



Neutral Citation Number: [2022] EWFC 55 ()

Case No: WH21C00033

IN THE FAMILY COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/06/2022

Before :

SIR ANDREW MCFARLANE (PRESIDENT OF THE FAMILY DIVISION)

Re G (Child Post-Mortem Report: Delays)

Miss Cheetham QC and Mr Gilmore (instructed by **Cumbria County Council**) for the
Local Authority

Mr Rowley QC and Miss Whiteley (instructed by **Atkinson Ritson Solicitors**) for the
Mother

Miss Bowcock QC and Mr Jones (instructed by **Cumbria Family Law**) for the **Father**
Mr Rothery and Mr Flood (instructed by **Bendles Solicitors**) for the **Child**

Hearing dates: 30 March 2022

Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....
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.

This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be 10.30am on Tuesday 14 June 2022

Sir Andrew McFarlane, President of the Family Division:

1. This is an unusual judgment. It has been handed down following a case management hearing in pending public law child care proceedings under Children Act 1989, s 31 [CA 1989]. The proceedings relate to the sibling of a 4 month old baby who died in suspicious circumstances in October 2021 following a profound collapse at the family home four days earlier. In the event, all of the directions sought at the case management hearing were resolved by agreement and, because of that, no hearing took place. In due course I endorsed an agreed consent order and remitted the case for hearing before the allocated judge, Mr Justice MacDonald.
2. Against that background, it will be plain that this judgment does not record any judicial decision whatsoever and, as such, nothing that is said in the paragraphs that follow can be taken as binding authority for any proposition. The judgment is, therefore, simply a narrative account of the problem that caused the case to be transferred to me, as President of the Family Division, for hearing, together with a distillation of the various solutions, put forward by counsel, seeking to address a significant problem which occurs in cases which concern child homicide in the Family Court. At the conclusion I will offer my own view on how such cases might proceed in the future. I repeat that, legally, what I may say is no more than a record of my current view, having considered the issues. How a future case should proceed will be a matter for the judge hearing that case, subject to any appeal. The solutions put forward to this court are untried and untested. In the event they may not be practicable or meet the needs of any future case. My purpose in capturing and recording them is to alert all concerned, in this public judgment, to the existence of a very serious problem, and to offer ideas that may assist in ameliorating its impact on future Family proceedings. As I will record, I am clear, as Head of Family Justice, it is no longer tenable for the Family Court simply to put up with the impact of this problem.

The Problem:

3. In short, the problem to which this judgment relates is the extreme delay that is now regularly encountered in the preparation of a post-mortem report from a pathologist following the suspicious death of a child. Whilst the post-mortem examination, which is conducted by a lead forensic pathologist, will normally be undertaken promptly and within days of the death, material collected during the post-mortem is then likely to be sent off for specialist analysis by other experts and it is this latter process which can generate extensive delay. The preparation of the overall post-mortem report can only move to a conclusion at the pace of the slowest contributor and it cannot be completed by the lead pathologist until the reports of each of the specialists has been received. In the present case the Family Court was told in February 2022 that it would be a further 9 to 12 months before the post-mortem report would be completed.
4. Delay of this magnitude plainly has a profound impact on both the pending criminal process and upon any related child protection proceedings in the Family Court. In the present case the surviving sibling [‘G’], who was born in February 2020, was removed from his parents’ care following his baby brother’s death in October 2021. After a short time living with a relative, he has been in local authority foster care since December 2021. If the post-mortem report were not available until November 2022 or February 2023, so that the Family Court could not even begin to conduct a fact-finding

investigation into the cause of the baby's death until the first half of 2023, it is probable that the long-term plans for G's care (in particular whether it is safe for him to return to the care of a parent or other family member, as opposed to placement for adoption) would not be settled until the summer of 2023 or even later. G was around 18 months old at the time of the death; he will be 3½ years old by the summer of 2023.

