information from Dr R was incorporated early on into the police records. There is a reference to mother contracting *"NG [gonorrhoea] from her partner the children's father"*. Having incorrectly recorded the conversation on 19th October, the matter rumbled on and the doctor fell into further error in recording on the 7th of November, among other confusing matters, that the mother had called to clarify that she had contracted chlamydia from the father and gonorrhoea from the extramarital affair. The records indicate that it was the surgery who had called the mother. This is consistent with the mother's evidence.

65. In oral evidence Dr R was emphatic that in what he had recorded as a *"frank conversation with mum"* at a consultation he had with her on the 19th of October, he clearly communicated to her that the situation would be escalated and *"would become a child protection case".* He also said that he explained to the mother fully about the role of social services and the police and the need for the mother to engage with them in the event of the children swabs returning a positive result for gonorrhoea. He was emphatic in confirming his written evidence about what he informed the mother. The mother disputes Dr R's account and says there was no mention of police or social services. The doctor's entry for that date is *"advise if positive for STI this would become a child protection case".* In my judgment it is likely that he would have attempted to have mentioned the issue of child protection in some form but possibly did not communicate it as expressly and clearly as he believes, particularly in the presence of all three children. I accept the submission on behalf of the mother that if this had been said as Dr R asserts, then D being of the age and intelligence and articulacy she has been reported to possess, would have understood what was being said and would have questioned the mother about it later, which she did not.

66. I can place no reliance upon the doctor's assertion that he gave the swab kit to the mother to take home during a consultation on the 4th of October 2023. Other than recalling swabbing taking place in November with the foster carer, Dr R

was unable to recall whether he took swabs from E on 4th of October or whether the mother was sent away with a swab kit to do this at home. His oral evidence was that he would have expected at this stage to have swabs taken at home. I prefer and accept the clear, consistent and confident account the mother gave as to how the swab was taken from E in that that the doctor performed the swab test there and then in her presence in the consultation. In light of the chronology of the lab testing and results which were available shortly after 11:00 AM on the same day, it is highly unlikely that the doctor's account can be accurate because this would have required the mother to have taken the child home, perform the swab, return the sample to the surgery and for testing to have been performed in that time scale. From his oral evidence it appears likely that he has misremembered and that in the general arrangements at the surgery, it was the swab that was performed at the surgery that was the one that was taken away as one of the two regular daily collections which resulted in the results at 11:14 AM that day.

The mother

67. There is an abundance of evidence that the mother loves her children, has cared for them well and that there are warm loving interactions between them.

68. The mother is essentially of “good character” in the sense that she has no criminal history and no prior involvement with the police. She comes from a stable and close, loving birth family and she has positive relationships with the extended family network.

69. The social worker acknowledged that the mother presented at GP with concerns of vaginal discharge and the social worker took the view that this evidence is a strength and a protective factor in respect of her abilities to ensure her children's health is prioritised.

70. Social work observations of her have been largely very positive. This is reflected in the social worker’s initial statement dated 6th November 2023: *“From Social Work observations since the referral to the Local Authority*

on 27/10/2023, [the mother] has demonstrated a loving and insightful approach to her children's needs. [the mother] has prioritised seeing the children for contact when this has been arranged. She has continued to be thoughtful and organised to ensure any items they need have been brought to them. This evidences that [the mother] is able to show her children she is thinking of them, and that she is present and available to them. It is also my view that [the mother] has good capacity to demonstrate emotional warmth, love and attentive care for D, E and F. These highly positive parental capabilities are evidenced by observations of Social Worker's during hospital visits and contact sessions thus far, which she has continued to demonstrate, despite experiencing significant emotional distress being asked to live separately from her children."

71. The local authority and the Guardian submit that the mother has been an untruthful witness in respect of some matters. There remain areas of concern about the mother's evidence. During these proceedings, I am satisfied that the mother has told some lies or otherwise been less than open and candid.

72. In her oral evidence to me the mother conceded that she had used cannabis, on a daily basis prior to the 2nd of November 2023. It was submitted on her behalf that such response demonstrated candour. However, that is not the account that she gave to the police at interview when in answer to a question about whether she used any drugs she gave a flat response of "no". Similarly at the LAC medicals of E and F on 29th December 2023, she told professionals she did not take drugs. I reject her evidence to the effect that she simply understood the questions to be confined to her usage at the time she was being questioned, as utterly disingenuous. I have formed the view that the mother is an intelligent and articulate woman, and she must have appreciated the context of the questioning. In my judgment she deliberately withheld this information. Her motivation for doing so is likely to have been because she knew it would be adverse to her interests to admit to it and to provide a full and honest answer. The fact that she readily informed me of her previous daily use of cannabis knowing that it would not paint her in a good light, does not excuse her lack of candour about this to the professionals.

73. Similarly, I find the mother has not been forthcoming in relation to not disclosing that she had a second, basic, “brick phone” even though she acknowledged that she would use the phone to speak with others. The mother handed in her phone for inspection on the 4th of April 2024 at court. The expert inspecting agency, “Evidence Matters”, provided their report and all extracted messages on the 11th of April 2024. The mother's case is that this second phone was a spare one and of limited value because it did not have internet and was mostly broken. The father's oral evidence confirmed that the mother had difficulties with all the phones that she has ever owned since BlackBerry days. I also take into account also that there are messages in October between the mother and her sister or her friend about the other phone not working, not sending messages, having died or broken.

74. I note that there was no specific mention by the mother of the existence of an additional “brick phone”. At the time of the forensic analysis of the mother's phone the local authority points to there being no call logs prior to February 2024. I note however that the agreed instruction to the investigating agency stipulated that this should only be disclosure for the period between 1st July 2023 and 28th October 2023 and then only disclosure of material identifying keywords as listed. I understand that attempts were made to extract the requested data but this turned out not to be possible using the usual tools. Therefore, disclosure was made by way of screenshots of various apps and conversations.

