Case No: ZW20C90014

IN THE FAMILY COURT AT WEST LONDON

West London Family Court,
Gloucester House, 4 Dukes Green Avenue
Feltham, TW14 0LR

Date: 20/11/2020

Before :

HIS HONOUR JUDGE WILLANS

- -

Between :

THE LONDON BOROUGH OF HILLINGDON — **Applicant**

- and –

(1) The Mother — **Respondent**
(2) The Father
(3) S (A Child)
(through her Children's Guardian)

-and-

The Uncle — **Intervenor**

- -
- -

Ms Elise Jeremiah (instructed by **Hillingdon Legal**) for the **Applicant**
Ms Jayne Harill (instructed by **IBB Solicitors**) for the **First Respondent**
Ms Fiona Griffin (instructed by **Reena Ghai Solicitors**) for the **Second Respondent**
Mr Mark Rawcliffe (instructed by **Creighton & Partners**) for the **Third Respondent**
Ms Emily Driver (instructed by **Direct Access Barrister**) for the **Intervenor**

Hearing dates: 2-5, 10, 12, 16-20 November 2020

- -

JUDGMENT

His Honour Judge Willans:

1. The names of the child and the adult parties in this judgment have been anonymised, pursuant to the Practice Guidance of the President of the Family Division issued in December 2018 having regard to the implications for the children of placing personal details and information in the public domain. The anonymity of the children and members of their family must be strictly preserved. All persons must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court. I can see no reason to anonymise the identity of the professionals in the case although I will make use of labels as appropriate to simplify the judgment. Pursuant to the above I will within this judgment refer to the first and second respondent by reference to their roles as mother and father. I will refer to the child by the initial S, and to the intervenor by reference to his relationship as uncle to the child. No discourtesy is intended to any of these parties by the use of such labels.

Introduction

2. On 15 March 2020 emergency services were called[1] to attend the parents' home address. The London Ambulance Service (LAS) attended within 10 minutes and on arrival S was scored as being at 3 on the Glasgow Coma Scale (and thus the lowest and most concerning score possible). S required resuscitative support before onward transmission by ambulance first, to Hillingdon Hospital A&E department and then,[2] and upon her being stabilised, for more specialist medical care at the Great Ormond Street Hospital (GOSH).

3. During her period of care in hospital a series of concerning injuries were noted. It is these injuries which lie at the heart of this fact-finding exercise. I am asked to consider the evidence and determine the likely cause of these injuries and if this has arisen out of the conduct of an individual(s) then to identify the individual(s).

4. To assist me in reaching my conclusions I have had the benefit of a final hearing bundle[3]; I have heard live evidence from: (i) Dr Adam Oates (Consultant Radiologist); (ii) Dr Patrick Cartlidge (Paediatrician); (iii) Dr Jeremy Allgrove (Consultant Paediatrician & Paediatric Endocrinologist); (iv) Mr Peter Shepherd (Advanced Paramedic Practitioner: London Ambulance Service); (v) the mother; (vi) the father; additionally I have considered the written and oral submissions made on behalf each party by their respective counsel.

5. The uncle was party to the proceedings and represented through to the conclusion of the applicant's evidence. At that point and with an opportunity to reflect on this evidence the applicant confirmed that it no longer sought findings against the uncle. I approved this approach and later in this judgment I confirm my reasons for doing so. As a result the uncle was then immediately discharged

---

[1] 1228hrs

[2] 2130hrs

[3] Separated into main bundle; supplemental bundle and medical bundle. Reference to page number will be as follows: to page A1 in the main bundle [A1]; in the supplemental bundle [SB A1] and in the medical bundle [MB A1]

from the proceedings without any finding being made against him and he played no further role in the proceedings.

6. This hearing had a hybrid format with the professional witnesses (i-iv above) giving their evidence during an entirely remote section of the hearing and the evidence of the parents being heard on an attended basis with the parents and counsel for each party present in the Court building. In addition the mother was supported throughout by an interpreter (who physically attended for the parent's evidence) and the father by an intermediary (who likewise physically attended for the parental evidence). The Court adopted ground rules suggested by the intermediary service and took regular breaks throughout the evidence. Having time to now reflect I consider the hearing was conducted fairly and gave all parties (but particularly the parents) the opportunity to have their case heard without undue delay; to follow the evidence presented during the hearing, and to have their own evidence properly heard and considered.

7. Given both the language and cognitive issues faced by the parents and given the significance of this decision I have decided it appropriate to provide a written judgment which will be carefully shared with the parents prior to formal handing down. At the conclusion of this judgment I provide a summarised version of my judgment to hopefully assist in this process. However, if there is any perceived conflict between that summary and this judgment then it is to this judgment that attention should turn to fully appreciate my decision.

