Neutral Citation Number: [2019] EWFC 33

Case No: CM18C05141

IN THE FAMILY COURT
SITTING AT IPSWICH COUNTY COURT

Date: 13/05/2019

Before :

MR JUSTICE NEWTON

- -

Between :

A Local Authority	**Applicant**
- and -	
M	**1st Respondent**
F	**2nd Respondent**
	3rd and 4th Respondents
P and T	

- -

- -

Mika Pine for **A Local Authority**
Paul Storey QC and Alexa Storey-Rea (instructed by **Wollens Solicitors**) for the **First Respondent**
Andrew Bagchi QC and Dorian Day (instructed by **Brendan Flemming Solicitors**) for the **Second Respondent**
Fiona Bailey (instructed by **Haywards Solicitors**) for the **Guardian**

Hearing dates: 1-12 April 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MR JUSTICE NEWTON

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.

Mr Justice Newton :

1. In the late afternoon of 11 April 2018, a four month old baby boy, T, collapsed and stopped breathing whilst in the care of his parents. He was taken to Hospital by the emergency services who had been summoned by the parents. His life threatening condition was such that he was later transferred to Intensive Care at Addenbrooke's Hospital where he was intubated.

2. On full examination T was found to be suffering from bilateral subdural collections; a haemorrhage on the brain; a lower spinal haematoma; and bilateral retinal haemorrhages. Neither of the parents could give any account as to what might have led to those injuries. There was no history of accidental trauma, or apparent predisposing medical condition; the inevitable corollary was that it was most likely that T had sustained some form of abusive trauma.

3. Those events happened almost a year ago. Since 11th April, an older child, P, went to live with his maternal grandparents, until 31/8/18 when the court approved a return to live with his parents, supervised at all times by other adults, under an Interim Care Order. When T was discharged from hospital he went to live with an uncle in Oxford where he remains. Both parents have continued to be significantly involved in their children's' care. They have devoted the last year to spending all their time between them, half the week at home and the other half in Oxford.

4. In this fact finding hearing spanning 10 days, the Court has had the benefit of some of the foremost experts in their fields. I wish to record my gratitude for the assistance of specialist counsel in this case who have focused really helpfully on the core issues. For a number of reasons, I have found this a surprisingly difficult case.

The Law

5. In determining the issues at this fact finding hearing I apply the following well established legal principles. These are helpfully summarised by Baker J (as he then was) in *A Local Authority v M and F and L and M (Children) (Fact Finding: Non-Accidental Injury)* [2013] EWHC 1569 (Fam).

    i) The burden of proof lies with the Local Authority. It is the Local Authority which brings the proceedings and identifies the findings that they invite the Court to make. The burden of proving the assertions rests with them. I bear in mind at all times that the burden is fairly and squarely placed on the Local Authority, and not on either parent. Recent case law (such as *Re B (A Child)* [2013] UKSC 33 and *Re B-S (Children)* 2013 EWCA 1146) reinforces the importance of proper findings based on proper facts; the principles are the same for whatever the proposed outcome. Here there is, as in many cases, a risk of a shift in the burden to the parents to explain occasions when injuries might have occurred. Whilst that can be an important component for the medical experts, it is not for the parents to explain but for the local authority to establish. There is no pseudo burden as Mostyn J put in *Lancashire County Council v R* [2013] EWHC 3064 (Fam). As HHJ Bellamy said in *Re FM (A Child: Fractures: Bone Density):* [2015] EWFC B26.

> "Where… there is a degree of medical uncertainty and credible evidence of a possible, alternative explanation to that contended for by the local authority, the question for the Court is not "has that alternative explanation been proved" but rather… "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."

ii) The standard of proof of course is the balance of probabilities (*Re B* [2008] UKHL 35). If the Local Authority proves on the balance of probabilities that baby A was killed by the mother or sustained inflicted injuries at her hands the Court treats that facts as established and all future decision concerning the future welfare of B, based on that finding. Equally if the Local Authority fails to prove those facts the Courts disregards the allegations completely.

> "the "likelihood of harm" in s31(2) of the Children Act 1989 is a prediction from existing facts or from a multitude of facts about what happened… about the characters and personalities of the people involved and things which they have said and done [Baroness Hale]"

iii) Findings of fact must be based on evidence as Munby LJ (as he was then) observed in *Re A (A child) Fact Finding Hearing: (Speculation)* [2011] EWCA Civ 12:

> "It's elementary proposition that findings of fact must be based on evidence including inferences that can properly be drawn from the evidence, not on suspicion or speculation."

That principle was further emphasised in *Darlington Borough Council v MF, GM, GF and A* [2015] EWFC 11.

iv) When considering cases of suspected child abuse the Court must inevitably survey a wide canvass and take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss P observed in *Re T* [2004] EWCA Civ 558 [2004] 2 FLR838.