75. Even if it is the case that the absence of call logs prior to February 2023 does not represent subterfuge by the mother but rather reflects the court's order and the work of the expert agency instructed, it remains the case that at no time did the mother make clear that she had this additional device when surrendering her Samsung smartphone for interrogation by the Evidence Matters agency. She did not inform any professional that she used two phones. Her explanation that nobody specifically asked her does not explain or excuse this omission. I accept what the Guardian has to say in closing submissions that it would have been very obvious to the mother over the course of these

proceedings that professionals and the court were very interested in the contents of her communications and so it would be obvious that she should have mentioned this. Her failure to do so does raise a question mark about why she failed to do so if there was nothing of concern that would be disclosed as a result. That does not mean that anything material would have been disclosed or that it would have been incriminating in any way and I cannot enter into speculation as to what it might have revealed. The burden of proof must not be reversed, and it is not for the mother to provide the local authority with evidence to support its case.

76. On behalf of the mother it is highlighted that there is evidence contained repeatedly in text messages sent in July, September and October indicating the existence of the second phone and so it is correct to say that a request/ application for the production of that phone could have been made by the local authority or the Guardian over a 9 month period and this evidence could have been obtained but no such request or application was made.

77. I am also satisfied that the mother has not been truthful about her sexual history when speaking with professionals. The undisputed collective expert opinion is that the incubation period for gonorrhoea is a few days to around two to three weeks. It is clear on the evidence that the mother's account changed as to the number and timing of her intimate partners, after D and E had moved into foster care. This is a time during which she was subject to police investigation and about to undergo a police interview on the 1st of November. The WhatsApp messages between herself and her friend in July 2023 would indicate that she was involved in a degree of sexual activity at the time, and she sought advice in relation to this from that friend on 17th July 2023. I am satisfied that the mother was seeking to obscure the true history of her sexual activity around this time. In my judgment it is likely she was motivated to do so because she knew that this would potentially cast suspicion on her culpability, but it does not mean that she sexually abused the children or allowed them to be sexually abused.

78. I am afraid the mother's account in respect of the sexual encounter and interactions with a man named L was unsatisfactory. I accept the submission on behalf of the Guardian that the paucity of evidence the mother provides about L is concerning and is at odds with an otherwise conscientious mother who is intelligent and articulate. The total lack of curiosity on her part about who he is and to follow up with him once she found out about the gonorrhoea or to try and establish any way in which she could contact him lacks credibility. I accept the submission on behalf of the Guardian that the mother's account that she and L, having spent approximately two months texting each other on the dating app before having casual sex, never reconnected again is implausible. She has provided no real detail of time location or identity.

79. This case has already demonstrated that professionals can make mistakes in recording information. The mother has been correct about other medical records containing wrong and misleading information. The mother has been consistent in her evidence about the fact that L was a one-night stand and the only sexual contact she had since separating from the father in May 2023. She has referred to it as being just one stupid mistake. Her telephone and text messages to friends have not identified any communication regarding any further sexual partner. However, on the evidence available to me, it is likely that the mother has been far more sexually active than she has been prepared to acknowledge.

80. It is correct to say that there is no evidence to support any contention that she had more than a one-night stand with L himself or that the children ever met him either at their home, in the community or when staying with the mother at the home of the mother's friend on one single occasion. In fact, the father reported to the social workers that he asked D if anyone had stayed at the house, and she said no one had. I note that during the summer of 2023 the children regularly spent time with the father and extended family. There is no suggestion that the children have mentioned to anyone that they have met anyone who might be L.

81. The sexual health clinic record notes an account of the mother informing that she had slept with three men instead of one. The notes reflect that she told the clinician she had three sexual partners in the preceding 3 months, one of whom she had unprotected sexual intercourse with one month before her first appointment. The local authority submits (and I accept) that this timing - sexual intercourse taking place a month before the medical appointment on 13th October 2024 is more in keeping with the typical incubation period for gonorrhoea. In her oral evidence, the mother was unable to account for this discrepancy and simply said she did not know where they got the figure of 3, as she had only mentioned 1.

82. In light also of my findings about the paucity of evidence she has provided about L and her lack of candour about having another telephone, taken together with it being unlikely, in my judgment, that a sexual health clinic (a large focus of which would have specifically been on the issue of sexual contacts) would have mis-recorded this information. This is a significant discrepancy between her evidence to me and what is recorded – even if this account attributed to her was only recorded on the one occasion on 13th of October and thereafter simply repeated on 16th of October. Furthermore, there was the additional detail that the mother provided that all three contacts were traceable on the 16th of October. I remind myself of the Lucas direction. I can discern no innocent explanation for this lie. In my judgment, the reason she has lied about this is because she knows and understands the potential link to the concerns in this case and in telling these lies, she was seeking to distance herself from any potential blame or suspicion. This does not mean the threshold allegations are established. Anyhow, there is no evidence to contradict her account that since these proceedings commenced, she has deleted the dating app ("Hinge") and has not been active on that app or any other dating app.

83. The local authority raises the possibility that the mother has lied because she is protecting a third party who might be the source of the gonorrhoea. In my judgment that is speculative and is not founded on any evidence.

84. In her interaction with Dr. R on 27 October 2023 when he telephoned her to inform her that the children had tested positively for gonorrhoea, she now acknowledges that she did lie about where she was, claiming to have been in Birmingham when she was in fact at home. In closing submissions on her behalf it is conceded that her reaction was *"totally wrong".* The doctor reported to the strategy meeting on 27th October that the mother informed him she would be returning on Tuesday 31st October. The mother and father agree that, for reasons which are unclear to me, the father was not around to support her as usual during October. The mother was entitled to have some time away from the children and had apparently made plans to go to a concert with friends and stay over in a hotel in Birmingham. She told me she had been planning this for some time and discussing it with her friend. Whatever the truth of that, she first told Dr. R this lie about being in Birmingham when he called her on 27th October.