The findings sought and the party's positions

8. The applicant has filed a threshold document[4] in which it asks me to find as follows[5]:

   i) <u>Head Trauma</u>

      On presentation at hospital on 15 March 2020 S had the following brain injuries:

      a) Diffuse subdural/subarachnoid haemorrhage

      b) Abnormal restricted diffusion to the brain substance

      c) Clefts within the brain substance with associated swelling tears and lesions

      These injuries are severe/very severe caused most likely by a shaking type mechanism with acceleration/deceleration/rotational forces. On balance the injuries were inflicted jointly or individually by either the mother and/or father. The injuries were most likely occasioned at the time S became noticeably unwell and shortly before 12:28pm on 15 March 2020. All organic causes have been excluded and these injuries would not have been caused in the normal cause of child-care. The

[4] *SB A39-50*
[5] *This is a slightly modified form of the threshold given no findings being sought against the uncle and given an original allegation 4 was not pursued.*

injuries are not birth related and neither parent has given an explanation for the injury save that they deny responsibility.

ii) Chest injuries

S was found to have suffered multiple fractures to the ribs. Such fractures in infants are exceptionally unusual. S was found to have suffered 9 rib fractures. The 1st, 2nd, 6th, 7th and 8th ribs on S's right side were found to be fractured posteromedially; the 6th rib to the right side was also found to have a fracture posterolaterally; the 3rd, 4th and 5th rib to the right side was fractured anterolaterally[6]. These fractures were most likely inflicted within a short period prior to S's presentation at hospital on 15 March 2020 and possibly on the same day and most likely caused by the same event that caused the head trauma. On balance the injuries were inflicted jointly or individually by either the mother and/or father. There is no organic cause to explain the fractures. They were inflicted 'non-accidentally' after the use of 'obviously excessive force' and not in the course of ordinary handling. They do not date to the birth of the child. They were not the result of CPR being performed or the result of a resuscitative shake. Neither parent has given an explanation for the injury save that they deny responsibility. Additionally there were equivocal left sided posteromedial fractures.

iii) Leg Injury

S suffered classic metaphyseal lesion (CML) fractures to both her right and left distal femur (to the thigh bone just above the knee). These most likely occurred as a result of direct shearing or twisting forces but could also have occurred when acceleration/deceleration forces were applied indirectly to the child's limb (i.e. when she was being shaken causing her limbs to flail). On balance the injuries were inflicted at the same time or similar timeframe to the rib fractures and close to the time of presentation at hospital on 15 March 2020 and at the same time as the head injury. There is no organic cause for the fractures; they were not caused during the course of ordinary childcare handling; they were not caused by a resuscitative shake. On balance the injuries were inflicted jointly or individually by either the mother and/or father. Neither parent has given an explanation for the injury save that they deny responsibility.

iv) S had no pre-existing medical condition, abnormality, weakness of susceptibility that made her susceptible to the injuries that were inflicted.

Failure to Protect

v) The mother and/or the father failed to protect the child from the inflicted injuries.

[6] *The ribs comprise an arc type structure with anteriorly meaning to the front of the arc (front of body) and posteriorally meaning to the back of the arc (back of the body). Anterolaterally means a point between the side and front of the arc; posterolaterally means a point between the side and back of the arc; posteromedially means a point at the extreme posterior aspect of the ribs and close to the spine*

9. After the conclusion of the evidence and prior to provision of final submissions the applicant informed the Court and the parties that it was not seeking any findings that the mother had inflicted the injuries noted above. The applicant left open the question as to whether the mother had failed to protect S. As the applicant agrees this does not preclude me from making findings against the mother as she has been able to fully challenge the case put before the Court. However, as I explain below, I agree with the applicant's analysis in this regard.

10. The mother denies causing harm to S or being aware of an event or action of a third party which likely caused the injuries in question. She does not consider the father would have shaken S in the way described or acted in any other manner that would likely have caused these injuries. The mother gives her own account of the events of 14-15 March 2020 and in substance agrees with the account given by the father as to their respective actions and responsibilities. She has raised appropriate avenues of investigation concerning alternative possible causes.

11. The father equally denies either causing the harm to S or being aware of any circumstances in which S might have suffered such harm. He does not believe the mother would have harmed S. His account of events places S in his care for the period during which S most likely suffered the trauma under consideration.

12. The guardian considers the evidence establishes it likely the father caused the injuries suffered by S in circumstances of stress and tiredness when caring for S. She considers the applicant has provided a clear explanation for the injuries. She does not agree the mother can be said to have failed to protect S.

Legal Considerations

13. I am assisted by a detailed and helpful summary of the law set out within the applicant's opening note[7]. No issue is taken with his summary. I endorse this summary whilst extracting the following important principles:

    i) It is for the applicant to prove each of the allegations and there is no burden on the parents to disprove anything. The applicant will succeed if it establishes an allegation as being more likely than not. The fact that these are serious allegations does not alter the test to be applied[8]. The inherent probability of an event is a matter to be weighed in the assessment but is not of itself deterministic. As was explained by Peter Jackson J (as then was)[9]

    > *It is exceptionally unusual for a baby to sustain so many fractures, but this baby did. The inherent improbability of a devoted parent inflicting such widespread, serious injuries is high, but then so is the inherent improbability of this being the first example of an as yet undiscovered medical condition.*

    ii) Whilst it is not for the parents to <u>prove</u> an alternative explanation or indeed to <u>provide</u> such an explanation, where an alternative is before the Court the question is

[7] *§34 [1-42] and repeated in a legal structure document provided with submissions*
[8] *See Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35, [2008] 2 FLR 141 cited at §3*
[9] *Re BR (Proof of Facts) [2015] EWFC 41*

…not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability.[10]

iii) The Court must remain astute to avoid unconsciously reversing the burden of proof by expecting a plausible explanation as to causation from a parent. Equally in considering all the evidence the Court must be respectful of the medical evidence but must not lose sight that this is but a part of the evidential landscape and that the Court is the ultimate decision maker and that the evidence from the parents will be of particular importance. Again the Court must guard against a medical explanation for causation effectively reversing the burden of proof against the parent(s)[11].