> "Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence, and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the Local Authority has been made out to the appropriate standard of proof."

v) The evidence received in this case includes medical evidence from a variety of specialists. I pay appropriate attention to the opinion of the medical experts, which need to be considered in the context of all other evidence. The roles of the Court and the experts are of course entirely distinct. Only the Court is in a position to weigh up the evidence against all the other evidence (see *A County*

Council v K, D and L [2005] EWHC 1444, [2005] 1 FLR 851 and *A County Council v M, F and XYZ* [2005] EWHC 31, [2005] 2 FLR 129). There may well be instances where the medical opinion is that there is nothing diagnostic of a non-accidental injury but where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts, that is on the balance of probability, there has been non-accidental injury or human agency established.

vi) In assessing the expert evidence, and of relevance here, I have been careful to ensure that the experts keep within the bounds of their own expertise and defer where appropriate to the expertise of others (*Re S* [2009] EWHC 2115 Fam), [2010] 1 FLR 1560). I also ensure that the focus of the Court is in fact to concentrate on the facts that are necessary for the determination of the issues. In particular, again of relevance here, not to be side tracked by collateral issues, even if they have some relevance and bearing on the consideration which I have to weigh.

vii) I have particularly in mind the words of Dame Butler-Sloss P in *Re U; Re B* [2004] EWCA Civ 567, [2005] Fam 134, derived from *R v Cannings* [2004] EWCA 1 Crim, [2004] 1 WLR 2607:

a) The cause of an injury or episode that cannot be explained scientifically remains equivocal.

b) Particular caution is necessary where medical experts disagree.

c) The Court must always guard against the over-dogmatic expert, (or) the expert whose reputation is at stake.

viii) The evidence of the parents as with any other person connected to the child or children is of the utmost importance. It is essential that the Court form a clear assessment of their reliability and credibility (*Re B* [2002] EWHC 20). In addition, the parents in particular must have the fullest opportunity to take part in the hearing and the Court is likely to place considerable weight of the evidence and impression it forms of them (*Re W* and another [2003] FCR 346).

ix) It is not uncommon for witnesses in such enquiries, particularly concerning child abuse, to tell untruths and lies in the course of the investigations and indeed in the hearing. The Court bears in mind that individuals may lie for many reasons such as shame, panic, fear and distress, potential criminal proceedings, or some other less than creditable conduct (all of which may arise in a particular highly charged case such as this) and the fact that a witness has lied about anything does not mean that he has lied about everything. Nor, as *R v Lucas* [1981] 3 WLR 120 makes clear does it mean that the other evidence is unreliable, nor does it mean that the lies are to be equated necessarily with "guilt". If lies are established I do not apply *Lucas* in a mechanical way but stand back and weigh their actions and evidence in the round. I bear in mind too the passage from the judgment of Jackson J (as he then was) in *Lancashire County Council v C, M and F* (2014) EWFC 3 referring to "story creep".

x) Very importantly, in this case in particular, and observed by Dame Butler-Sloss P in *Re U; Re B (supra)*:

> "The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generations of experts, or that scientific research will throw a light into corners that are at present dark"

That principle was brought into sharp relief in the case of *R v Cannings (supra).* As Judge LJ (as he was then) observed:

> "What may be unexplained today may be perfectly well understood tomorrow. Until then, any tendency to dogmatise should be met with an answering challenge."

As Moses LJ said in *R v Henderson Butler and Oyediran* [2010] EWCA Crim 126 [2010] 1 FLR 547:

> "Where the prosecution is able by advancing an array of experts to identify non-accidental injury and the defence can identify no alternative course, it is tempting to conclude that the prosecution have proved its case. Such temptation must be resisted. In this as in many fields of medicine the evidence may be insufficient to exclude beyond reasonable doubt an unknown cause. As Cannings teaches, even where, on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown."

6. Strongly submitted, and I bear in mind, is the need to avoid speculation or jumping to a particular conclusion from an unknown cause: *E v Harris* [2005] EWCA Crim 1980 (in relation to the triad of head injuries), *Re R, Cannings and R v Henderson* all demonstrate situations where injuries singly or taken together could give rise to presumptive or misconceived findings, especially where there may be (as here), naturally occurring conditions that may have caused or contributed to, a particular medical finding.

7. I have in mind also what Hedley J said in *Re R* [2011] EWHC 1715 (Fam), [2011] 2 FLR 1384:

> "A temptation described is ever present in Family Proceedings and in my judgment, should be as firmly resisted as the Courts are required to resist it in the Criminal Law. In other words, there has to be factored into every case which concerns a discrete 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… a conclusion of unknown aetiology in respect of an infant represents neither a professional or forensic failure. It simply recognises that we

> still have much to learn and … it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism."

8. Finally, when seeking to identify a perpetrator of a non-accidental injury the test as to whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or real possibility that he or she was the perpetrator (see *North Yorkshire County Council v SAV* [2003] 2 FLR 849). In order to make a finding that a particular person was the perpetrator of non-accidental injury the Court must be satisfied on the balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interests of the child although where it is impossible for a judge to find on the balance of probabilities that for example parent X rather than parent Y caused injury, then neither of them can be excluded from the pool and the judge should not strain to do so (*Re D* [2009] 2 FLR 668 and *Re SB (Children)* [2010] 1FLR 1161).

The Background

9. Both parents had good close loving stable childhoods. They are both part of close knit, supportive families. The parents are respectable, intelligent and articulate, very obviously sensitive and intuitive people. On one level that might lead to this case being the more perplexing. The mother went to a top university and has had a variety of interesting employments. The father grew up in Yorkshire and ultimately, through his love of the outdoors, settled into a specialist occupation at which he has obviously excelled. It was the parents shared interest and passion for travel and outdoor, physical, pursuits that brought them together in France in 2010 or 2011, when their relationship began. The parents are very different, both, it seemed to me, compliment the other. Both the children were planned, P was born in June 2015 and T on 12 December 2017.

10. Whereas P's trajectory has been straightforward, T's life has been anything but; it has for him and his parents been something of a rollercoaster. He arrived unexpectedly 5 weeks early, and by "precipitate labour". In hospital he had prolonged jaundice. Whilst the parents had coped with P's silent reflux, T was a totally different baby – unsettled, extremely focused on his mother. Three separate events require recording.