85. In the general scheme of things, it seems to me it would have been unusual for the doctor to have contacted the mother so late at night on 26th of October, but it is likely that, in the particular circumstances of this case when the children had tested positive for gonorrhoea, the doctor was very concerned and wanted to address the matter urgently. Doctor R was clear and consistent about this aspect of his evidence and whatever the shortcomings of his record keeping, and other aspects of his evidence may have been, I am inclined to accept the truth and accuracy of this part of his evidence and what he told the mother about the need for the children to be presented to the hospital that evening. The doctor's account is corroborated by what the mother is recorded as having told the social worker on the 2nd of November 2023. She said hearing from the GP that the police and social services were involved, she panicked, and lied about being in Birmingham, but when going to the hospital on Saturday morning, she says she realised she *"messed up."* That was an account that the mother repeated to the police in her interview four days later on the 6th of November 2023. The mother's evidence was that she had informed the professionals the truth about the Birmingham trip *"at the first opportunity".* That is not true. The fact is she repeated the lie twice to the social worker, SW1 in telephone calls on the 27th of October. I am satisfied that the

social worker also highlighted the concerns to the mother that the children must be seen that evening.

86. The mother's explanation is that she lied because she panicked. The submission on behalf of the mother that Dr. R informing the mother of the test results for the first time was a shocking, emotional overload which set her head spinning and was totally unexpected, is rather overplayed in my judgment and it does not excuse her actions in telling lies or failing to present the children to hospital at the earliest opportunity. In my judgment, there must have been at least the possibility in the mind of the mother that the test results might return a positive result given her own request that the children be tested. The local authority submits, and I accept this was not a panicked response but a fully constructed lie, involving tales of her father's severe ill health, plans for a family meal, and supported with detail and information such as her hotel booking. The guardian submits, and I accept, that in telling the lie, sustained as it was from approximately 4:00 PM on 27th of October until 11:00 AM the next day, the children's welfare was not the mother’s first priority and her actions stopped the children from receiving medical attention they ought to have received that evening. I also concur with the observation on behalf of the Guardian that this would appear to be very out of character for this mother and the care that she provided for the children before this time as well as the effort she made in getting the children medical attention for the discharge she had noted in the girls.

87. The mother said that once she told the lie, in a panic, there was nothing more in it than that she became entangled in the lie and repeated the lie. It appears that the mother in fact managed to telephone her own mother for comfort, and also to telephone the father that evening to ask whether he could take the children to the hospital, as advised by Dr. R. The father did not assist. Allowing for any initial panic, it appeared to me that this mother, who had after all been caring for the children and could see their presentation in terms of their condition (by now diagnosed as gonorrhoea), took the view that nothing much was going to be lost by waiting overnight and attending hospital the next morning - which she did. In my judgment, she knew she should take the advice

of the doctor but did not consider it particularly urgent or pressing and from her oral evidence I gained the impression that she did not particularly want to spend a long time in hospital overnight with the children. The father's evidence to me was that he could not understand how the mother continued to contemplate making the trip to Birmingham, but of course he himself had not assisted when she asked him to. Clearly neither parent felt that there was any need for urgent action.

88. I am reinforced in reaching the conclusion I have on this issue by the evidence of the social worker that the mother informed her the girls had the symptoms for a while and that she, the mother, had been the one chasing the GP for the results and now professionals were suddenly asking her to act urgently. It is also possible the mother may have been motivated by a desire to continue with the plan that she told me about to go to Birmingham. She did confirm to the social worker that she would attend the medical the next day as requested and did so at 12 noon as arranged. She corrected the lie about Birmingham during Dr. T's examination of the children. This was in the context of the medical professionals, two police officers and two social workers being present.

89. Even if not immediately, the mother did acknowledge that she had lied and told the social worker on the 2nd of November 2023 that hearing from the GP that the police and social services were involved, she panicked and lied about being in Birmingham but realised she had messed up and therefore called the emergency duty team in the morning because she realised it was very serious. It seems the mother shared that D had been aware that she had lied about Birmingham, and she stated that she had told the children to tell the truth before going to the hospital, acknowledging that children have minds of their own. Although in her oral evidence the mother told me that admitting the lie felt like a weight off her shoulder, it strikes me that she may have been motivated to come clean, at least in part, by a worry that the children would have said something that would expose her lie.

90. In the final analysis I accept the submission on her behalf that my findings about these lies do not impact in any significant way on the main allegations pleaded

by the local authority; namely, that the mother herself, or L, sexually abused any of the children. In my judgment, the lies the mother has told do not serve to fundamentally undermine the credibility of the mother and the truth of her evidence in relation to the findings sought by the local authority. Similarly, the fact that she withheld information from the father (who complained about being kept in the dark by both the mother and professionals about events), about the involvement of the doctors in relation to the children's gonorrhoea and tests up until the point that there were positive test results, are not material or probative of the issues that I have to decide.

The father

91. In his oral evidence, the father maintained the case I have already outlined earlier in this judgment. His oral evidence was consistent with his written evidence and what he told the police in interview about his knowledge of events and his involvement in the lives of the children.

92. He was made aware of the mother being on the dating app by a friend and did not know that the mother was seeing another man in the summer of 2023. He confirmed the contents of his witness statement and that he had been considering reconciling with the mother but wanted a clear STI test before resuming any sexual relationship. He was not aware that the mother underwent testing nor the test result of 16th October.

93. He told me that he was shocked to see the discharge in D in September and that when he told her, the mother explained the children’s discharge was thrush. He told her to go and see a doctor about it. He was aware the mother was in London on the evening of 27th October and he did not know that the mother had lied about this until after the children were removed from her care.

The Expert Evidence

94. I have had the benefit of the opinion evidence of two experts, Dr. Ghaly and Professor Masterton. They have referred to the term “Neisseria Gonorrhoea” which is viewed as a generic entity covering all the organisms that cause gonorrhoea.

95. Each of their written evidence and discussions during the professionals meeting was detailed and measured. They each adhered to their respective letter of instruction and stayed within the ambit of their individual expertise, and appropriately deferred one to the other in matters within the other’s expertise.