iv) Findings of fact are to be based on evidence, including inferences that can be properly drawn from the evidence, but not on suspicion, speculation or anecdotal evidence[12]. The applicant must not only prove the facts in dispute but must also establish a causative link associating the findings with the crossing of the legal threshold set out in section 31 of the Children Act 1989. It is the crossing of this threshold, and the finding that the child has suffered significant harm attributable to the care given to the child not being that which would be expected from a reasonable parent which is central to the fact finding. In this case the allegations are of harm suffered and so the Court is not focused on the question of risk of harm as found in the same section.

v) The Court operates a binary system such that if it is found to be more likely than not that an event happened then it is treated as a fact. If the assessment fails to meet this threshold then the allegation is wholly ignored thereafter.

vi) In considering the available evidence the Court must have regard to the broad canvas of evidence and must avoid evaluation and assessment of evidence within restricted compartments. The value of evidence may vary as it is held up and considered alongside other available evidence (even when these derive from different 'compartments'). So the totality of the evidence must be considered, and the Court must ensure it undertakes a proper overview of all the evidence. In doing so it is vitally important to have regard to the 'wide canvas' of evidence available to shed light on the family relationships, home life and other valuable evidence which may inform the Court as to what did or did not occur.

vii) Medical and expert evidence is plainly important as well. In cases of this type it is common for the Court to receive evidence from multi-disciplinary experts. This deserves respect and the Court should be in a position to provide reasons if it intends to disagree with such evidence[13]. But the Court is entitled to disagree[14] and must continue to remember

[10] *Re FM(A Child: fractures: bone density) [2015] EWFC B26 cited at §6*
[11] *See Lancashire County Council v D, E [2008] EWHC 832 (Fam) cited at §7 and Re M (A Child) [2012] EWCA Civ 1580 cited at §8*
[12] *Re A (A Child) [2015] EWFC 11*
[13] *Re B (Care: Expert Witnesses) [1996] 1 FLR 667 cited at §19*
[14] *A County Council v KD and L [2005] 1 FLR 851 cited at §18*

that this evidence is part of the canvas for consideration[15]. The Court will always remember that medical understanding and knowledge develops over time and medical certainty today can be shaken tomorrow just as medical uncertainty is removed over time[16]. The Court in these cases should be careful to ensure each expert properly confines him/herself to the boundaries of their own expertise.

viii) Ultimately the Court has to be open to the potential for the cause to remain unknown[17]:

> *…there has to be factored into every case which concerns a disputed aetiology giving rise to significant harm, a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities.*

ix) In many cases the Court is confronted by more than one potential perpetrator of an injury under investigation. In such cases the Court has to examine the situation relating to each of the potential candidates. In doing so the Court has to ask[18]; (a) is there a list of persons who had the opportunity to cause the injury?; (b) Can the Court identify the actual individual who was responsible for the injury?; (c) if the Court cannot then in respect of each individual on the list the question will be "is there a real possibility that the individual was the perpetrator of the inflicted injury". There are many reasons why it is much better to identify the actual perpetrator, but the Court should not strain to identify an individual if the evidence does not permit this.

x) In considering the evidence the Court may conclude a witness has told lies to the Court. The Court should not use this finding as a basis for concluding the witness has lied about all matters. There are many reasons why a person may tell a lie or lies but this does not mean they have lied about everything. The Court should examine the context of the lie to evaluate its probative value to the overall evaluation[19]. In considering whether the lie is corroborative of responsibility the lie must be deliberate; it must relate to a material issue and the motive for the lie must be a realisation of guilt and a fear of the truth. But even then, the lie does not establish responsibility rather it is then capable of amounting to corroboration of the allegation in question.

xi) Finally in assessing evidence the Court must continue to remember that the purpose of evidence and examination is to understand and test the evidence. The Court reflects on the evidence and considers, among other matters, its content and whether it is logical, consistent and how it fits with other evidence available to the Court. The Court will likely gain far less assistance from the manner or demeanour of the witness when giving the evidence[20]. The Court should be cautious in assuming a confident witness is a truthful witness for example. Also when

[15] *A County Council v A Mother and others[2005] EWHC Fam 31 cited at §21*
[16] *Re U (Serious Injury; Standard of Proof) [2004] EWCA Civ 567*
[17] *Re R (Care Proceedings: Causation) [2011] EWHC 1715*
[18] *Re B (Children: Uncertain Perpetrators)[2019] EWCA Civ 575*
[19] *R v Lucas [1981] QB 720*
[20] *The Queen on the Application of SS (Sri Lanka) v The Secretary of State for the Home Department [2018] EWCA Civ 1391*

considering oral testimony the Court should bear in mind the fragility of human memory and where an account has been given on multiple occasions the risk of 'story creep[21]', namely a changing story that arises out of repeated telling rather than intention to mislead. Again this should lead the Court to examine the evidence with care.

Proceedings

14. By way of a very short summary I would first refer to section B of the main bundle for the procedural steps taken within the proceedings. The proceedings commenced on 8 April 2020. I have dealt with all case management hearings as the allocated Judge. On 4 May 2020[22] I heard a case management hearing and interim care hearing. I made an interim care order with a plan for continued care within a family placement. S has remained within that placement throughout the proceedings and there is a positive special guardianship assessment in respect of the family carers. I also approved a cognitive assessment of the father and the appointment of both Drs. Oates and Cartlidge. On 1 June 2020 I approved a consent order for the appointment of Dr Allgrove[23]. On 3 June 2020[24] I heard a directions appointment when I gave further directions with respect to the role of the uncle as intervenor. I gave permission for an intermediary assessment and timetabled the proceedings towards this fact-finding hearing. On 23 October 2020 I conducted a pre-trial review. At this hearing I refused an application for the instruction of a neurosurgeon as being unnecessary. I did not dismiss the application but gave liberty for it to be restored in the light of the live evidence. There has been no application to restore the application and it now stands dismissed.