11. On the morning of 15 March T was scheduled to have his second 6 in 1 vaccine. During the afternoon, T was temporarily in the care of the father. T's crying escalated quite quickly into screaming. The mother hurried downstairs where T, being comforted by his father, was screaming loudly and inconsolably. He sounded as if he were in pain. As he was passed by the father to the mother, he "arched over like a banana" and fell silent, with his eyes wide open. His irises appeared to be flickering. The mother, frightened that he wasn't breathing, repeatedly called his name. On two or three occasions he came around, started screaming and then would fall silent again. T's body then erupted in sweat all over, he was soaking wet, small purple/red pin prick dots were noticed on his shoulders and neck. He was of course taken straight to the local A&E department and kept in overnight, but apart from a low haemoglobin level, all observations were apparently normal. T was discharged home on 17 March

12. On 18 March the father was changing T's nappy and once again T's crying escalated and intensified into screaming. Although not as bad as the occasion two days

beforehand, he was again arching his back and became wet with sweat. Again, T was taken to hospital, being discharged the following day, 19 March.

11 April 2018

13. The family spent the morning together, walking and playing in the forest. During the afternoon T had been unsettled and difficult to feed. T was put in the pram for a sleep but woke up instantly and was unsettled, spending most of the afternoon on his mother, intermittently feeding. The mother, wishing to give a birthday card to a friend who lived nearby, went out for a few minutes and left the father and P watching a film, the father rocking the pram backwards and forwards. T's distress intensified. When the mother returned about 10 minutes later the mother could hear both T's crying from outside the house and, the father calling for help from the top of the stairs, whilst endeavouring to calm T. As T was passed to the mother he made a strange muffled groan. The mother immediately took him in her arms. He fell completely silent and limp. He was warm and sweaty. In her absence all had clearly not been well.

14. The father said that T's crying had been increasing. P had complained about the noise, so the father removed T in his pram to the hall, where he pushed him up and down. When that failed he removed T from the pram and carried him up and down the stairs. The crying increased steadily. The father began to panic. The father told the Court that such was his panic, he was later unable to collect himself even to recall the emergency number, 999. The emergency services were summoned; the father was crying and upset. I have listened to the recording. The father's recorded account and conversation may or may not be significant.

15. The operator, who was impressive, talked the mother through CPR. As she did compressions liquid was coming out of T's nose and mouth and he was making a strange groaning noise. He was not breathing; the mother repeated compressions and cleared his airways. Ultimately the mother "shook" or "jiggled" him and turned him gently to help the liquid come out. The mother was obviously panicked too but, whatever she might think now, her focused resolve and actions undoubtedly saved the precious life of this little boy.

16. On the journey to the hospital T was fitting. It took several hours for T to be stabilised. A CT scan revealed a bleed to the brain. Initial opinion was that head trauma had occurred in the preceding 2-10 days. T required intensive care at Addenbrookes' Hospital. This was not the only time T was taken to hospital; in early June 2018 T was taken to hospital over similar concerns, crying inconsolably, on another occasion, again because of inconsolable crying, he was admitted to hospital in Oxford.

17. Some of the experts have been pessimistic about the prospects of T's recovery. Very sadly the Court has heard many hundreds of such cases, the one thing the Court has learned is that each baby is unique. Neither science nor anything else can predict prognosis; apparently very minor injuries can lead to enormous lifelong deficits, yet often children recover fully from apparently very serious injuries.

18. Whilst seemingly suffering some impairment and deficit, thankfully T appears to be recovering and developing so far much better than expected. I have no doubt that the

intelligent, focused love and attention poured on him by his family has played, and will continue to play a large part in that recovery.

19. I have recorded that T's life has been eventful. In about the middle of May 2018 the parents noticed a lump on T's jaw. T was admitted to hospital, the lump was fast growing. The lump was diagnosed a sporadic desmoid tumour. Genetic testing confirmed a genetic mutation, but only within the tumour. Treatment has contained and reduced the tumour. It is not a type of cancer which is thought to spread.

20. As if all of that was not enough, in addition, T has also had an isolated hypoglossal nerve palsy, manifested by a weakness to the tongue on the affected side. It is a very rare finding, thought to be a brain issue, but unconnected to the injuries discovered on 11 April.

The Expert Evidence

21. Mr Peter Richards Consultant Paediatric Neurosurgeon is highly experienced and respected in this difficult field. As he describes, on 11 April 2018, T suddenly changed from a state of being well to becoming profoundly unwell, such that cardio pulmonary resuscitation was necessary. Neurological investigation identified fresh subdural bleeding in all intracranial components and the spine and changes within the brain substance comparable with hypoxic/ischaemic change. There was also a small volume of fluid over both cerebral hemispheres, likely to be acute traumatic effusion. Ophthalmological examination revealed multi-layered retinal haemorrhages.

22. Absent any pre-existing infective, genetic metabolic or blood clotting disorder, cardiorespiratory arrest is known to be caused by an episode of head injury, as are fresh subdural bleeding, acute traumatic effusion and retinal haemorrhages.

23. The most likely cause of T's collapse was that he had suffered a recent head injury. Very specifically T presented with features which are clinically associated worldwide with infants who have been forcibly shaken. Such cases commonly present with a sudden onset of acute encephalopathy together with all the features displayed by T on 11 April 2018.