96. They are both agreed that Royal College of Paediatrics and Child Health’s publication, the “Purple Book” 2015, operates to provide guidance which informs their professional opinions, even though it is not currently in print/ or awaiting an update. At the professionals meeting both experts were agreed that the Purple Book is the recognised authority on this issue in the United Kingdom and that it has an international reputation. Neither expert deviated from the principles set out in the Purple Book that for childhood cases of gonorrhoea the commonest mechanism of transmission is sexual contact.

97. This was confirmed by Professor Masterton at the experts’ meeting when he said “*the bottom line is I agree entirely with Dr. Ghaly, I think the Purple Book is the recognised authority on this issue in the United Kingdom, and I agree with him, it actually has an international reputation. I also agree with him in terms of his interpretation of its conclusion, which is that for childhoods cases of gonorrhoea the commonest mechanism of transmission appears to be sexual contact*.”

98. There is no other authoritative source that has been relied upon by either expert or any party. I note that the Purple Book itself cautions that it is not intended to be a guideline for the diagnosis of sexual abuse. The Purple Book made clear that it did not review the literature in respect of all reported modes of transmission.

- *"This book has been developed as an evidence-based aid to clinical-decision making rather than as the sole source of guidance in relation to examining children referred for evaluation of possible sexual abuse. It is not intended to be a guideline for the diagnosis of child sexual abuse. The medical assessment of a child where there are concerns about the possibility of CSA is one part of the detailed multi agency and multidisciplinary assessment which is needed before CSA can be confirmed. The presence of suspicious anogenital signs or the diagnosis of an STI cannot be used in isolation to establish whether or not a child has been sexually abused. Where anogenital signs or STIs are present, other possible causes and differential diagnoses should be considered. Findings must always be interpreted in the broad context of history and full forensic medical examination as well as the child statements and a detailed multi-agency assessment. It is important to take into account the child's behaviour prior to the disclosure and during the interview and examination. Careful note must also be taken of what the child says."*

  "*Establishing sexual abuse as a source of the infection with any degree of certainty requires consideration of other possible modes of transmission. A review of the evidence for all reported modes of transmission of the included infections in children was outside the scope of this project, so the review included only those studies of a population of sexually abused children evaluated for STI's or a population of children with STI's evaluated for sexual abuse.*"

99. In summary, both experts agree that the presence of gonorrhoea infection in a child is a rare condition in children and that it strongly suggests acquisition through sexual contact. Professor Masterton opined in his report dated 16 February 2024 "*it is widely held that the presence of a gonococcal infection in a child strongly suggests acquisition through sexual contact. Because gonococcal infection in children is a rare condition there are not, to the best of my knowledge, strong data in the medical literature that supports the above assertion on a statistical basis. This position is, in my opinion,*

maintained on the basis of multiple case study reports and expressed clinical experience." At the experts meeting he confirmed *" I agree with Dr Ghaly that sexual contact with a male is by far and away the most common mechanism of childhood gonorrhoea like this*"

100. Both experts agree that it is possible for gonorrhoea to be transmitted non sexually in the right circumstances and that non-sexual transmission cannot be excluded. Transmission can occur through a number of other possible mechanisms particularly over a period of time. Both experts recognise that there is a distinction to be made between the bacteria's ability to survive and to be infectious. Both are agreed that there is a paucity of literature/ research on the subject and that there are a small number of cases of sporadic episodes of childhood gonorrhoea which are quoted in the literature and which, in turn, are quoted in the Purple Book. At the experts meeting Professor Masterton referred to ad hoc case reports which he said are the weakest of reports because they not really systematic reviews nor controlled studies and therefore not really statistically significant so as to draw robust conclusions from.

101. In his report Dr Ghaly opined that theoretically it is possible for the children to have been infected by the mother at the relevant time undertaking the basic care tasks for the children, but he said that for this to happen the mother would have to show that an infected material collected from her vagina was inoculated timely to the child's inner genitalia in a non-sexual mechanism. His also stated that in respect of fomite transmission of infection through contact with infected objects such as towels or toilet seats, there was very little contemporary evidence about such transmission, given the fragility of the organism and its susceptibility to dryness. Furthermore, modes of transmission other than through sexual contact through, inter alia, contaminated hands toys, bath, fomites have not been established/ substantiated but cannot be totally excluded in their entirety due to lack of robust published research evidence.

102. Professor Masterton opined that in cases of gonorrhoea, disease acquisition is through direct contact with viable organisms. In adults, in the vast majority of instances, such acquisition is through sexual activity. He stated that the gonococcus organism can be transmitted readily between subjects, but it does not survive naturally for long periods in the environment. He referred to *"a study investigating survival on towels demonstrated that at room temperature viable organisms were present for up to around 17 hours. The organism survives better in a moist environment where survival for up to 24 hours has been recorded. In dry environments the organism dies quickly."* Gonorrhoea can be transmitted between people readily, but it does not survive naturally for long periods in the environment. In this respect Dr Ghaly, quite properly, defers to the expertise of Professor Masterton.

103. The difference in opinion between the two experts lies in Dr Ghaly's view that it is likely that the children were infected as a result of sexual abuse, whereas Professor Masterton *opines "that contamination is an alternative viable method….. within a family living dynamically where they would in my opinion have been multiple opportunities for transmission"*. He states in his report that *"should the court firstly exclude any other possible source, and then accept the available medical records and the statements, it is my opinion on balance of probabilities that D, E and F most likely acquired their episode of gonorrhoea from contact with their mother. In my opinion, it is a matter for the court to determine whether such contact was sexual or non sexual in nature."* He went on to say *"in my opinion the details of the contact that [the mother] described in her various statements and interviews i.e. assisting in the toileting of the children, the sharing of facilities and close physical contact both between [the mother] and the children and between the children themselves, will have permitted opportunities for cross infection to occur."*

Dr Ghaly

104. Criticism is levelled against Dr Ghaly on behalf of the parents. The doctor's medical opinion throughout his written and oral evidence remained faithful to the analysis in the Purple Book: that sexual abuse is the most likely

cause of infections of gonorrhoea in children. He was consistent about this and did not depart from it in his written or oral evidence, but he did not rely entirely on the Purple Book.