Background

15. The parents live together with the uncle in the father's family home. Their relationship is of short history having met through an arranged family process whilst the mother was living overseas. Having communicated remotely for a period they physically met and married in February 2018. The mother joined the father in this country in June 2019 and shortly afterwards she fell pregnant.

16. I note the history of the pregnancy detailed in the mother's first statement. Whilst there were some concerns along the way it proceeded without real issue. At week 37 the clinicians decided it was appropriate to induce a pregnancy and this course was taken. However after a significant period of medical care a natural birth did not follow and so an emergency caesarean section was undertaken. The evidence tells me the father's family offered support to the mother through the pregnancy and indeed a relation accompanied the mother into the operating room. After a period of post-natal care S was discharged with her mother on 1 March 2020.

17. Neither parent have a history of concern whether with respect to criminality (there is no offending); drink or drugs. The father reports some modest mental

[21] *Lancashire County Council v The Children [2014] EWHC 3 (Fam):*
[22] *B60*
[23] *B108*
[24] *B110*

health (depression) but this is not of real significance. The parents report a happy relationship and excitement over both the pregnancy and following S's birth. The father has a small family compared to the mother, but the mother reported working to form a relationship with the paternal family and it is clear she has valued their support. As noted above S has been cared for within the family since the commencement of these proceedings. There is no suggestion of domestic violence in the relationship. The father works and the mother has good educational qualifications.

18. In this case the Court has received an expert report as to the father's cognitive capacity[25]. In its conclusion the expert reports:

> *[The father] does not meet the criteria for inferring that he has a learning disability (because his non-verbal reasoning skills are in the average range); however, he does present as having significant deficits in a number of key areas. [The father] is a vulnerable adult; he is likely to experience difficulty in keeping up with his peers in a wide variety of situations that require thinking and reasoning abilities, especially those that rely on language.*

An intermediary has subsequently been appointed to assist the father.

19. On discharge from hospital the family returned to their home. There were the expected family visits and the father arranged to take some time off work (although this had not been planned and so he had to work for part of the first two weeks between S's return home and later readmission to hospital). The parents account of this period of is a relatively routine process of becoming used to a new and first child at home. They did notice some unusual noises but were informed this was likely wind and given simple advice. However, it seems the parents were finding S's routines tiring (as might be expected) and the father signed off work between 11-13 March 2020 as he was tired and feeling dizzy through lack of sleep and dehydrated. Nonetheless the parents speak of the father being supportive during this period (as were the family) with cooking and other household support.

20. The evidence suggests the parents were cautious with S. The father in police interview speaks of the mother asking what he had done on one occasion when S started crying. In his evidence the father told me by 15 March 2020 he would not have changed S's nappy alone as he would want the mother there to support him with the process. My sense was of a relatively high level of perhaps understandable apprehension for new parents with a small baby, and perhaps in the case of the father a heightened level of caution arising from his own cognitive challenges. But they report no issues of concern and certainly no incidents that caused them to worry for S's welfare.

21. However on 13 March 2020 the family were concerned as to S being unsettled and appearing to be in pain with related crying. In any event there was a planned appointment with the midwife at hospital on the next day. On 14 March 2020 the parents attended the appointment. The midwife was not overly concerned as to the information shared and was of the view the issue was likely wind. General advice was given to include feeding advice. The mother also received some post-operative care with respect to her c-section wound. However that evening S was more unsettled and was crying throughout the night. She was on a feeding

[25] *E31*

regime every two hours or so and the parents experienced an unsettled night with the regular feeds and S being unsettled and crying. The evidence suggested this period or irritability and crying was worse than the more general crying that had come before. Both parents agree they received poor sleep over the evening. S slept on the father's side of the bed in her cot because of the mother's difficulties with lifting as a result of her operative wound. At one point during the night (between 4-6am) the mother was soothing S whilst in bed and placed her to sleep between the parents. The father then woke and was surprised to find S next to him and was concerned as to her being hot (damp and sweaty). He told me there was some contact with S as he turned over before being aware of her presence in the bed.

22. By 6:30am (15 March 2020) the parents were awake. The parents each confirmed that they were both present in the bedroom throughout the night as all they needed for S was in the bedroom. At approximately 10.30am the mother went to the bathroom leaving S with the father. She returned 15-20 minutes later. Within the hour she took a call from a family member in a different bedroom again leaving the S with the father for a similar period. At about 12 noon the mother left the bedroom and went downstairs to have some breakfast. S remained in the bedroom with the father. The parents agree that S was unsettled and crying for much of the period between 10.30 and 12 noon. In his evidence the father spoke of being worried and scared and particularly so when left with her alone. The sense was of him deferring to the mother for a better understanding of how to sooth and care for S in this situation. However it is clear S remained unsettled and crying during the period; there was some feeding and a little vomit. S remained in this state when the mother is reported to have gone downstairs.

23. After about 10-15 minutes the father came downstairs with S in his arms. The father reports S stopped crying as he was coming down the stairs. The mother's evidence was that she believed S stopped crying at some point when she was downstairs or that she could no longer hear her crying. By the time the father was downstairs S was no longer crying. In evidence the father indicated he then passed S to the mother and took steps to arrange the change mat so as to change S. He had noted she felt cold. In her evidence the mother suggests the father arranged the mat before passing S to her. In any event the parties agree the mother quickly expressed concern that S was not breathing and told the father to get help. S was noted to be blue and cold. I also note in the evidence a suggestion that the father expressed a concern about something being wrong before passing S to the mother[26].