5. The timeline that I have just sketched out is, in any event, over simplified. A further consequence of delay in receipt of the post-mortem report is that the police investigation is likewise stalled. It is only after the report becomes available that the police can conduct formal interviews based upon it with the parents and other family members. In order to maintain confidentiality with respect to some of the evidence that the police have obtained from other sources, that other evidence will only be made available to the parents during those interviews and to the Family Court proceedings thereafter. This additional important step in the police process will therefore cause the Family proceedings to be delayed yet further.
6. The potential delay encountered in the present case is not unusual. Indeed, this court has been informed that it is now the norm for there to be delay of the order of one year in the preparation of a post-mortem report following the suspicious death of a child. This is certainly not the only such case that I have seen in recent times. For surviving siblings to have to wait in limbo in foster care or elsewhere for a period of two or more years before the plans for their future care can be determined is wholly unacceptable. The Family Court is required to 'have regard to the general principle that any delay in determining [any question with regard to the upbringing of a child] is likely to prejudice the welfare of the child' [Children Act 1989, s 1(2)] and must work to a timetable to determine an application for a care order within 26 weeks from its issue [CA 1989, s 32(1)(a)]. The timescales that are now regularly encountered in care proceedings following the death of a child are wholly outside those required by Parliament and they are plainly contrary to the welfare of any surviving sibling who is the subject of such proceedings.

Post-mortem reports on child death: the cause of delay

7. I have already described the need in most cases for a lead forensic pathologist to obtain reports from other specialist experts before a final post-mortem report can be compiled. For example, in the present case, where there was evidence of bleeding to the brain and in the eyes, a healing rib fracture and an injury in the mouth, specialist reports are required from:
 - a) a consultant neuropathologist;
 - b) a consultant paediatric pathologist (in particular with respect to the eyes);
and
 - c) a consultant osteoarticular pathologist.

Each of the instructed specialists has a contract to work in the NHS so that work in contributing to a post-mortem report must be undertaken privately outside their commitments to the NHS. Such specialists are, apparently, in short supply. In terms of osteoarticular pathology there is only one expert in the country who is prepared to take on this work. He is Professor Mangham who is a NHS consultant and a professor at

Manchester University in histopathology. Prof Mangham undertakes this privately paid work from a unit that he has established for the purpose. He is thought to be instructed in around 100 cases each year. This court has been told that it currently takes 16 weeks to create the necessary microscope slides of bone tissue at the professor's unit and this period is plainly part of the overall time taken to complete the assessment work.

8. In the present case it is Prof Mangham's timescale which is dictating the date for completion of the overall post-mortem report. The order made by MacDonald J on 10th February 2022 transferring the issue to the President of the Family Division recorded the following:

‘AND UPON Professor Mangham currently being the only consultant osteoarticular pathologist approved by the Home Office to undertake pathology reports in that field and Professor Mangham having indicated that his report will not be available for some 9 to 12 months.’

After the case had been transferred, the timescale was revised on 15 February to 6 to 8 months from the date of receipt of the post-mortem material, which was 16 November 2021, giving a likely completion window between mid-May and mid-July. The revised timetable is no longer controversial and it was on that basis that case management directions were agreed and the hearing before me was vacated.

9. The fact that the delay generated by the post-mortem process is no longer an issue in the present case does not mean that the problem is solved or will not reoccur in another case. Whilst the court is grateful to Prof Mangham for being prepared to undertake this work, and nothing that is said in this judgment is intended to be personally critical of him in any way, even the revised timetable with a period of 6 to 8 months between receipt of the materials and the submission of a report is, itself, entirely outside acceptable timescales in the Family Court.
10. The court is grateful to the Secretary of State for the Home Department [‘the Home Secretary’] who, rather than intervening, has submitted an ‘Explanatory Note’ describing the background circumstances. It is helpful to set out certain key passages from that Note here:

‘... the medical professionals available to conduct the relevant type of work, sub-specialty pathologists, such as Prof Mangham, are not ‘approved’, employed by or contracted to the Home Office.’

‘1. The Home Office, through the Pathology Delivery Board, oversees the provision of forensic pathology services in England and Wales. This is done by maintaining a register of forensic pathologists who have the relevant qualifications, knowledge and experience to conduct forensic post-mortem examinations and act as expert witnesses in suspicious death and homicide cases. Home Office registered forensic pathologists are not employed by or contracted to the Home Office, but act in a private capacity and are paid a case fee by the police or a coroner. The Home Office maintains the register on which they are listed and oversees the rules and standards by which they agree to work. At the time of writing, there are 39 Home Office registered forensic pathologists serving police and coroners in England and Wales, plus 6 trainees being funded through their training by the

Home Office. This provides sufficient capability to serve demand in England and Wales.