105. He considered the literature relied upon to support an explanation of fomite transmission not to be sufficiently robust and that it cannot be relied upon; he cited Professor Goodyear-Smith's 2007 paper in respect of a systemic review. Based on the Purple Book, he said there was a distinction between the mere presence of the bacteria's DNA on fomites or fomite surfaces and the bacteria's ability or sufficiency to infect. Professor Marston did not disagree.

106. He explained that if transmission was via passive or environmental process of Neisseria gonorrhoea, the children would likely have developed ocular infections because that is an easier site for exposure than the internal mucous membranes of the throat, vagina or anus. He excluded the likelihood that ordinary washing and drying would enable the bacteria to penetrate beyond the vulva of a child. Regarding the vaginal infections in D and E, Dr Ghaly's view was that infective mucosa would have needed to come into contact with the inner part of the labia which, in children, is a highly sensitive area. To contextualise this, he said that a child would typically jump when a cotton swab came into contact with the inner part of the labia.

107. For the purposes of my conclusions, I discount the intemperate outburst by Dr Ghaly, under robust but appropriate cross examination on behalf of the mother when he was recalled on the afternoon of 15th January 2025. It could not have helped that early on in cross examination it was commented by leading counsel that a court had previously not accepted his opinion. In what appeared to be clear frustration at repeated testing of his expressed opinion, he exclaimed *"counsel, what is wrong with you"*. I intervened to say that this was unacceptable and to his credit he immediately apologised and repeated that apology at a later stage also.

108. I disregard also the criticism made of Dr Ghaly about a professional disagreement he had with Professor Goodyear - Smith in a previous criminal

case in which both were instructed (and in which the jury appeared to have accepted his opinion and convicted the Defendant of sexual abuse) and also the reference to his approach and opinion not being followed by the court in a previous family court case. I do not have full details of those proceedings nor was this issue examined in any detail in the hearing before me. I note that Professor Masterton, in his own evidence, appeared aware of the controversy the Goodyear-Smith paper appears to have provoked.

109. However, a valid criticism is made on behalf of the mother in respect of Dr Ghaly strongly asserting in oral evidence that the Purple Book had considered all the literature available in respect of sexual and non sexual transmission of gonorrhoea. That is not correct as the Purple Book itself makes clear that *"a review of the evidence of all reported modes of transmission of the included infections in children was outside the scope of this project."* Therefore, they had not considered any non sexual transmission potential when publishing.

110. That does not, however, undermine the reliance Dr Ghaly could, and did, place upon the Purple Book itself. There are no other research papers that have been produced which are capable of rebutting the contents of the Purple Book. The papers referred to by Professor Masterton are also unreliable to an extent, and the Professor acknowledged as much to me in his oral evidence.

111. Doctor Ghaly wrongly stated at the experts meeting that the Purple Book had been updated in 2023 and that it contained exactly the same guidance when it comes to gonorrhoea infection in children. Having initially said in oral evidence that the 2023 version was available online, he then conceded in his oral evidence that it was not and in fact there was not an updated version. I have been directed to the RCPCH website, which I have viewed, and which indeed specifies that the 2015 edition is out of circulation and no longer available. There is a pending update, which is not yet available, but is stated to be "coming soon." I have no reason to doubt Dr Ghaly's evidence that he

has had an opportunity to see a pre-print draft chapter that was provided to him, although it was not the full intended updated publication

112. There is also valid criticism made of Dr Ghaly's evidence in which he sought to rely on a reported case study from 1999 "the Groothuis paper" which he characterised as a "robust" paper from the Purple Book. He told me that the study reported that in 103 cases (and therefore involving a significant number of children) who he said had tested positive for gonorrhoea and which could all be traced to infection by sexual abuse by a male perpetrator. This of course supported his evidence in respect of the male perpetrator mode of transmission.

113. Having raised this in his oral evidence, Dr Ghaly was asked to produce the research paper. I am unclear as to what efforts were made thereafter to secure this from him. However, leading counsel for the mother sourced the document online and relied in submissions on the fact that it did not reflect the evidence given by Dr Ghaly, and therefore Dr Ghaly was recalled to give further evidence. The Purple Book refers to this particular paper for the purpose of documenting the prevalence of Neisseria Gonorrhoea in sexually abused children. It appears that gonorrhoea was found in 45% of those considered sexually abused. There is a distinction between that and the evidence of Dr Ghaly. He accepted that he had got the date wrong, and that the paper dated in fact from 1983. By careful cross examination of his evidence, it was established that 16 of the 103 children had suffered sexual abuse and out of those 16, 13 had swabs taken. Of those 13, seven had cultures which tested positive for gonorrhoea, and in those cases it had been possible to trace the transmission to male perpetrators.

114. During cross examination Dr. Ghaly did not read out the correct wording of the abstract of the paper, including incorrectly inserting the word "sexual" in between the words "child abuse' I do not consider that he was being deliberately selective. However, I accept the submission on behalf of the mother that if his evidence on this had not been challenged, there was a risk of

reaching a wrong conclusion that the possibility of non sexual transmission could be excluded because it was so infinitely rare or impossible.

115. Dr Ghaly also asserted that the Purple Book had considered the Goodyear-Smith report of 2007 and essentially dismissed it as wholly unreliable, but it is clear from the Purple Book itself that Goodyear was not considered or referenced because a review of the evidence of all reported modes of transmission of the included infections in children was outside the scope of the project, and therefore the review only included those studies of the population of sexually abused children evaluated for STI's, or a population of children with STI's evaluated for sexual abuse.