24. The uncle was present in the home. In his evidence he reported working night shifts and returning home on 15 March at about 1am and immediately going to bed. On that day he had got up for a short period to go to the toilet and had looked into the parents' bedroom and asked if everything was okay, as S was crying. He then went back to bed until hearing disruption downstairs and the mother calling for him to come. He went downstairs and found S in a collapsed

[26] *Mother's evidence C84 §71*

state and the parents in a distraught state. Both parents agree the uncle's account of only having contact with S after her collapse.

25. Emergency services were called and arrived promptly. Prior to their arrival telephone advice was given as to resuscitation. It seems for a period S was placed on her chest with her back being rubbed before being turned over. Problematically she was also placed on a sofa rather than a hard surface with the result that any CPR force might be dissipated through the underlying sofa. In any event on arrival the ambulance service report they witnessed CPR being wholly ineffective due to the limited force being used by the uncle. They then provided support through an oxygen mask/artificial ventilation and S commenced breathing. They did not in fact provide CPR to S.

26. At the same time police officers also attended. Reference was made in the hearing to the limited accounts provided by each parent which suggested that S had been laid to sleep following a vomiting episode and that she had been found in a collapsed state when checked:

> *Parents state he had vomited this morning at 7am, parents feed baby at 12:20pm and put baby down to sleep and then went in to check baby and noticed she wasn't breathing*[27]

This did not accord with either parent's account of the ordering of events. The father accepts the truth of the paramedics account (i.e. that the paramedic is reporting what he heard) but believes his own shock and confusion likely led to this mis-report. In any event he stands by the account given above. The mother likewise stands by the account above.

27. The mother accompanied S to hospital in the ambulance. Thereafter S received the care summarised in this judgment above and trauma was identified as in the threshold document. I do not intend to detail the complete medical history whilst in hospital care but note the report of Dr Lucinda Carr (Consultant Paediatric Neurologist) which provides a detailed overview of this period[28].

The Expert Evidence

28. I would say at outset that I found the expert clear and balanced. Each expert appropriately kept within their own sphere of expertise and made clear if they were moving outside their specialism. Dr Oates in particular informed me as to the experience he has in liaising with his clinical colleagues and how this provides him with important experience but was clear where the questions fell outside of his skills. He was also clear to distinguish between what the evidence told him on dating as to range of dating period and his professional opinion as to the probability of timing. That is not to say I was not equally impressed by the evidence of both Drs. Cartlidge and Allgrove. Dr Cartlidge was open to alternative explanations and had himself raised for consideration the possibility of an ALTE (apparent life-threatening event or as he preferred to refer to a 'funny turn'). This was not the approach of a dogmatic or entrenched expert. Dr Allgrove had been called into this case to deal with Encrinological features (although he is also a consultant paediatrician) and he dealt with all the points

[27] *See A 70 but variously reported by LAS*
[28] *E1-22*

clearly and confidently. He was able and willing to access the GOSH system as required to clarify outstanding results and shared and explained the same, with and to the Court. This was not the actions of a defensive witness. Importantly, no party sought to suggest anything to the contrary with respect to any of the expert witnesses.

29. As might be expected the experts evidence dealt with the following matters:

i) What identified trauma was suffered by S?

ii) What was the likely timing of such trauma?

iii) What was the likely mechanism or action that caused the same trauma?

iv) Are there other possible explanations which might explain some or all of the items of trauma?

In my assessment the evidence was clear and consistent between the experts. In setting out their summarised conclusions I have regard to their respective expert reports; the experts meeting and their live evidence.

Trauma

30. I can summarise by confirming the experts (Oates/Cartlidge) identified the injuries set out within the threshold document. These comprised the haemorrhaging and associated damage around the brain and to its substance; the rib fractures and the CML fracture to the knee region. There is no dispute that these injuries are present. The parents accept this evidence without challenge.

Timing

31. In this regard Dr Oates gave lead evidence with which Dr Cartlidge agreed/deferred. In relation to the head injury there was clear evidence of acute (new) bleed as demonstrated by the white presentation (attenuation) on the scanning. This is a clear indication of an acute bleed and therefore of recent trauma (within 7-10 days). This conclusion is supported by the likely effect on S of the brain trauma. In S's case she suffered bleeding but also damage to the substance of the brain and her collapse can be understood in this context. The clear evidence of Dr Cartlidge was that this presentation (collapse) would be closely associated in time with the episode which led to the injury. In short S would have collapsed very shortly after suffering the brain injury. The experts were very clear and agreed this was a severe injury[29]; that S would have been 'profoundly unwell' and the trauma could in other circumstances have been fatal. In the context of this case and assuming the correctness of the parental history this times the incident to not very much before the call to the LAS. It was also clear to me that the presence of such harm would be inconsistent with the child acting in an otherwise normal behaviour (e.g. smiling; interacting and feeding). The sub-arachnoid bleed causes irritation/pain. But the overall brain injury was significant and would have overwhelmed any pain arising from the

[29] *See Dr Oates [E132]*

other trauma. In the light of the above any suggestion of trauma arising from birth would fall far outside of the dating of this trauma.

32. Turning to the rib fractures Dr Oates explained how the process of healing takes place and how it is the healing of the fracture which assists with the dating of the fracture. The fact that there was no evidence of healing on the first chest radiograph (15 March) but there was on the subsequent radiograph (23 March) leads Dr Oates to conclude it is likely the fractures occurred within a short time period of the presentation on 15 March and possibly even on the same day[30]. Once again plainly birth related injury falls outside of the relevant time frame.