24. T displayed no other symptoms or injuries. His presentation was therefore compatible with a forceful shaking during a momentary loss of control. The question is whether that occurred whilst in the father's care, or once the mother had taken T from the father and during her attempts to resuscitate him as she stated at an early stage. Mr Richards spoke to the Semmekrot Dutch findings, that more than a third of parents shook their children when they had become profoundly unwell. He made clear, as he put it, whichever alternative, it was at the lower end of the scale (no other impact, fractures, or bruising being evident). Peter Richards was a powerful witness, the Court has heard evidence from him very many times. His evidence was compelling not just because of his experience, but also because of his care, attention to detail and moderation in every aspect. He was prepared to contemplate and question different possibilities. Ultimately, he said as in all such cases an assessment of the parents' evidence is necessary to reach any conclusions, since a number of hypotheses may be capable of explaining the medical findings.

25. Mr John Elston Consultant Ophthalmic Surgeon, advised as follows. T had severe, very serious, retinal haemorrhages in both eyes (described as very, very extensive), such that he was very guarded about his visual prognosis. He likened the injuries to those occasioned in a road traffic accident or a heavy object crushing the head. The findings in eye movements on 15 March denoted brain dysfunction.

26. He concluded that in the absence of any described accidental trauma, the findings are consistent with severe (the most severe) abusive head trauma in the form of shaking. He was subject to firm cross-examination, not just in relation to his findings, but his extrapolated conclusions, not least in part because, whilst the extent of the deficit is not clear, T's progress appears at the moment to far exceed medical expectation, (he was tested as recently as 19 March 2019). Of more immediate concern to me were his very different conclusions as to mechanism and force. Mr Richards thought a single movement, whereas Mr Elston maintained acceleration and deceleration, and with force. There is a stark difference in perspective between the neurologist and the ophthalmic specialist, a difference which the court has encountered before. I do, with respect, ally myself to the former, partly because the neurological findings are more numerous in terms affecting different parts of the neuro system but mostly because there was a greater capacity to be more open minded to other possibilities. Having spent very much of my professional career examining such cases, the one thing which can be learned is that this is still a comparably new area of science, where, as for example Dr Saggar so amply demonstrates, we know really very little. So, whereas Mr Elston may be right, I prefer to align myself with the more open minded, contemplative perspective that other factors or explanations might have some bearing here before coming to a conclusion that inflicted injury is established, or in any event, I prefer the evidence in relation to mechanism and force as being, with respect, more measured and less dogmatic.

27. Mr Neil Bateman Consultant Otolaryngologist, agreed with oncological expert opinion – a desmoid tumour is very rare in a child. In 15 years Mr Bateman had only seen 2 such cases. It was impossible to say how painful the tumour was. Possibly it was very painful. It was not reasonable to attribute T's injuries to the developing tumour. He thought it unlikely that T's isolated hypoglossal nerve palsy was related either, it being an upper motor neurone palsy.

28. Professor Ian Judson Consultant Oncologist gave evidence by telephone from New Zealand where he is on secondment. His evidence was crystal clear. He said there was no evidence of a developing tumour or mass in the early scans in April. In his experience he would have expected the tumour to be painful after appearing (even when relatively small): but "we simply don't know". Such tumours, he said, were idiopathic (i.e. arise spontaneously), so necessarily there is little information on their aetiology. They occur very rarely, "one in a million", a figure similar to that given by Mr Bateman. Professor Judson was a concise, clear and helpful witness.

29. Dr Patrick Cartlidge Consultant Paediatrician is well known to the Court. He helpfully summarised T's unusual trajectory from (but also including) birth. T was premature, he had breathing difficulties post birth, a long period of jaundice, a period when he was congested, an element of reflux and the episodes on 15th and 18th March. Dr Cartlidge confirmed his clear conclusions that most likely the head injury was sustained at the moment of collapse, i.e. prior to when he was handed over from his father to his mother, limp and lifeless. He did not consider that either CPR or artificial

breathing would have caused the injuries. A frightened parent reacting by vigorous shaking, if the shaking was in an uncontrolled manner could cause further injury (i.e. in addition to whatever it was that had caused the initial collapse). That further shaking could be characterised by an innocent bystander thinking "that looks dangerous to me". He also helpfully spoke (in relation to the firm handling by the mother) that T was already very unwell, and required sustained resuscitation, a lot more than could be caused by gastro oesophageal reflux.

30. Dr Cartlidge was of the same view as Mr Richards and Mr Elston. That is, injury is likely to have occurred at the point of collapse, and not caused by a seizure; the profound injury had occurred by the time the mother began CPR. The symptoms were not explained by hEDS. Shaking during resuscitation was most likely to be irrelevant. He dismissed the father's explanation of walking up and down stairs generally as being potentially causative. He was looking for a demonstration of a particular head movement. He did not understand why the father would display such a degree of panic.

31. Dr Cartlidge was very helpful, calm and thoughtful in his evidence. He is highly experienced and was prepared to consider any realistic possibility, remaining focussed and objective.

32. Dr Saggar Consultant in clinical genetics is a senior lecturer in medicine and has the great advantage of years of general training and expertise (I think 35 as a medical doctor, 28 subsequently in specialisation in clinical genetics.)

33. He concluded that there was no evidence of a connective tissue disorder, and tests demonstrated genetic normality and no sign of hypermobility, vascular fragility or hEDS. So, whilst a number of features might lead to T's injuries being comparable with connective tissue disorders and hEDS, there was no evidence of it, and no evidence of vascular hEDS, i.e. whether spontaneous or precipitating a higher facility to bleed.

34. Significantly, even if T was within the 50% cohort of probability (the father scoring 6/9 on the Beighton scale), it did not explain the spinal and subdural bleeding. Dr Saggar acknowledged that there may well be some form of connective tissue disorder from the mother's family too, although this did not raise the probability for T above 50%.