116. I do not consider it a fair criticism of the doctor that he did not reference other case studies cited in the Purple Book which examined the incidence of sexual abuse in studies of children with gonorrhoea. It is correct that the Purple Book does not appear to have reviewed the Goodyear -Smith papers. However both the Goodyear- Smith paper of 2007 and the 2021 pan African paper were case studies and were accepted by Professor Masterton as having shortcomings in terms of the reliance that could be placed upon them. These papers did not sufficiently exclude sexual abuse.

117. Professor Masterton agreed with my suggestion in his oral evidence that at the time of the Goodyear overview, the proposition that there could be non sexual transmission was unorthodox. I accept the submission on behalf of the mother that this expert interpreted the Goodyear review as a call for clinicians to be more open to considering non- sexual transmission.

118. I accept that in some of his responses Dr Ghaly did become a little defensive under cross examination on behalf of the mother. As I have already mentioned, this probably wasn't assisted by references being made almost at the outset of that cross examination in respect of his opinion not being accepted by a family court previously. His firm opinion led to him expressing the view that the lack of any evidence of a male perpetrator was not exhaustive and that further efforts should have been made by way of testing all adults who may

have had any contact with the children to identify a likely male contact who potentially sexually abused the children. In his oral evidence he relied on some peculiar assumptions about sexual activity, for instance that grandparents are likely to be sexually inactive and an apparent belief that women did not sexually abuse children. As noted on behalf of the guardian in closing submissions, the assumption that women are not instigators or perpetrators of sexual abuse is expressly rejected in the Purple Book.

119. I do not consider that Dr Ghaly relied entirely on the Purple Book as his guiding light, nor that he failed to discharge his duties as an expert, nor that he strayed outside his letter of instruction or the bounds of his expertise. It is quite clear that he was relying also on his clinical experience and expertise. He was entitled to provide the expert opinion he did, which was evidence based and he deferred to Professor Masterton where appropriate.

120. He did consider the potential non-sexual methods advanced by the mother but in light of his clinical knowledge and experience of how gonorrhoea is transmitted, he was not able to consider these explanations as plausible to explain the facts of this case of 3 children contracting gonorrhoea in multiple sites. In his oral evidence, Dr Ghaly told me that he had seen probably 12 to 15 cases of children of a comparable age having contracted gonorrhoea in his 30 year career, and that he had seen well over 50 in the last three years in his medico legal experience (although he said he could not be precise) and that the cases seem to be creeping up. I accept his considerable experience and expertise.

121. I reject entirely the attempt on behalf of the mother to rely on the fees claimed by this expert to answer additional questions submitted by the parties, resulting in funding not being secured in time for his written responses, and the fact that Professor Masterton (in comparison) supplied his responses promptly and claimed lower fees which enabled those responses to be provided, as in any way relevant to my assessment of the reliance I can place upon Dr Ghaly's evidence, or indeed that of Professor Masterton.

122. Despite these valid criticisms, it does not fundamentally undermine the force of Dr Ghaly's evidence, with which Professor Masterton agrees, and which is based on the Purple Book, about the most likely mode of transmission being sexual abuse, as opposed to nonsexual transmission of gonorrhoea. At no point did Dr Ghaly diverge from his express agreement that gonorrhoea in children can be transmitted non sexually.

123. In my judgement Professor Masterton puts it aptly when he says that each of the experts approaches this case from a different emphasis. They have each done their best to assist me. Based on his experience and expertise, Dr Ghaly was not as open to considering non sexual transmission as Professor Masterton was. Professor Masterton's evidence was more aligned to what my task as a judge is – to consider the expert evidence in the context of the wide canvas of evidence in the case.

Professor Masterton

124. In oral evidence he stated that on the particular facts of this case, environmental or non-sexual transmission was more likely than not. This was premised on the veracity of the accounts given by the mother in her written and oral evidence being accepted.

125. Professor Masterton was certainly more open to the possibility of a non sexual mechanism of transmission to the children in the specific circumstances of this case than Dr Ghaly was. As Professor Masterton put it at the experts meeting *"we rely on the same science, we interpret it in the same way… I don't believe there is any disagreement, I get a sense that there's a slight difference in emphasis in that I'm more open to the non sexual route of transmission".* His opinion was that the details of the contact given by the mother between herself and the children such as assisting in the toileting of the children, the sharing of facilities in close physical contact between the mother and the children and between the children themselves will have permitted opportunities for cross infection to occur. His opinion was that it was significant

that all three children were living in the same environment and exposed to the same factors.

126. The mother described the piling up of damp towels and flannels on a heated towel rail and day-to-day living in close circumstances where mother was providing ongoing intimate care as well as the common tactile, loving interactions between the whole family during this time in circumstances where the mother was asymptomatic but infective. I note that the bathroom had no window/ ventilation. I accept the evidence of the mother that it was possible to have all three children in the bath at the same time and reject the submission on behalf of the guardian that this account by the mother was in any way *"hard to follow".* I note that Professor Masterton was of the opinion that these circumstances afforded multiple opportunities for transmission. I note that although the mother in oral evidence indicated that she had shared baths with the children in the time leading up to D and E presenting with symptoms, the local authority points out that this was not an account mother gave to the police in interview or set out in any of her three signed statements. The criticism of the mother that she did not offer explanations previously about activities which might explain possible modes of infection, has to be considered, firstly in the context of the mother possibly not knowing how the children came to be infected and therefore retrospectively, desperately casting around for any possible explanation. Secondly, the burden of proof must not be reversed and it is not for her to provide an explanation.

127. There were contradictions in the evidence of Professor Masterton. Despite repeatedly confirming his reliance upon the Purple Book, just like Dr Ghaly, and asserting its definitive status, at a later stage in his oral evidence under cross examination he commented that he did not find the Purple Book a particularly helpful tool in his work and that it was poorly referenced.

128. He acknowledged that the sources he relied on also had shortcomings in terms of the reliance that could be placed on them on the facts of this case. He accepted that in his written report he had referred to the systemic review undertaken by Dr Goodyear- Smith. However in oral evidence he accepted that

many of the papers relied upon in Dr Goodyear-Smith's review of the literature were in fact potentially unreliable in their conclusions because of the age and approach of the sources it drew upon. For example, the series of epidemics described within the paper were published in the late 19th or early 20th century. Therefore, he acknowledged, the Goodyear -Smith case study could not be relied upon to have robustly excluded sexual abuse as a root of possible infection.