33. The position with the CML fracture is more complex due to a less clear healing response. However, with some caution Dr Oates considered there was evidence to suggest resolution which supported a conclusion of infliction at around the time of the rib fractures[31].

34. Dr Oates was quite clear that there was no way to confirm whether the fractures all happened at the same time and that certainly at a theoretical level one could have had up to 11 separate events (with 9 rib events; a head event and a leg fracture event). However, both he and Dr Cartlidge (see mechanism below) felt the injuries fitted with a single event. Importantly, the radiological evidence permitted such a conclusion.

Mechanism

35. With the caveat noted above as to the theoretical possibility for multiple events both experts agreed it was possible, indeed probable that the injuries derived from a single event. In simple terms both were of the view the likely mechanism was a shaking type mechanism which would have been associated with the injuries as follows:

    i) The rib fractures would have been caused by a S being firmly gripped whilst shaken. I was asked to have regard to the placment of the fractures in suggesting a common origin (i.e. all in a line down the rib cage)

    ii) The brain trauma would have arisen from S's head being unsupported and proceeding through a process of rapid acceleration/deceleration / hyperflexion/hyperextension. This creates a shearing process and the related bleeds.

    iii) The CML fracture arises as a result of the lower limbs being free to flail with the weight of the foot acting as an anchor to create a force which causes a large number of micro-fractures which accumulate into the CML fracture.

    iv) These injuries are known to be associated with shaking type insults and fit together in a logical manner.

[30] *E137*
[31] *E138*

v) There is no way of assessing the exact forces used or indeed the number of shakes required but what would be required would be a level of force which fell outside of the normal band of child handling and was such as would alarm an observer. The injuries here are severe and the suggestion was of this likely being a forceful motion to cause the damage to the brain substance.

36. This is certainly the preferred explanation of the experts. But as Dr Cartlidge made clear the injuries might be explained by any process which was either a shake or equivalent to a shaking mechanism. With this in mind he raised the possibility of a panicked parent either shaking a baby to resuscitate it or losing focus and moving without supporting the baby causing the movements noted above. But as he also noted no such account is provided in the case of S.

Other explanations

37. The experts were obviously open to considering any history given which might shed light on the injuries. They were asked to consider whether the injuries could be birth related. However, for the reasons given above the birth fell outside of the dating period and in any event would be most unlikely to cause the injuries in question.

38. There was also a specific question as to whether CPR procedures might have caused the rib fractures. However, it was noted that the evidence of both the family and the LAS was of the CPR given being ineffectual due to insufficient force. Moreover Dr Cartlidge made clear significant force is required to cause such rib fractures and they are not commonly found following effective CPR. A further complication was the presence of posterior fractures which would not fit with pressure being applied to the anterior of the body.

39. A range of testing had been undertaken with respect to S whilst in hospital. It was noted one test had suggested the possibility of whooping cough. This was felt to be relevant as it might be associated with bleeding on the brain. However, Dr Cartlidge clarified that whilst this was an initial assessment follow-up tests had shown that S was not in fact suffering with the form of the strain which is linked to whooping cough.

40. Dr Cartlidge's role was to provide a paediatric overview. As part of this he considered a range of test results provided with respect to S. He found no basis for suggesting a genetic or organic cause for the injuries. In any event as he noted whilst certain condition might explain a brain bleed, they would not explain the multiple fractures. But he did not find a reasonable basis for concluding S had an underlying condition or disorder.

41. Dr Allgrove was brought into the case in the light of certain test results for S falling outside the normal range to be expected. However, he clearly explained that these results were not unexpected as a consequence of the trauma S had suffered and that follow up results had shown the readings returning either to normal levels or to levels inconsistent with underlying endocrinological issues.

42. Dr Cartlidge was asked about the failure to undertake a heel prick test in the case of S and it was questioned whether this might leave a gap in understanding. He did not agree and noted that a blood test could be taken at any time. However, he had a range of tests and other evidence and had no basis for considering S was subject to a condition that might have caused these injuries, and which would have been picked up by a heel prick test.

43. In summary the experts agreed there was no history or medical explanation for the constellation of injuries (or indeed any of them taken separately) and that it was probable they were inflicted at the same time and in the light of the brain injury in close approximation to the time at which the LAS were called (probably close to 12:28pm on 15 March 2020).

Analysis of Evidence and Findings

44. I would at outset make clear that there were two aspects of the evidence and argument which on reflection I have not found to be of great assistance.

i) Some significant examination time was taken up with consideration of what the father did or did not say to the LAS. It is plain the very short note of this account does not fit with the parents account given to me or to police or in their written evidence. The sense of the examination was that in some way the truth had slipped when speaking to the LAS.

Ultimately and by the time of submissions no party was asking me to place weight on this discrepancy. For my part I agree. There are many reasons as to why that short note might represent a misunderstanding or mis-speaking during what was evidently a period of real crisis and emotional shock. It frankly does not fit with the consistent evidence elsewhere found within the papers. I note the account talks about the child being put down to sleep at 12:20pm and then the parents checking her and finding her in a state of collapse. If this were correct, then this would be a highly concertinaed process given the call was made to the LAS at 12:28pm.