35. In relation to susceptibility/contribution, he was open to the suggestion that T may have an undetected collagen disorder (i.e. not detected by genetic testing) which might mean as a generalisation that T was more likely to bleed easily. He could not exclude a degree of fragility in the small veins and capillaries, but considered it very unlikely to have caused the spontaneous presentation of the problems in T.

36. Dr Saggar is justly a widely respected witness, who speaks with considerable authoritative experience, which on this, as on previous occasions, I have found particularly helpful. He was prepared to entertain a number of possible contributory, or more remotely causative factors, both individually and collectively. Nonetheless, his conclusions were perfectly clear and in line with the other expert evidence available to the Court, that in the absence of explanation, the spinal and subdural bleeding more likely occurred from some other and as yet unrelated cause, i.e. it

would not have occurred during normal handling. He added that the examining paediatric haematologists have produced nothing of relevance.

37. The Health Visitor. I thought the health visitor a rather a good witness; she had excellent recall, was friendly and approachable, but unerringly professional, questioning in all her contact with and examination of T, looking, as she said, for normality. She remarked on the haemangioma (if that is what they were) on T's head and chest. On 22 February 2018 she noted what she thought might be a hemiplegia. On 6 April 2018 she notes that T was crying inconsolably, staring vacantly into nothingness and sweating profusely. The Health Visitor was very anxious about T, it was not normal (which is why she sought further information). When she learned of T's injuries on 11 April her first thought was that something else was going on (to the extent that she carried out her own researches).

38. Overall, she struck me as a highly experienced, insightful as well as intuitive witness, who as I observed, almost seemed to sense that something else was brewing and affecting T. If I need it, her first hand knowledge of this family supports my own favourable view of them.

The Parents' Evidence

39. The Mother is a highly articulate, intelligent and sophisticated individual; she was a most impressive witness. She spoke a little about her interesting and varied background and of her relationship with the father and what drew them together. They have a strong and enduring relationship, but one in which I am satisfied, albeit I believe there is good in most people, they are not blind (or unrealistic) to the strengths and weaknesses of their personalities, which are extremely different. They do in fact complement each other. The mother described both parents in wide terms which I found helpful and illuminating, and having now heard them both, obviously accurate.

40. She spoke in some detail of the salient events and in particular of 11 April, her return to the house, going up the stairs to the father and T and then hearing this awful noise. It occurred to me then, as I think it did to her then, that T's life was literally leaving him. She went straight into the bedroom with him, removed his clothing, she knew she had to do something, she knew he needed CPR. In an important detail she told the father to call an ambulance. The father was "flapping about", he could not even bring to mind the emergency number – 999. The mother followed the guidance given by the emergency services. I particularly want to record, as I have before, how very, very impressive the emergency services were; their clear, determined, calm, instructions together with the mother's completely focused efforts to follow that information undoubtedly saved T's life.

41. During cross examination the mother said because T regurgitated liquid after each compression she turned him and placed him upside down to remove, jiggle, or shake the liquid from his mouth and nose. I remind myself that he was floppy but supported by his mother's hands, his jaw in the mother's hand. It is perfectly understandable that what occurred might be described as a "shake", although I'm not sure in truth if that's what it was. With the benefit of hindsight the mother believing that she might have caused or contributed to T's injuries told me that whilst she would still turn him, she would not "jiggle" him again, at least in the same way. She of course was asked about the degree of force she used (not least because of the desperateness of the

situation and fuelled no doubt by the previous 2 episodes in March). Whilst of course it is possible to misremember, and I well understand the mother's evidence of feeling strangely calm, as if it were a parallel experience, having regard overall to the mother as an individual, and as a narrator I think, that whilst she acknowledges the possibility that she may have contributed to T's condition (even possibly caused it) I do not consider on the evidence that that fear and hypothesis is really tenable. I am sure she is a ferociously protective mother, in the best sense, nothing in her background, personality or the background suggests the Court should do other than rely on her evidence, it is as I say, of the highest quality, reflecting in every sense the mother herself. I do not consider on the evidence that her unexpected and isolated panic attack in December has anything to do with my evaluation of the facts. It was entirely isolated and related to the overwhelming, unique circumstances.

42. The Father is an altogether contrasting figure. He was palpably extremely anxious and nervous. Like the mother though, he too is an articulate and sophisticated man. Sensitive, quite reserved, private, a proud man. I have concluded however that he is emotionally quite vulnerable; it should not be thought however that I consider him to be anything other than a thoroughly decent, respectable and impressive man. The conundrum for the Court is reconciling two very different and apparently contradictory aspects of his personality. One foreshadowed so presciently by the mother. The father is able to carry out and supervise industrial rope access at a very high level – 3. The sort of activity just the thought of which would discomfort most individuals. The father is able to climb up a rockface or a tree without, it seems, a moment's hesitation or doubt. Yet that resolve and strong sense of "holding things together" is not reflected in his emotional responses. Since the events of 11 April, the father has suffered something of a breakdown. He told me in an increasingly intense way of the events of 11 April. An important question is whether those descriptions were a genuine reflection of his state and conduct on 11 April or a performance for the benefit of the Court. The mother had already to an extent, painted a picture of the father's serious resulting anxiety and treatment, e.g. lying awake worrying night after night. He quickly became suicidal, wanting to end it. But the evidence suggests that that neurosis was well established long before 11 April. T was very focused, fixated even, on the mother, he was by no means a straightforward child. That is not uncommon. But the father's anxiety in relation to their relationship was remarkable. The father was paranoid, that T did not like, even love, him; he found it hard to accept, he felt like he was failing. All really rather extreme, and surprising. He is a pessimistic person, glass ½ empty, and self critical. "I feel a bit irrational, a bit erratic".