129. In his own clinical experience Professor Masterton confirmed that he had only encountered non-sexual transmission of gonococcal infections as gonococcal conjunctivitis or infections of the eye.

130. He stated that the risk of passive transmission could have increased when the mother was displaying her own symptoms of infection, the concentration of bacteria in symptomatic exudate being greater. However, I could not follow the logic of some of the conclusions that Professor Masterton reached.

131. His evidence was that normal social hand hygiene such as ordinary hand washing would be sufficient to prevent the spread of Neisseria gonorrhoea. However, he opined the transmission by, for example, infected hands would have required direct contact with the perineal region of the girls. In my judgment, the local authority correctly identifies that it is difficult to understand how this would have happened if the children and their mother were simply cuddling on the sofa, which was the example given by the Professor.

132. Part way through the oral evidence of Professor Masterton, on day three of the hearing and following consultations with her legal team, the mother produced a statement setting out details of the use of a paddling pool by the family during summer 2023 where the water was not replaced but topped up with warm water. I permitted the statement to be introduced into the proceedings. There was no objection from any party to this course. I accept the submission on behalf of the local authority that this would have required the mother depositing highly infectious secretions into the paddling pool before it

was packed away, she said sometime after 16 September 2023. Professor Masterton considered the transmission via the shared use of a paddling pool in the summer of 2023 and concluded that it could be a potential route of transmission from the mother to the children and amongst the children themselves. The mother was at that stage asymptomatic, but the expert acknowledged that there would have been a greater risk had she been symptomatic.

133. Professor Masterton clearly opined that it was more likely than not that the potential methods of transmission advanced by the mother, (via bath water, paddling pool water, towels or flannels) were how the children became infected by gonorrhoea. His opinion in his written evidence was that the circumstances in the family home, where the mother was undertaking care tasks of the children and in close physical contact with them over an extended period, lent themselves to a greater likelihood for fomite transfer also because of the multiple opportunities it provided for transmission of infection. His oral evidence was that it was more likely the mother's explanations provided a credible explanation for the infection in the children.

134. The local authority quite rightly points out that if these were the source of the children's infections then, on the available evidence it is highly likely that at least one child or the mother herself would have contracted an ocular infection of gonorrhoea. Those fomites / fluids would come into contact with external, uncovered parts of the body before internal parts. The presence of only internal infections does raise some doubt as to this as a possible mechanism.

135. Professor Masterton opined that the *"vast majority"* of transmissions occur sexually and that the risk of non sexual transmission was *"very small".* His own clinical experience, he told me was that he had come across only one child in practise who had a gonorrhoea infection, and that was sustained as a result of sexual abuse. Both he and Dr Ghaly agreed that there is a difference between contamination of fomites and subsequent transmission. However, Professor Masterton opined that fomite transfer could be operative in this case.

He was of the view that the circumstances in the family home lend themselves to a greater likelihood of this. At one point in his evidence, he said that *"the risk of fomite transmission is there, although it is very small*". He was cross examined on this. He said that gonorrhoea could have been passed onto the skin of a child. I appreciate that Professor Masterton, as a microbiologist, has greater expertise than Dr Ghaly in respect of the possibility of inadvertent transmission via fomites. However, he was unable to provide any coherent and credible explanations of how it could have passed unknowingly to the children by the mother if they were snuggling up on a couch or even when washing with soap, or any of the other suggested scenarios. On the basis of the evidence before me and the scenarios described by the mother and analysed by the Professor during his oral evidence, I cannot be satisfied that on a balance of probabilities it is more likely than not that such matters translated to a child contracting an infection vaginally, anally or orally. This is particularly so in the context of his evidence that there needed to be *"a fair amount"* of infected material to make such transmission possible.

136. The agreed expert evidence is that Neisseria gonorrhoea is a fragile organism, which may survive on surfaces, but survival is not equivalent to infectivity. The local authority submits that it is highly improbable that in the reasonable care of the children the mother's hand would have come into contact with D and E's perineal regions, or into any child's mouth, while inoculated with sufficient of mother's own vaginal secretions to cause a transfer of her infection. The local authority contends there is no reasonable element of parental care which would explain this transfer. I accept the submission on behalf of the mother that the more accurate record of Professor Masterton's evidence (which was unchallenged by Dr. Ghaly at the experts meeting) is that "*gonorrhoea is an organism that's acquired by contact, so that is all you need, it doesn't have to be high infectious load, so all you need is contact with the organism which can occur through a number of other possible mechanisms, particularly over a period of time*". In his oral evidence he told me the infecting dose of gonorrhoea is low so infection by transient contact with a straw would be unlikely and a mug passed around and sucked on would be

more likely. At the end of that evidence, the precise amount of infecting dose required is unknown and remains a scientific or medical uncertainty.

137. The local authority submits the cuddling on a bed or a sofa would not offer sufficient mechanism and the mother would have been highly unlikely to have wiped any of the children's intimate regions with her bare hands, having previously touched herself with bare hands and without washing her hands in between.

138. The local authority points to the mother's own evidence of treating E and F's bath water with emollient and that she took care to dry them carefully afterwards so as not to exacerbate their eczema, and submits this makes it even more unlikely that the bacteria responsible for the children's infections would be transmitted into the children's throats, anus or vagina.

139. The possibility of infection via an oral thermometer has also been raised. I note that the mother did not describe witnessing this herself directly in either her police interview or her signed statements but mentioned it in oral evidence, following Professor Masterton's discussion of it in his oral evidence. I have already addressed my approach to how the explanations by the mother should be treated.