2. To provide an informed opinion in some suspicious death cases, however, it is necessary for a Home Office registered forensic pathologist to consult the services of other pathology experts. These experts tend to be organ specific sub-speciality pathologists such as neuro, eye, bone and heart pathologists. They are also employed by the NHS or universities. Professor Mangham is a sub-speciality bone pathologist. The Home Office regulates the professional activities of the aforementioned forensic pathologists in order to protect the criminal justice system. The only relationship the Home Office has with these sub-specialty organ specific pathologists is to identify and try to encourage them to take on police cases. They are not registered by the Home Office, although a list of medical professionals willing to do such work is maintained by the National Crime Agency with whom the Home Office Forensic Pathology Unit work closely. The regulation of these sub-specialty pathologists is provided, as it would be to any medical doctor, by the General Medical Council. The Home Office has no role in their professional conduct.

3. ...

4. The dearth of sub-speciality pathologists willing to engage in the criminal justice system impacts child and baby death cases. These cases are also particularly complex due to the need to exclude natural disease and conditions associated with age. This has meant that the few sub-speciality pathologists who are willing to take on such cases are overburdened with case work. It is not unusual for a report from a sub-speciality pathologist to take up to six months before it is ready to send to the forensic pathologist (and nine months for bone examination). If this position persists, it is likely that the ability of the police and coroners to thoroughly investigate complex deaths will be severely hampered, and court dates will continue to be missed.

5. It is worth noting again that the system of medical death investigation in England and Wales is a private service, not provided by the state, but reliant on coroners and the police paying for services of self-employed professionals. The Hutton Report was an independent government commissioned report into the current state of forensic pathology capability and made recommendations for a national autopsy/death investigation service, but this recommendation has not been taken forward to date. The report was sponsored by the Home Office as it was intended to examine the current delivery of Home Office forensic pathology services, but it soon became apparent that it was not possible to focus purely on Home Office pathologists without considering the wider picture of pathology services to coroners. The MOJ will therefore be the government department with policy responsibility for implementation following the report.'

11. The Home Office Note continues by explaining the steps that have been taken to encourage other specialist pathology experts to take up this work. There are grounds for hope that at least two in the field of bone analysis may do so. In addition an expert in the USA may be available to take on some work in the interim to relieve the backlog of cases allocated to Prof Mangham. Finally the Note confirms that the situation that

now exists is not materially different from that which obtained when, prior to 2012, the national Forensic Science Service was in operation as that Service did not employ or authorise sub-specialist pathologist who were, as now, privately contracted to work on particular cases by the police or the coroner.

12. The Note concludes:

‘The Home Office does observe, however, that what appears to have changed over the last ten years or so, is that there are fewer medical doctors choosing to become pathologists as a specialty. This problem has been compounded by the fact that forensic pathologists often used to qualify as generalist histopathologists, where they learned to examine all organs of the body, but this is no longer the case due to the fact that, in 2012, forensic pathology became a speciality in its own right, and no longer a sub-speciality of histopathology. Another major shift in this time is the expectation of the Courts. It used to be the case that suitably qualified forensic pathologists did their own organ specific examinations, but we understand that the expectation of Courts now is that a highly specialised expert is requested.’

13. It is helpful for the position to be laid out with clarity in the Home Office Note. Whilst some ameliorating action may be in hand to increase the number of experts in the specific field of osteoarticular pathology, this may only trim back the extent of delay, rather than eradicate it. The system is similarly vulnerable, albeit to a lesser degree, by shortages of experts in other fields. It is no business of the court to engage in policy matters, but it is to be noted that the option of establishing a national service is not currently being taken forward by government. In September 2020 the Chair of the Pathology Delivery Board wrote to Lady Justice Thirlwall, as Senior Presiding Judge, with the aim of alerting the criminal courts to these extended timescales. Since then there has been no improvement and the unacceptable situation that currently exists seems likely to remain. It is a matter for the police and the coronial system, who are the primary commissioners of this work, what they may choose to do to improve matters. It is a situation which is outside the control of the Family Court, yet this court, and the wider child protection system, are currently forced to put up with the consequences of a regime which, from the perspective of meeting the needs of vulnerable children within the timeframe set by Parliament, is wholly unfit for purpose.