43. On 11 April, the father told me that his considerable apprehension (at being left with T for a few minutes whilst the mother went out) developed into a blind panic, fuelled no doubt by what occurred on 15 and 18 March, both occasions having made the father much more anxious and nervous. T's unsettled behaviour quickly developed into crying and more, despite the father's best efforts. The father then described in an emotional, indeed, harrowing way, the unfolding events; removing the pram to the hall, then removing T from the pram, because T was arching his back, throwing off the pram covers, the situation quickly developing into the sort of situation which had occurred before, feeling out of control: "I was like a caged animal. I'd look like a madman", urging himself on, he said repeatedly to himself "I can do this, I should be able to do this, I'm in control of this". The father was desperate for the mother to

return, he was very stressed. The father's hazy recollection of events seemed to me to be genuine. He could not bring to mind T's noise on being handed over, nor the mother's CPR He repeated that he was very, very panicked. Of course, that state might have arisen in the way he described or because he knew what had occurred and was consequently in a state of panic.

44. Ms Pine properly explored the apparent dichotomy between the performance of a top level high stress employment with the uncontrolled, indeed rather hysterical description of his care of T that afternoon. It was suggested that the father was exaggerating and was seeking refuge in his recounted distress and panic, which the father denies.

45. The fact remains that in his statement to the Court, and within the police interviews, he is at pains to describe how in going up and downstairs (proceeding slowly and gently.) Everything thus far would suggest the father's behaviour was under control, as his employment might underscore. Yet something caused this man to lose control. I have reviewed the father's evidence many times, and not without hesitation have ultimately decided that there is a significant vulnerability in his personality. Something which his high functioning, stressful occupation would not suggest. He would not be the first high functioning individual who had apparent gaps in his emotional foundation. The factors which convince me finally, taking account of the powerful and persuasive points made by Ms Pine, are, inter alia, his reaction to P's labour, the 999 call on that day, his inability to navigate to the Hospital that day, and his almost complete collapse in his proper functioning since. If, as he says, he is now in a much better place, the father's desperate earlier anxious state can only be guessed at. He is still off work, and I think likely to remain so for a while. In his evidence he frequently forgot the question, and from time to time became really quite distressed; on occasion, to be frank, appearing to "lose the plot" completely. Also, watching the mother closely during the father's evidence, it seemed to me that whilst she loves the father very much, that love does not outweigh her fiercely protective and realistic instincts as a mother, and individual. Much of the father's evidence was, I confess, for the Court, rather unexpected. The mother watched the father intently, but importantly gave no indication that the content and bearing of the father, was, to her surprising, that it was in any way exaggerated or staged. Of course, she could be blind to such things, it would not be the first time, but I did not get any such sense that the mother was sentimental or had misplaced priorities.

46. So, standing back, reviewing the totality of the father's evidence and actions, not without significant hesitation, on balance I am satisfied that the evidence points to a quite extreme and largely irrational blind panic, the like of which would not be anticipated from any of the other aspects of the father's life. It is an aspect which troubles me going forward, the lack of understanding as to what it is that underpins this deficit and how best to predict and protect T and his brother.

Discussion

47. Where serious assertions are made, as here, even where there is a consensus amongst the medical experts as to causation, although not the degree of force, today's apparent medical consensus, even certainty, may be discarded by a future generation of better informed experts. It is therefore incumbent on the Court to exercise caution when considering the significance of expert opinion where established or known conditions

or behaviours of a child are unusual. Together and in isolation rare and unknown conditions do exist, and can lead to surprising results. It is not possible to identify what is not known. So particular scrutiny is required here where at least one witness remarked on the extraordinary, extreme improbability, of T suffering from 3, possibly more, rare and apparently unconnected conditions. That heightens the need for the most careful and cautious scrutiny with particular attention being paid to the possibility that the injuries, individually or collectively, may well have resulted from an unknown cause. That is the more so where the medical evidence is only one part of the evidence. There is no direct evidence of inflicted injury, that diagnosis may as much be a hypothesis, and just as contentious, as an unknown cause. Self-evidently of course it is not for the parents to prove anything.

The Approach of the Medical Experts

48. I have already recorded the thrust of each expert, all from appropriate specialisms. I have endeavoured to stand back and look at the medical canvas as a whole to assess the merits of each piece of evidence in relation to all the evidence. All doctors gave evidence appropriate to their professional standpoint. All our specialists are within their own disciplines, conspicuously respected and at the frontier of their knowledge and expertise. Most were willing to acknowledge perspectives of the others, and helpfully possessed a good knowledge of the science and research beyond their own specialisms. There is a remarkable degree of unanimity between the experts – the one exception being the ophthalmic evidence which puts the injuries at the extreme. I note the findings, but do not rely on the conclusions, since they fail to acknowledge other possibilities or have regard to other opinions.

49. The Court has benefitted greatly from hearing the evidence of the experts instructed in this matter. Just as it is vital to be able to consider the manner and quality of the evidence of the parents from the witness box rather than only from their written statements so is it imperative to judge any disagreement or challenge to the expert evidence after having heard that evidence tested in cross examination. Without that crucial tool the Court would be left with an incomplete understanding of how the views are formed, how they compare with each other, and how they fit into the evidence as a whole. The Court has the ability to disagree with part or whole of the expert evidence but would be denying itself that important part of the jigsaw if it did not hear the experts give that evidence and be tested. There is sometimes, as here a difference in emphasis between experts, how they deliver that evidence and how they respond to cross examination, all can inform the Court as to the conclusions that can be drawn.

