Neutral Citation Number: [2020] EWFC 76

Case No: MA19C00680

**IN THE HIGH COURT OF JUSTICE**
**FAMILY DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/11/2020

**Before** :

**THE HONOURABLE MR JUSTICE HAYDEN**

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**Between :**

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|---|---|
| **A Local Authority** | **Applicant** |
| **- and -** | |
| **M** | **1st Respondent** |
| **- and -** | |
| **F** | **2nd Respondent** |
| **- and –** | |
| **L and K** | **3rd Respondent** |
| **(by their Children's Guardian)** | |

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Miss Frances Heaton QC and Miss Natalie Powell (instructed by **A Local Authority**) for the **Applicant**
Ms Barbara Connolly QC and Mr Neil Mercer(instructed by **Pluck Andrew Solicitors**) for **M**
Mr Aidan Vine QC and Miss Fiona Holloran (instructed by **Bromley's Solicitors**) for the **F**
Ms Jane Walker (instructed by **Broudie Jackson Canter Solicitors**) for the **Children**

Hearing dates: 5th October 2020 to 30th October 2020

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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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THE HONOURABLE MR JUSTICE HAYDEN

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 Hayden :

**1.** This is the Local Authority's application for Care Orders in respect of two boys K, who is 4 years and L, who is 8 years 10 months. The Court first made Interim Care Orders on 5th August 2019 which have continued to be renewed. The children have remained with their mother under the aegis of the Interim Orders. A fact-finding hearing was scheduled to be heard in May 2020 but was adjourned in consequence of the restrictions required by the public health crisis. The hearing was adjourned until 5th October 2020. It has been conducted as a Hybrid hearing, by which is meant that some of the witnesses have given evidence via a video conferencing platform whilst some have attended in person and spoken from the witness box. The children's father and his legal team have been in court throughout as have the Local Authority's. The Guardian, who was 'shielding' for much of the case, has attended remotely and her lawyers have attended court as and when they considered it necessary to do so. The mother and her lawyers have also alternated between attending court and joining via video conferencing platform.

**2.** The Civil Justice Centre at Manchester, where this case has been heard, is better placed than most courts to accommodate a hearing whilst ensuring Covid-19 safe distancing regulations are adhered to. The court is sizeable. It can accommodate 18 people under the regulations, though no more than 14 have ever been present. Court staff have been vigilant to ensure rigorous hygiene standards. I should like to pay tribute to them not merely for their considerable efforts but also for creating an environment in which all involved have felt comfortable and safe. In the context of a case of this kind that is a very significant contribution which requires to be recognised.

**3.** The children first became known to Children's Social Care on 25th June 2019, following an incident which had occurred at the family home whilst, it is agreed, the children were in their father's sole care. In response to a 999 call, made by the father, at 19:39, an ambulance arrived at 19:45. Paramedics identified that infant N (the youngest of the siblings with whom I am concerned) was pale, unresponsive showing poor respiratory effort. The paramedics commenced bag valve mask resuscitation. A second crew arrived minutes later and established the closest hospital as X Hospital. N's airway was secured with a laryngeal mask airway and monitored. N's heart rate began to drop and he went in to cardiac arrest. Intra osseous access was gained to establish a drug route and three cycles of adrenalin were administered along with Cardio Pulmonary Resuscitation (CPR). This was all in accordance with Advanced Life Support protocols. An advance paramedic was consulted and pre-alerted X Hospital. N's mother, who was working on a late shift that evening, had been contacted by the father and arrived at the scene shortly before the ambulance left. She travelled with N to the hospital.

**4.** During the 999 call the father (F) told the Ambulance Service operator that… *"[N] fell off his bunkbed high up."* F was manifestly very distressed. He became agitated at the delay caused by the operator's necessary enquires. *"come on its wasting time this!.." "he's gonna die!, he's dying."* He was asked when the fall had happened and he replied, *"just now, just now!"* In response to the question *"What caused the fall?"* F responded, *"he was just with my.. youngest on well either way he's [inaudible] the bed, while I was just going getting a towel… he just fell off."* The telephone call was recorded and transcribed. I have listened to the recording and read the transcript. The seriousness of N's situation is all too clear. The operator asked F to count between

N's breaths. The interval is disturbing to listen to and resulted in the operator immediately instructing F on the mechanics of CPR. It is important to note that F now denies that he was *"going to get a towel"* at the point he claims that N fell. He accepts, as he is bound to, given the recording, that he said this during the course of the call, but he is at a loss to understand why he should have said it. He attributes this error to his general distress at the time. Experience reveals that the first account of an injury may be significant both for the medical profession and forensically more widely. I highlight these passages because they are F's first account of what he claims happened to his son.