140. The local authority contends that if the oral thermometer, having been inoculated from the mother's vaginal infection was then passed on to the children, then the mothers hygienic practises in deploying a thermometer from her vagina to a child or the child's mouth without cleaning it amount to care which it would not be reasonable to expect a parent to give. This is not in line with what the local authority has pleaded in its threshold document.

141. I accept the submission on behalf of the mother that the evidence does support the finding sought on behalf of the mother that the pooling of vaginal secretions is the most likely cause of transmission from vagina to rectum in the two girls. That was a mode of transmission suggested by Dr Z, the Consultant in sexual health at the hospital who stated this in the early strategy meeting,

and this might explain why both rectal and vaginal samples were positive. It appears to be a commonly accepted mode of transmission between these two areas and stands to common sense. Nonetheless, there remains the difficulty of how they came to be infected in the vagina to begin with.

CONCLUSIONS

142. The perplexing facts of this case are encapsulated in the closing submission on behalf of the guardian*. "The guardian notes that one of the distinguishing features of the case is an evidential landscape which provides no obvious answers as to how the children contracted gonorrhoea; and that even after 5 days of evidence we are almost no further forward in respect of having acquired information we can use confidently to determine the mechanism, the date or the circumstances through which the children contracted the infection."*

143. There is a striking lack of corroborative evidence but, as with other cases of this sort, this neither obviously proves nor disproves any other matters as alleged in this case.

144. In the context of the facts of this case overall, I am not assisted by either expert evidence in determining how and when the children contracted gonorrhoea. There is no additional evidence that they have been sexually abused apart from the fact of their diagnosis. In fact, the other circumstances of the standard and quality of care by the mother and their interactions with others would tend to indicate away from the likelihood of sexual abuse.

145. What has been established on the evidence available to me is that there is little research evidence, case studies or robust clinical trial data in this area which would assist me in resolving the issues in this case. The rarity of incidents means that statistical probabilities cannot be reliably asserted. Such papers/ studies as there are, have their own limitations.

146. I accept the agreed opinion evidence of both experts that gonorrhoea is rare in children and non-sexually transmitted gonorrhoea is very rare.

147. However, fomite transmission is accepted as a possible cause for the spread of the infection, including but not limited to shared bath water, shared paddling pool, towels, shared thermometer, clothing, shared sleeping arrangements, toilet seat and pools. It is accepted as a known cause in published medical reports. Although it is a rare cause, even extremely rare, it cannot be ignored, as was accepted by both experts.

148. The facts of this case are different because there is a whole family, living dynamically, where there were multiple opportunities for transmission. There is no evidence of any source of gonorrhoea infection of the children other than the mother. For gonorrhoea to been transmitted by way of sexual abuse there would have had to have been, at the very least, seven different sexual transmission acts in respect of all the children. I accept the submission on behalf of the mother that the wider canvas evidence simply does not support this.

149. I accept the evidence of Professor Masterton *that "in my opinion it was significant that all three children were infected with gonorrhoea. In my opinion this finding is entirely consistent with the fact that all three children were living in the same environment and exposed to the same factors. In my opinion the fact that all three children contracted gonorrhoea cannot be used to determine the mechanism of acquisition of the disease".*

150. None of this assists me in identifying which child may have become infected first, when and how. It is possible that once one child became infected, the risk of onward transmission vertically within that child and to the other children grew so that they were each at a higher chance of infection than children not living in that environment. It is not possible to know which child was first infected or the sequence of infection acquisition.

151. There is nothing in the evidence to suggest from the children's physical, social, emotional or other presentation, including words spoken and behaviours, which has given rise to any suspicion that they have endured an inappropriate experience let alone sexual abuse.

152. I accept the expert evidence that nonsexual transmission is possible, but I also bear in mind the submission on behalf of the Guardian that if this were so it would be much more commonly found within families who lived together. On behalf of the father in closing submissions the upshot of the evidence of Professor Masterton is accurately set out. At paragraph 36 of those submissions, it is stated that Professor Masterton's evidence, when taken with the accounts given by the mother *"do (prima facie, at least) provide an arguably reasonable explanation for transmission".* I can place the probability no higher than that.

153. The local authority cannot be criticised for bringing proceedings and for pursuing them to the conclusion of the fact-finding hearing. Given the rarity and complexity of the facts of this case and the nature of the conflicting expert evidence, the action of the local authority was justified and it was not simply an exercise in erring on the side of caution. The fact-finding process has shed light and clarified some matters.

154. However, the local authority has not discharged the burden of proving the disputed allegations in support of its contention that the threshold criteria are met, including the way it has reframed the findings it seeks in written closing submissions: i) that the most likely explanation for the children's infections, and in particular the vaginal infections identified in D and E, is sexual abuse of one or more of the children, although a finding that one or more of the children has been sexually abused does not exclude the possibility that non-sexual transmission between the children (and between sites on each child) may have taken place inadvertently after that abuse and ii) that within the context of the mother not knowing that she was infected, that the children could not have contracted gonorrhoea unless the mother's hygiene was so poor it was unreasonable. Furthermore, the local authority's final submission includes the

widening of the pool of perpetrators to include mother, L “or another individual”. The evidence simply does not justify the inclusion of an unknown third party in the pool in this way. There is no evidence of any other individual having come into contact with the children or that they have been victim to a deliberate act of contamination by sexual abuse.

155. The local authority has not satisfied me on the evidence that on the balance of probabilities the allegations it makes and the findings it seeks are established. Accordingly, this being a single-issue case, the threshold is not met.

156. There is no evidence to support a finding that any of the children have been sexually abused by their mother or that she allowed them to be abused. The local authority never pleaded an alternative threshold that the mother’s poor hygiene resulted in the children contracting gonorrhoea, and other than being put to Professor Masterton briefly, it was not explored in evidence. Accordingly, I find that matter also not proved.

157. No finding is sought against the father by any party, but for the avoidance of doubt I make it clear the evidence does not support findings that father was infected with gonorrhoea at the relevant time or at all; or that he infected the children; or that he sexually abused any of his children or exposed them to any abuse or risk of infection.

158. That concludes my judgment.