50. This case is unusual. I therefore approach the evidence with special caution, where there might be a natural cause or combination of causes. I have taken time to reflect on the helpful and though provoking submissions which this judgment cannot reflect in their nuanced detail.

Connective Tissue Disorder, Hypermobile Elhers-Danlos Syndrome (hEDS), or otherwise

51. Whilst genetically T has a 50% chance (at least) of having hEDS (or a 50% chance of not having hEDS), Dr Saggar, noting the father's condition and that of the wider family, on examination, and whilst observing that a diagnosis was difficult, concluded that there was no evidence that T had hEDS. He concluded that there was no clinical

evidence that T had hEDS. He was however importantly prepared to contemplate or acknowledge the potential for contribution but thought that in the absence of any other evidence it was unlikely to have caused the spontaneous presentation of T's problems.

52. It can be easy to under or over state the signs of hEDS, having heard in many such cases evidence from Dr Saggar to Professor Hollick (about whom I am waiting to publish a judgment). The important aspect is to assess whether, as here, acknowledging all the unknowns or anomalous, or unexplained conditions, the advices remain sound. Dr Saggar, an acknowledged leading world expert, despite the above, maintained that where there is no other explanation for the spinal and subdural bleeding, it would have most likely occurred through something other than normal handling.

Unknown cause

53. Standing back I must of course consider the possibility of a new unknown condition or conditions, and whether they maybe in some way related to prematurity, the previous admissions, the hypoglossal nerve palsy, the rare form of cancer, or the likelihood of hEDS playing some part, or some other condition, or a combination of all or any of them and noting the absence of other common, but in my judgment, by no means determinative factors of more serious manifestations, e.g. bruising or fractures.

54. Dr Saggar is well known to the Court for his experience and open mind. He was clear, as was Mr Richards – who reflects his approach, his expertise from a different perspective, that there are far greater medical difficulties in the way of a conclusion that the medical findings are the result of a wholly, or in part, of an unknown condition(s). Most of the witnesses were prepared to acknowledge the possibility but were nonetheless clear in their ultimate conclusions. All were agreed that a catastrophic collapse such as occurred here was in effect difficult to envisage. The issue of birth related injuries was not fully investigated, but was some months away and none thought it worthy of inclusion or active consideration. All agreed that such injuries did not occur as a result of normal handling.

55. Having considered all the evidence, and in particular that of Dr Saggar, I conclude:

1. That I have greater difficulty in adopting a conclusion that the medical findings are in whole or in part a result of an unknown condition or combination of conditions.

2. That I do not accept that T's condition arose from some unidentified medical cause.

3. That there is no other known overlooked condition or combination of conditions.

4. However, I do accept that what is known about T could make it as equally likely or unlikely, slightly more likely probably – having regard to the wider information – that he has some unidentified but nonetheless increased likelihood of susceptibility to vascular fragility, but which is unlikely to have caused the spontaneous presentations of the injuries.

5. I do not conclude that T's condition is a result of an unknown pathology beyond our current understanding.

56. With that background I turn to the evidence of the parents. The parents' evidence and my assessment of them in the witness box has been strongly determinative of my conclusions.

57. Mr Storey QC makes bold submissions about the mother. It is rare for counsel to be able to do so. In this instance he felt, justly, able to do make firm assertions about her. The mother was, as I have described, a quite outstanding witness, accurately portraying the person she is, an intelligent, sophisticated, enquiring woman, and a ferociously protective mother. She of course was not there when T collapsed, but it is possible to pin point almost to the second when that collapse occurred, sometime between when she heard T screaming, outside the house and coming up the stairs, to him being handed by the father into the mother's arms, either limp and lifeless and having made as the mother describes T making an awful noise, the like of which she had never heard before and which in all likelihood signified his cardiorespiratory arrest. It is somewhat melodramatic but quite likely, the moment that T's life was literally leaving him. Having thought carefully about what the mother then did up until the emergency services quickly arrived, I am unable to identify anything which would suggest that she either caused or contributed to his condition, because a) the collapse had already occurred and b) because she acted with great presence of mind and focus; even when she felt compelled to invert T and jiggled or shook him (taking into account the fact he was floppy, supporting him firmly whilst holding his jaw), she had it seemed to be an accurate focussed recall. Taking into account Mr Richards' fair appraisal of the possibilities, and Dr Cartlidge's assessment, there is nothing in the mother's evidence (or the father's), notwithstanding that she says she would not do it again, to suggest that the mother's actions were either causative or contributory at all. But for the actions of the mother, T would not be with us today.

What of the Father?

58. Accepting the medical evidence, I do not accept Mr Bagchi QC's primary submission of an unknown aetiology. Something happened in those moments before or just as the mother was entering the house, there are 4 possibilities:

i) The injuries were caused by the father in temper or momentary loss of control.

ii) The injuries were caused by the father in a heightened state of anxiety in effort to calm T.

iii) The injuries were caused by the father, unaware of what he was doing.

iv) The injuries were caused by the father in panic which fell below the level of care that could be reasonably expected.

Options 3 and 4 may well be connected.