Having heard the father give evidence it is clear he at times mixes up his explanation of sequencing of events. When questioned by the guardian he mixed together various stages between 10.30 and 12.00 noon. I am in little doubt the evidence of the Mr Shepherd was truthful and a correct account of what the father said to him, but I am unpersuaded it is in fact a correct account of what happened.

ii) Some time was taken questioning the parents as to whether the mother was socially isolated in this jurisdiction. Having heard the evidence I was left with the clear impression that the mother had forged a good relationship with the father's family who were offering support. It is true to say the parent's relationship had limited foundations but there is no reliable evidence to suggest disharmony in the relationship let alone controlling or other problematic behaviour. I gained no assistance from the fact the father was not present at the birth. This is by no means a unique situation. Importantly, the submissions appear to proceed on the

> basis of a suggested loss of control arising from the developing stress and exhaustion of caring for S. Self-evidently such an account does not require a background history of relationship disharmony for it to be established.

45. I consider it is also important to make clear that the father's cognitive difficulties are not themselves probative as to what happened. Whilst I will return to this point below, I consider it would be wrong to factor this feature into my assessment when considering matters of causation. I frankly have no evidence to suggest the father is more or less likely to respond to stress by losing his calm with S and shaking her. He is of course entitled to ask me to bear in mind his character and history which does not suggest such vulnerability.

The uncle

46. I turn next to the role of the uncle. I approved of the applicant's decision to remove the uncle from the list of perpetrators. Having considered the applicant's evidence it was clear its case required an event of significance shortly prior to the call to the LAS. However it was abundantly clear all the evidence indicated the uncle had no physical contact with S until after the call was made. In these circumstances there could be no basis for concluding the uncle either caused the injuries or that there was a real possibility that he caused the injuries. It was right to drop the case against the uncle and he leaves the case with no stain on his character.

The mother

47. For reasons which I will develop below I also agree with the applicant as regards its ultimate position in respect of the mother. Short of a collusive and false case from the parents it was clear the mother left S with the father when she went downstairs at 12 noon. At that time S was crying and not exhibiting the symptoms later seen. She was an irritable but ordinary presenting baby. When she next saw S, she was silent, cold, turning blue and lifeless. On that basis she was plainly not present when S suffered whatever occurred.

48. Of course this does not deal with the possibility that the accounts given are false and collusive. I should note no party makes such a suggestion and I agree the evidence does not support such a conclusion. The accounts given by the parents have been (subject to the LAS point above) consistent throughout. I have to say I doubt the parents have the sophistication and the father the cognitive capability to hold such a false and alternative account together throughout this period. I also consider such an alternative scenario is inherently improbable and there are significant pointers to the contrary. I find it improbable that S was harmed whilst in the common care of the parents. I consider their joint presence would itself be a limiting factor on any improper conduct. For reasons given I find it most unlikely the parents have contrived a completely false account to cover for the mother having harmed S and having agreed for the father to take the blame.

49. I also consider the failing to protect allegation is misconceived on the facts of the case. There is nothing within the evidence to suggest either of the mother or the father would have sufficient understanding of risk to S whilst with the other

to establish the necessary causative link. I am not satisfied that a knowledge of the exhaustion and lack of confidence of the other parent with the child is sufficient to make out this allegation. Allegations of this sort are serious with real implications and it would be surprising indeed if such regular levels of understanding (i.e. many parents of new babies are exhausted and learning as time passes but this does not create a state of knowledge of risk on the part of their partner) could meet the test to establish this allegation.

50. Having considered the evidence I have reached the following clear conclusions:

i) I accept the evidence of the experts as to the form of trauma experienced by S (the brain/rib and leg fractures).

ii) I accept the evidence of the experts as to timing and on balance consider it likely the injuries were caused at the same time. I accept the evidence that this constellation of injuries fits together as a result of a single event. The evidence does not suggest multiple incidents over what was a short period of time at home. There is an inherent probability associated with one event rather than multiple events and my assessment of the evidence is that the event arose following a climax of stress and exhaustion rather than flowing from repeated misconduct. The evidence of multiple rib fractures, located as they are, signify a single event and the CML fracture is best understood through the flailing motion associated with a shake. It is more than coincidence that they are all dated within the same range of time.

iii) As to the mechanism for the injury I am confident the experts are correct when they point to the likely mechanism being a shaking action. As noted above this logically links the constellation of injuries and explains how they might all have been occasioned. The rib fractures fit with a gripping process and the injury to the brain and leg then fits with the child being shaken whilst gripped. It makes intuitive sense. I accept the evidence that this would have been a forceful process but on balance it was likely to have been short-lived and over in seconds.

iv) Whilst having regard to the point that the parents do not have to disprove the allegations, I do bear in mind that there is no alternative history that might explain any (let alone all) of the injuries. As a matter of fact this trauma occurred, and something must have led to it. Yet S is an entirely dependent baby and one would expect the event to have been witnessed by one or other of the parents. Of course it might be that the injuries reflect an underlying disorder. The difficulty with this and the reason I reject it is that alternatives have been properly considered and rejected and further there really is no condition that would explain both a tendency to bleed with associated rib and other fractures.

v) I have considered the point as to an ‘unknown cause’ and of course bring this into my analysis. But here the medical evidence is clear and cogent. There is no medical doubt held by the experts and they offer a logical and comprehensible explanation based on significant experience. From the expert perspective this case does not touch on areas of uncertainty.

There is a settled body of understanding around these issues. To reach a conclusion of 'unknown cause' would in my assessment be perverse on the facts.

vi) I have listened with care to the parental evidence. It is plain to me the mother can shed no light on the cause of the injuries, but she sheds much light on the surrounding circumstances. It is very clear to me that these were anxious new parents who were really struggling with the demands thrown up by a small baby. I have no doubt they remained excited and happy, but they were finding the process draining/exhausting.