14. The impact on Family proceedings is summarised well in the Skeleton Argument on behalf of the father, who is represented by Samantha Bowcock QC and Michael Jones:

‘Whilst each case must be dealt with on its own individual facts, it is our experience that the delays in numerous sets of care proceedings involving a deceased infant are extensive and directly attributable to awaiting the completed post-mortem investigations. Delay is then compounded by the assertion by the police that certain evidential materials should not be disclosed pending receipt of the post-mortem report and re-interview of the parents. That is precisely the case in these proceedings. We submit that the delay can and should be addressed, if possible.’

15. A similar point is firmly made by counsel for the mother, Karl Rowley QC and Ginny Whiteley:

‘Nothing in this document is intended to be or should be construed as a criticism of Professor Mangham. It is, however, an intolerable situation for children who are

the subject of care proceedings, and their families, to have resolution of their cases (and thus, often, welfare decisions as to where they live and whom they see) delayed by months and sometimes years because of one expert. That delay often entails a child who has suffered no actual harm in their parents' care being separated from them or their wider families at a crucial stage in their emotional and psychological development. The effect of the delay, therefore, is that the State is apt to occasion greater harm to a subject child than they have hitherto experienced. That cannot be right: there is a statutory injunction to avoid delay and there is a unique statutory requirement to dispose of a Part IV application within 26 weeks precisely because delay in decision-making is known to be prejudicial to the welfare of a child.'

What solutions are open to the Family Court?

16. In the circumstances, it is necessary for the Family Court to consider what alternative processes may be followed to meet the needs of the child protection proceedings, but without having to wait for up to a year to receive the results of a post-mortem exercise commissioned by the police or coroner.

(a) Instruction of an alternative post-mortem expert

17. It is common knowledge that, on occasions, a second post-mortem may be undertaken with the leave of the coroner. A more common situation, certainly in terms of addressing the problem in the present case, is more simply for a second expert to be instructed to conduct analysis in relation to a specific specialty, for example bone injury. In that respect, the permission of the coroner would be required for slides, samples and other material collected during the post-mortem examination to be made available to the second expert. There will be a pressing need to ensure the security and evidential integrity of those materials if they are to be the subject of a second examination.
18. The instruction of a second expert is, however, unlikely to provide a viable solution in most cases. Firstly, where, as is the case with paediatric osteoarticular expertise, there is only one pathologist in England and Wales currently undertaking this work, it is likely to be impossible to identify a suitable second expert in the jurisdiction. Secondly, whilst a foreign expert may be instructed, the need to ensure the security of the primary evidence is likely to give rise to complications. Thirdly, simply obtaining a second bone expert, for example, who can report more quickly than the primary instructed expert will not, of itself, accelerate receipt of the final full post-mortem report which would, presumably, have to await the opinion of the original expert.
19. It is apparently the case that there is currently no agreed protocol between the Police and the Family Court concerning the safe and secure physical transfer of samples for analysis by experts instructed in Family proceedings. On the publication of this judgment, I will invite the newly re-constituted Family and Criminal Interface Committee to consider this and the wider issues raised here.

(b) Use of evidence gathered prior to death

20. In the present case, during the four days between the baby's profound collapse and his subsequent death, a broad range of assessments, tests and scans were undertaken. From these there is said to be evidence of the following:
- a) a torn frenulum in the front of his mouth;
 - b) a petechial rash to his forehead, chin and right wrist;
 - c) a healed fracture to the left 7th rib (confirmed on post-mortem survey);
 - d) CT and MRI scans showing extensive subarachnoid, subdural and intraventricular haemorrhage and multifocal areas of loss of grey white matter in keeping with hypoxic ischaemic injury;
 - e) Whole spine imaging showed areas of pooling of subarachnoid haemorrhage within the spine;
 - f) Extensive retinal haemorrhaging to both eyes.
21. Counsel have submitted that one option open to the Family Court where, as here, there is evidence which is gathered while the child was still alive and which is capable of supporting a finding of child abuse, is for the case to proceed on the basis of that material without the need for the court to go further and consider post-mortem evidence.
22. The two principal questions for the Family Court are:
- i) Whether the 'threshold criteria' in CA 1989, s 31 are established, and, if so
 - ii) What order to make on the basis that the surviving child's welfare is the paramount consideration.

The s 31 threshold criteria require the court to be satisfied, on the balance of probability,

- (a) that the child concerned is suffering, or is likely to suffer, significant harm; and
- (b) that the harm or likelihood of harm, is attributable to:
 - (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or
 - (ii) the child's being beyond parental control.