59. There was nothing in the father's evidence to suggest that he was an unreliable reporter in the sense of dishonesty, i.e. lying. I watched him closely and listened to him intently. Both in and out of the witness box, he maintained a steady gaze. He is

either a consummate actor, or telling the truth, or conceivably, genuinely has no recall. I have in mind Ms Pine's pertinent submissions that there is nothing in the father's police interview or statement that would suggest his more newly stated avowed vulnerabilities, sensitivities and panic. It would be wrong to say other than this aspect has troubled me, as too have the history and descriptions of the previous episodes on 15 and 18 March, both occurring in the father's care. Against that I record that there have been other serious incidents before and since which are nothing to do with the father at all. The mother knows the father very well. I am confident that the mother herself would have sensed, and acted appropriately if she concluded or even suspected that the father was lying. In particular, in terms of reliability, that notwithstanding the mother's love for the father, that that would have to also suborn her strongly protective maternal instincts. The mother has been far from unquestioning either previously or now. She is well placed to describe and assess the father's character, but she does not doubt him. I am entitled to take that into account. I am satisfied finally that the injuries were not caused as a result of some "intentional but momentary state of anger or frustration".

60. Ultimately, I conclude that there is quite a lot of evidence to support the father's more recently expressed contention of functioning, characterised by "blind panic", which he describes as "flapping about", but which I consider significantly under describes his condition or state. There is an aspect here which at least requires further risk assessment and probably psychological even possibly psychiatric enquiry.

61. The context of the two previous occasions on 15 and 18 March obviously additionally contributed to the father's heightened state on this occasion. There are other examples, the mother's first labour, his inability to bring to mind the emergency services' telephone number, and the mother's own appraisal of the father, all might suggest that he would not be able to operate at the high level that he in fact so evidently has. These are surprising but not unique emotional or personality vulnerabilities. Many people at the top of their profession are driven by other, often unacknowledged, deficiencies. The odd thing to me is his ability to compartmentalise, either to shut out, or not shut out, what is at a given moment, the ability to focus on the mountain top but not focus rationally on dealing with a comparatively normal domestic event.

62. The aspect with which I have wrestled, is the father's own paranoid and extraordinary descriptions of his relationship with T, exampled by worries that he did "not love him", and being incapable of caring for T even for a short while. His perspective was I thought as unrealistic as it was bizarre, and which I find hard to reconcile or put into context. What occurred that day is very worrying; the mother went out for just a few minutes, she was just a few houses away, but the father's state quickly deteriorated into something like a cornered animal, he said himself that he was like a caged animal, incapable of reason or moderation. T was just a tiny baby, it is by no means unusual for such a small child to be so dependant and focussed on their mother. What is totally remarkable is the father's apparent sense of rejection and helplessness, which was of course not just inapposite but ultimately in view of what occurred very troubling.

63. On the evidence a momentary loss of control must remain one of the differential diagnoses; taking into account all that I have heard and seen, I consider the father to be a truthful witness. I must consider whether he has simply blocked out what

happened, through panic fear or distress. His recall of some of the salient events was poor. The father is not given to temper, quite the reverse. I am entitled also to rely on the mother's assessment of him, she knows him best. If as I say she suspected he was lying she would I am confident say so. Not without hesitation therefore, I conclude that there is no evidence (other than the injuries themselves) to suggest that they were occasioned by some momentary loss of temper or control.

64. Of the other possibilities, for the same reasons, I do not conclude that in a heightened state of anxiety or in a misguided effort to calm T that something occurred – with the caveat described above in paragraph 62, I do not believe he was lying, and there is no evidence that he has blocked something out, other than the fact he was in a panic and as one might expect can remember very little.

65. That leaves two possibilities remaining: the injuries were caused by the father, unaware of what he was doing or the injuries were caused by the father whilst in panic, but which self-evidently therefore fell below the level of care that might reasonably expected.

66. Taking these together, I have reviewed at length the father's evidence, which he gave in an increasingly intense way. The father describes himself in a "much better place", thus describing how low a place he has been in. There were already signs before April 11 that the father held unrealistic expectations, indeed inadequacies in relation to T. His descriptions of 15 and 18 March and April 11 bear testament to that.

67. His descriptions of blind panic on 11 April, of repeatedly urging himself on, "I can do this, I'm in control", and his comment that he would have looked like a madman, a caged animal, do nothing to assuage my disquiet. The situation was completely and dynamically out of control.

68. There is a significant vulnerability in the father which his high functioning career would not suggest.

69. I am persuaded (notwithstanding the strong and thought provoking points made by Ms Pine) that there are sufficient evidential indications that what the father told me from the witness box, was, as far as it goes, an accurate portrayal. Additionally, in support, (whilst it could be taken a number of ways and for which there could be other explanations) by his almost complete collapse since those events of 11 April in his proper functioning. He has been off work, and likely to remain so for some time. He was unable to focus on the questions being asked in the witness box, or even stick to the topic – all outward manifestations of the father's current condition.

70. So, I conclude that

    i) The father's account is accurate and reliable account, but as I say, as far as it goes.

    ii) Having regard to my previous conclusions something injurious occurred whilst T was in his father's arms at the top of the stairs, probably moments before the mother re-entered the house.

iii) There is sufficient evidence to support the proposition that T was more likely than not to be more susceptible to venous fragility.

iv) Whatever happened was caused by the all consuming desperation of the father's panic and vulnerabilities, but was not intentional.

It is that aspect about which I have the greatest anxiety and apprehension.

71. A finding that the injuries sustained by T were caused by the father, in panic, or unaware what he was doing and therefore satisfies the contention that the level of care provided by him fell below, far below, the level of care that it is reasonable to expect a parent to give.

72. The father's functioning or condition is an aspect which requires urgent attention so that this family can be finally reunited.

73. T needs to return to the care of his mother now. The role of the father in the short term may now need careful, objective and sensitive management at least by her pending further enquiry and consideration by the Court.