The father provides a similar account. I have no hesitation in accepting their evidence as to the challenge this was posing. They were getting little sleep and unfortunately were so dependent on each other that one could not take time off whilst the other provided sole care. As a result both were exhausted. The father was forced to take time off work and felt dizzy. I accept the tiredness was having a significant physical impact upon him.

Additionally it seems to me there was a somewhat poor level of communication between the parents as to how they were feeling. I am cautious in how I approach this point, but the evidence was very clear that on the morning of 15 March the father felt out of his depth, scared and worried and wanting the mother to return from the bathroom/telephone call to support S. Yet when she returned he suggested she should have breakfast leaving him alone for a further period. I have a real sense of the father attempting to 'do the right thing' and support the mother when he was in fact on the edge himself. This showed a lack of awareness as to his own vulnerability.

vii) I was struck by the father's evidence when questioned as to whether anything might have happened to S whilst in his care. On a number of occasions he answered he did not think so as he could find no image in his mind of anything happening. With due respect to his cognitive challenges I found this a somewhat puzzling response. It is right to note at other points he was clear in his denial of any shake but nonetheless this initial response left a lingering concern in my mind.

viii) But more sigificant is the reality that something did happen to S during this period leading to her serious injuries. No-one else had care of S and the account/description given by the father of soothing her simply fell outside of anything that might have led to the injuries. At most he described rocking and lightly bouncing her in a cradled and fully supported position and without any possibility for chest compression or the forces associated with the brain injury. If I were to accept this account I would be in the territory of the unknown cause which I have rejected for the reasons already given.

ix) Having considered the evidence I find that S did suffer the trauma in question whilst being cared for by her father and that this arose out of a shaking mechanism as described by the experts. I consider it most likely

this arose out of a loss of control derived from exhaustion and an inability to otherwise stop S crying. I can find nothing in the evidence to suggest a motive other than loss of control.

x) I do wonder whether the father's cognitive difficulties provide some level of explanation for what happened. It may be that he struggled to find a reasoned way through the challenge he faced and found the situation overwhelming and with no solution acted as he did. On the evidence it is most likely the shake occurred whilst S was still upstairs with the father and that her collapse followed shortly afterwards. I do not accept the father's account of a change in presentation on the final few steps as he came downstairs. I find it most unlikely this was the point at which she was shaken. It is clear she was in a state of collapse seconds later when seen by the mother.

xi) My strong sense is that the father realised he had acted wrongly and that S might have suffered some harm as a consequence. I consider it likely this is why he came downstairs and gave S to the mother. It seems likely he realised matters had gone too far and he needed help. In reality this realisation likely led to S's circumstances being discovered quickly and this decision assisted in her receiving the prompt care she needed.

xii) I find it striking that the mother was immediately conscious that something was wrong. It seems clear S's condition was readily apparent (she was going blue and was lifeless). On the father's case he was cradling her in his arms when walking down the stairs and considered she needed her nappy changed. I find this account difficult to accept. As set out above I consider he had a developing realisation of what he had done and recognised he needed help.

51. I have reached the following conclusions:

i) The applicant has proven the allegations contained within the modified threshold save with respect to the failure to protect

ii) S suffered the said injuries whilst in the care of the father and as a result of a likely vigorous shake. This was a single event over a short period and likely arose in a moment of loss of self-control.

52. As planned, I will hand out this judgment so it can be considered by the parents in advance of the formal handing down. I will hand the judgment down at 2pm (or as soon thereafter as the parties are ready) on 20 November 2020. It seems likely I will thereafter adjourn the matter for a period of about 2 weeks for the parties to take stock of the decision. It is likely I will want the parents to provide statements setting out their response to my findings. I suspect I will want the parties to consider the assessments and timetabling required to take this case through to a final welfare hearing. These matters can be considered at the hearing tomorrow.

His Honour Judge Willans

Summary of Judgment

1. **I have considered all the evidence provided to me. The parties have agreed the law that applies, and I agree with them.**

2. **I agree the uncle was not responsible for the injuries. He was not in contact with S at the time she likely suffered her injuries. He had no opportunity to cause the injuries.**

3. **I accept the expert evidence. I found it provided a clear explanation as to the injuries; as to when the injuries happened and how the injuries likely happened. I agree the injuries were to the S's brain; ribs and leg. I agree it is likely they all happened at the same time and only shortly before the ambulance was called. I agree it is likely the cause of the injury was a shake and that this was behaviour which would have alarmed someone watching. It was a shake which was outside of acceptable parent behaviour. It probably lasted for only a few seconds but was enough to cause the injuries.**

4. **I do not believe the mother was responsible for the shake. I accept she was downstairs for about 10-15 minutes before the father brought S downstairs. She did not have the opportunity to shake S. By the time S was downstairs the injuries had already occurred. This is clear from the fact that she was lifeless by this time and turning blue.**

5. **I do not believe the mother could have done anything to stop this from happening. Whilst she knew the father was tired and struggling this was not enough to lead her to believe he posed a risk to S.**

6. **I find it likely the father shook S. He was caring for S when she went from normal behaviour (crying) to being lifeless. No-one else was present during this period. I consider it likely this happened upstairs when caring for S became too much and the father lost his self-control and shook S.**

7. **I consider all other reasonable explanations have been considered and none provide an alternative explanation for what happened. The experts provide a clear explanation, and this is not a case in which it is likely the answer is some unknown cause.**

8. **Having reached this conclusion I will now need to consider what the Court now needs to do to decide what is best for S in the future.**