**5.** At hospital F told Dr JB that *"[N] had been playing with his 3-year-old brother on the top bunk… [he] had been sorting clothes just outside the bedroom when he heard a 'bang' he turned around and entered the room and found [N] face down on the floor…"* I will return to this below but it is important to highlight that neither F nor any other witness, lay or medical, has been able to suggest any coherent sequence of events to explain how N could have been found in the position F suggests, in consequence of a fall from the bunk bed. I am also bound to observe that, notwithstanding the wide array of expertise garnered to assist this investigation, this rather striking detail has received little attention. I asked the father, in simple terms, how he thought N came to land in that position. He told me that he had *"no idea."* Neither do I nor does it seem anybody else in the case has. Though I will analyse the mother's circumstances later in this judgment, it seems to me pertinent to observe that this is a question that I might have expected her to ask F about and return to, given his own response, as I have recorded it.

**6.** Shortly before 1am on 26th June 2019 N was transferred to the XY Children's Hospital (XYCH). At 02:59 on 26th June a telephone conversation took place between the out of hours Children's Social Care team and the duty out of hours doctor, Dr Y. Dr Y assessed the CT scan findings that had been taken by that stage, to be *"rather unusual."* The absence of skull fracture and bruising also struck him as difficult to reconcile with the account given, though he was clear that the investigation was at early stages and he did not discount the explanation as *"impossible."* In fact, as will emerge below, a hairline fracture to the skull was subsequently identified.

**7.** Dr S, a Consultant Paediatrician, with an interest in safeguarding, met with both N's parents the following morning (26.06.2019) at approximately 9.30am. In a confidential medical report, dictated that day, Dr S records the history taken from both parents. This was the first opportunity for the parents to discuss, in detail, what had happened to N. The meeting took place on the Paediatric Intensive Care Unit (PICU). Ms JM, Senior Specialist Safeguarding nurse, was also present. The key features of the account, as recorded, require to be set out:

> *"Mother told me that on Thursday evening of last week [N] was a bit unsettled. She gave him some Calpol before putting him to bed. On Friday morning mother took [N] and [K] to a Play Centre with some friends and he seemed fine. On Friday afternoon mother was getting [N] ready and putting him into the car seat ready to go and pick up his brother, [L], from school. He then had a fit with shaking of all four limbs and he became unresponsive. This lasted for 2-3 minutes. Mother called an ambulance; it took about an hour and a half for the ambulance to come by which time [N] was recovering. They were taken to X Hospital where he was assessed in A & E and then*

> *transferred to the ward for a while. Mother said that when he arrived in A & E he did have a fever. Mother says she spent some time with [N] in the A & E Department and then went to the ward. At 11.00 p.m. on the Friday [N] was discharged with a diagnosis of a febrile convulsion due to viral tonsillitis. Mother said that on Saturday he was still 'a bit off', so not quite back to his normal self, but by Sunday he was back to normal. On Monday and Tuesday he appeared well and on Tuesday he was eating and drinking normally. Mother says she gave the boys their tea and then went out to work at about 5.30 p.m.. Father said he did his normal routine which included bathing [N] and putting on his pyjamas. He then put [N] in the top bunkbed in the children's bedroom along with his three year old brother, [K]. Father said that his seven year old brother, [L], was in the same room on his laptop. Father said that he left [N] at the pillow end of the top bunk. The ladder is at the other end, which is the only gap in the railings. [N] was on his back .. playing with a balloon when father went outside. Father went onto the landing to sort out the children's clothes and do some ironing. Father said the next thing he heard was a thud and went in and found [N] on the floor. His head was next to the ladder of the bunk bed. Initially [N] cried. Father picked him up and then he went floppy. Father said he noticed some blood in his mouth. He then decided to take [N] downstairs so that he was away from the other two children. Father says he put [N] on his side as he had been advised to do this after he had the febrile convulsion. Father then called the ambulance and was advised to put him on his back and to do CPR. Father said he was concerned that there was a lot of blood in [N's] mouth so he did not do any breaths for him. He was advised to start chest compressions and was about to do this as the ambulance arrived. Father said that [N] had been very well and happy in his bath earlier that evening. Father had sent a photo to mother from his phone showing [N] looking happy. [N] was born at term by normal delivery. Apart from this attendance at X Hospital for the febrile convulsion he is previously fit and well. Developmentally he is crawling and rolling. His two older brothers are fit and healthy. There is no family history of any bleeding problems as far as parents are aware."*

**8.** It is important to record Dr S's interpretation of the Radiological investigations and the Ophthalmic examination. Dr S noted that the CT scan of N's brain showed *"extensive swelling of his brain."* She also noted *"bilateral, shallow, acute, subdural haematomas with extension into the interhemispheric fissure."* The CT scan of his spine was normal. The CT scan of his thorax showed some consolidation within his lower lobes, worse on the left. The CT scan of his abdomen and pelvis was normal. There were no obvious bony injuries on the scans.