Counsel submitted that, just as would be the case where a child, who has apparently been injured in this way, has not died, evidence of significant pre-death injury attributable to abuse is likely to be sufficient for the purposes of the Family Court in proceedings under s 31 in determining the threshold criteria and evaluating which of any competing care options best meets the welfare needs of any surviving child(ren).

23. Counsel for the father summarised the situation with clarity:

‘In a case such as this, involving what is a suspected inflicted head trauma to an infant, the Family Court does not necessarily require a completed post-mortem report in order to proceed to adjudicate upon threshold issues. Experts such as a neurosurgeon and neuroradiologist are regularly instructed in cases involving similar clinical presentations to those observed [here], but where the subject child survives the precipitating incident. Such experts would not ordinarily require tissue or other samples and usually prepare their reports based on the medical documentation and imaging. It is however, the case that any osteoarticular expert instructed by the Family Court would need to examine the necessary bone samples to provide a full report and specifically in order to provide an opinion in relation to causation and dating of any fractures and to rule out any underlying medical cause. That said, radiologists can examine x-rays and provide likely timeframes for the causation of fractures, such as those observed [here], whilst medical records including blood testing and analysis are often sufficient for paediatric and haematological experts to consider the issue of underlying medical conditions.’

And later:

‘Accordingly, in cases such as this, we submit that it is open to the Family Court to consider instruction of experts pursuant to Part 25 of the FPR at an early stage of proceedings, should such instruction be capable of providing the Court with the evidence necessary to determine threshold issues without having to await the full post-mortem report from the Home Office instructed pathologist. There is for example, the potential for a neurosurgeon, ophthalmologist and neuro-radiologist to be instructed, with those experts providing an opinion in relation to causation based upon the available imaging and medical records. Such expert evidence could allow the Court to consider the issue of causation and whether it is directly attributable to the actions of a parent, without needing to await the reports of any experts instructed by the police for the purposes of the completion of any final post-mortem report. Further to this, we submit there is no prima facie reason why any samples required by independent jointly instructed experts cannot be disclosed to the parties within the family proceedings by the police, subject to the caveat referred to above at paragraph 15 and in particular, the need to ensure for the safe carriage of any tissue samples.’

24. In recent times consideration has been given to the circumstances in which it is, or is not, necessary for the Family Court to engage in fact-finding with respect to serious allegations made within CA 1989, s 31 proceedings. In *Re H-D-H and C (Children: Fact-Finding)* [2021] EWCA Civ 1192; [2022] 1 FLR 454 the Court of Appeal endorsed the approach that had been described in a judgment that I had given at first instance in *Oxfordshire County Council v DP, RS, BS (By the Children’s Guardian)* [2005] EWHC 1593 (Fam), subject to some additional considerations in order to meet the overriding objective.
25. The overriding objective in all family proceedings is set out in Family Procedure Rules 2010, r 1:

“1.1

(1) These rules are a new procedural code with the overriding objective of enabling the court to deal with cases justly, having regard to any welfare issues involved.

(2) Dealing with a case justly includes, so far as is practicable –

(a) ensuring that it is dealt with expeditiously and fairly;

(b) dealing with the case in ways which are proportionate to the nature, importance and complexity of the issues;

(c) ensuring that the parties are on an equal footing;

(d) saving expense; and

(e) allotting to it an appropriate share of the court's resources, while taking into account the need to allot resources to other cases.”

26. The original (non-exhaustive) list of factors identified in *Oxfordshire County Council v DP* were:

“The authorities make it plain that, amongst other factors, the following are likely to be relevant and need to be borne in mind before deciding whether or not to conduct a particular fact finding exercise:

a) The interests of the child (which are relevant but not paramount);

b) The time that the investigation will take;

c) The likely cost to public funds;

d) The evidential result;

e) The necessity or otherwise of the investigation;

f) The relevance of the potential result of the investigation to the future care plans for the child;

g) The impact of any fact finding process upon the other parties;

h) The prospects of a fair trial on the issue;

i) The justice of the case.”

27. In *Re H-D-H*, Peter Jackson LJ suggested that these factors should be approached flexibly in the light of the overriding objective in order to do justice efficiently in the individual case as follows:

“(i) When considering *the welfare of the child*, the significance to the individual child of knowing the truth can be considered, as can the effect on the child’s welfare of an allegation being investigated or not.