**9.** Dr S records that N had been examined by Miss A. Consultant Paediatric Ophthalmologist, at 1.00 p.m. on the 26.06.2019. She documented that he had multilayer retinal haemorrhages that were too numerous to count in both eyes. N was also found to have perimacular folds in both eyes.

**10.** By this stage it was appreciated that the extent of the injury to N's brain lay at the highest end of the spectrum of seriousness, described variously as catastrophic and devastating. The intensive care team recognised that N would not survive, and discussions were commenced with the parents regarding withdrawal of care.

**11.** When analysing her conclusions Dr S was plainly exercised by the CT scans, which revealed subdural bleeding and the findings, on examination of the eyes, of extensive retinal haemorrhages. In her report she made the following observations:

> *"Subdural haemorrhage means bleeding into the potential space between the thin arachnoid membrane which intimately covers the brain and the thicker dural membrane which lies between the brain and the skull. Subdural bleeding is most commonly the result of head trauma and can occur after accidental injury. In the absence of a history of a significant accident this pattern of bleeding raises the suspicion of a non-accidental head injury such as shaking or shaking and impact injury. Biomechanical modelling suggests rotational forces such as those generated by shaking with or without impact are important factors in causing*
> *subdural bleeding. The bleeding is described as acute which means recent. There was no bruising or swelling evident to [N's] head. There was no evidence of any skull fracture on the CT scan. [N] was also found to have extensive swelling to his brain. During an episode of shaking damage to the brain itself which can occur via shearing and tearing forces through the brain. This causes secondary damage and swelling. [N] was also found to have extensive bilateral retinal haemorrhages. This means bleeding at the back of both eyes. Retinal haemorrhages occur in 70-80% of infants who have suffered subdural bleeding caused by shaking. Retinal haemorrhages can occur following severe accidental injury but again are strongly associated with inflicted head injury, particularly when they are extensive as described in [N]'s case. Miss A also described that [N] had perimacular folds in both his eyes. This is when there has been more extensive force to the back of the eye so that the retina is torn and this suggests significant major trauma."*

**12.** All this led Dr S to come to the following conclusion:

> *"It is my opinion that [N's] injuries are not consistent with a fall, even a fall from a significant height. It seems that developmentally it would be possible for [N] to have crawled to the ladder of the bunk bed and fallen out. However, from a fall from a height I would expect signs of some external injury such as bruises, swellings or skull fracture. I would not expect such a devastating brain injury or such widespread subdural bleeding or retinal haemorrhages from such a fall. As discussed above, [N's] injuries are highly suggestive of a non-accidental shaking injury."*

**13.** A strategy meeting was convened at XY Children's Hospital attended by Dr S, representatives from L's school, police and social workers. Following this meeting, at 17:25, the father (F) was cautioned, arrested and taken to Z police station. Mother

consented to the accommodation of the children with maternal grandparents, pursuant to Section 20 Children Act 1989 (CA).

**14.** F was interviewed at 22:34 concluding at 23:55. F declined his right to have a solicitor present. He denied any 'deliberate injury', explaining that he had *"put him on the bunk bed… Now I'm blaming myself for that but I haven't caused him to fall off"* He went on to explain having bathed N earlier in the evening and that he had taken a photograph of N on his phone and sent it to the mother (M). He related having put N into his pyjamas and placed him on his back on the top bunk at the pillow end, on top of the covers. F described N as playing with a dinosaur balloon, *"pulling it down... while he was playing with that… L was on his laptop in his bedroom and I was getting K his pyjamas on... K then climbed up onto the bunk bed with him… I iron their clothes ready for her in the morning so she can get them ready… and as I was putting N's clothes on here I just heard the bang turned round and that's when it, when he were there on the floor."*

**15.** During his interview F made a number of drawings setting out the floor plan of the house and how he found N. He said L *"kept going up to N, he'd be able to tell you what position he was at, he was at the top end… giving him a kiss and then he [L] went back down and then I seen him back up again and N… K sorry the three year old kept robbing the balloon off N so I tied it to the bed of the bunk bed. I tied the balloon there and I said "No N's…" so he just sat there laughing at N smacking it."* F said as he was putting N's clothes on [the bannister] he heard a bang and turned and saw N on the floor. He expressed his surprise at N moving from the pillow end to the ladder end so quickly *"I don't know if he's [K] caused him to come off or or what but I don't know how he's got from [the top end] crawled….and got to there [ladder end] that quick"*

**16.** F struggles in his police interview to understand how N came to be face down at the bottom of the bunk bed ladders. *"but if he had gone head forward I don't know how he would have landed on his belly but that is, that is how I found him, like in that position."* F reinforced this by demonstrating the position in which he says he found N.