(ii) *The likely cost to public funds* can extend to the expenditure of court resources and their diversion from other cases.

(iii) *The time that the investigation will take* allows the court to take account of the nature of the evidence. For example, an incident that has been recorded electronically may be swifter to prove than one that relies on contested witness evidence or circumstantial argument.

(iv) *The evidential result* may relate not only to the case before the court but also to other existing or likely future cases in which a finding one way or the other is likely to be of importance. The public interest in the identification of perpetrators of child abuse can also be considered.

(v) *The relevance of the potential result of the investigation to the future care plans for the child* should be seen in the light of the s. 31(3B) obligation on the court to consider the impact of harm on the child and the way in which his or her resulting needs are to be met.

(vi) *The impact of any fact finding process upon the other parties* can also take account of the opportunity costs for the local authority, even if it is the party seeking the investigation, in terms of resources and professional time that might be devoted to other children.

(vii) *The prospects of a fair trial* may also encompass the advantages of a trial now over a trial at a possibly distant and unpredictable future date.

(viii) *The justice of the case* gives the court the opportunity to stand back and ensure that all matters relevant to the overriding objective have been taken into account. One such matter is whether the contested allegation may be investigated within criminal proceedings. Another is the extent of any gulf between the factual basis for the court's decision with or without a fact-finding hearing. The level of seriousness of the disputed allegation may inform this assessment. As I have said, the court must ask itself whether its process will do justice to the reality of the case.”

28. An example of how the approach endorsed by the Court of Appeal in *Re H-D-H* may be applied in a case of suspected child homicide is provided by the decision of Lieven J in *Lincolnshire CC v CB* [2021] EWHC 2813; [2022] 1 FCR 99 in which a delayed listing for a four-week fact-finding hearing was refused in favour of an earlier five-day consolidated hearing with more limited findings of fact. Lieven J identified the ‘true question’ for the court as being ‘whether the fact-finding is truly “necessary” for the ultimate welfare decision that the court has to make’.

29. Whilst neither *H-D-H* nor *Lincolnshire CC v CB* dealt with the situation facing the court as a result of delays in the provision of post-mortem reports, evaluation of the case management options available to the court in such cases through the lens described in *Oxfordshire CC v DP* and *H-D-H* is likely to be appropriate. In cases where the death of a child is sudden, with little or no evidence of pre-death injury or symptoms, for example where the cause of death is suspected to be suffocation, there may be no alternative but to await receipt of the full post-mortem report. But in other cases, for example the present one, where there is apparently a range of evidence prior to death which, if established, would be sufficient for the court to determine both the s 31 threshold and the ultimate welfare decision, it may not be ‘necessary’ to await the full post-mortem report where the impact on the child’s welfare in postponing the process until that report is received may be disproportionate and unacceptable.

Summary

30. In conclusion, I would again stress that the purpose of this judgment is to bring a spotlight to bear upon the wholly unsatisfactory delays that are now regularly being encountered in obtaining post-mortem reports in suspected child homicide cases, and to describe possible alternative ways for the Family Court to proceed.
31. Whilst I have been at pains to stress that this judgment is not intended to lay down how any particular future cases should be determined, as it will be a matter for the judges in those cases to evaluate the options available on the facts of each case, I wish to be plain that it is no longer acceptable for the Family Court simply, and passively, to accept that a post-mortem report will take a year and that the Family proceedings must therefore be put on hold. The need to meet the welfare needs of the surviving child(ren) and the statutory duty to conclude the proceedings within 26 weeks impose a requirement on the Family Court to be proactive in considering options by which such evidence as is ‘necessary’ to establish the s 31 threshold and determine the ultimate welfare question can be obtained from other sources.
32. It is a matter for the Police, HM Coroners and others what steps may be taken to alleviate the current extreme reported delays in obtaining post-mortem reports for use in the criminal justice and coronial systems. I am clear that the Family Justice system should no longer passively put up with the consequences of a wholly unacceptable regime. In future the Family Court should only be obliged to delay its proceedings to await receipt of a post-mortem report in a suspected child homicide where it is truly ‘necessary’ to do so in order to achieve the overriding objective of dealing with cases justly, having regard to the welfare issues involved. In all other cases, the court should consider adopting alternative strategies to achieve a more expeditious resolution of the proceedings, whilst still meeting the overriding principles.