**17.** F was asked in interview about N's level of physical development (aged 9 months). He explained that N was able to *'crawl'*, variously describing it as a *"drag"* and an *"army shuffle"… "he's not like fully knees, arms, could roll over, sit up but sometimes he falls backwards."* F was asked whether N could sit up unassisted. He responded, *"I wouldn't like to try just in case he did go back but obviously we have sat him up and he has gone back like that but he can sit up."* During the course of the hearing both parents and NX (M's sister) have agreed that N was unable to stand, was not yet crawling and had not started *"cruising"* by which is meant propping himself up on furniture or other objects. Dr S, who gave evidence, considered this level of development to be entirely normal for an infant of N's age.

**18.** On F's account L (aged 7 ½) is said to have been in the bedroom when N fell off the top bunk. He is reported as playing on his computer game, 'Roblox.' F told the police that L went downstairs when he had taken N down… *"Literally when the paramedics come erm the only thing I said to L was take K upstairs."*

**19.** On 27th June 2019, L was collected from school, at lunchtime, by maternal grandmother (MGM), she told L's school teacher, Ms G, that she was taking L to say

goodbye to N. Ms G described MGM, in the course of her evidence, as being visibly distressed at this point. This, according to the family's evidence, was an uncharacteristic betrayal of her emotions as she steadfastly maintains a stoic "stiff upper lip" approach to adversity, as it has been described. At the XYCH L did not feel able to go to see his brother and say goodbye. L was spoken to by DC H at the XYCH, and later that evening spoken to alone at MGM's home. This was an informal enquiry, though notes were taken by DC H's colleague, RS. I am perplexed as to why L was spoken to at the hospital, given the distressing situation he was in, nor do I sense that a great deal of thought had been given to the scope and range of the meeting at MGM's home. It struck me as rather free flowing and discursive. DC H is plainly an experienced and committed professional and I am clear that she was sensitive to minimise any distress to L. DC H was at pains to point out that this conversation was intended to be no more than a preliminary inquiry. The purpose was to evaluate whether L should be interviewed in accordance with Achieving Best Evidence (ABE) guidelines.

**20.** In her statement, DC H records that she had *"introduced some rules"* to L She notes, *"one of these is that they should only talk about things that really happened and which they saw with their own eyes or heard with their own ears."* She assessed L's capacity to understand truth and lies by way of an app developed by 'Triangle,' a specialist victim and witness interview strategy, devised to incorporate the Code of Practice for victims of crime (Ministry of Justice 2015; the Association of Chief Police Officers (ACPO) Positional Statement (NII SSG), interviewing child witnesses in major crime investigations and the Youth Justice and Criminal Evidence Act 1999. She had little difficulty in establishing that L understood the distinction clearly.

**21.** Having formed that conclusion, which is entirely consistent with the views of his parents and his teacher, she informed L that when he talked to her he should only tell the truth and about things that have *"really happened."* DC H described L as reserved and providing *"relatively short answers to open questions."* She elaborated this by explaining that she considered that *"when asked specific closed questions* (for example, who, what, where)*"* he was able to provide relevant and understandable answers. This resonates very closely indeed with the description of her interactions with L, given by L's form teacher. It is important to set out the following passage from DC H's statement in which she provides illustrations to support her conclusions. It is also significant when evaluating the weight to be given to and the significance of what L has said:

> *[L] did appear to be slightly worried and I asked him:*
> ***"Has there been anything recently that has made you unhappy?"***
> *To which he replied,* ***"No"***
> ***"Has there been anything that has made your family unhappy?"***
> *To which he replied,* ***"No"***
> *I asked him who was in his family and he told me that he had a mum and a dad. I asked if he had any brothers or sisters and he told me that he did, they were [N] and [K].*
> *A short while later I said to [L]:*
> ***"I heard something happened to [N]?*** *and he replied that [N] had* ***"fell off the bed."***

**22.** DC H spent some considerable time emphasising that L should *"only talk about things he had seen with his own eyes."* She distilled the following, in her statement,

which accurately reflects the transcript, and which has remained an unchanged account, since the date of the conversation on 26th June 2019:

> *"I then asked him if he had seen this happen. …he was also able to tell me that he did not see N fall because he was playing on his laptop at the time. His laptop was on his table and his eyes were looking at this at that time.*
>
> *L was also able to tell me that dad was downstairs at the time, and K was on the bunkbed with N. he was alerted to the fall of N by the fact he heard a big bang."*

Though F contends that much in L's account is both accurate and reliable he most strenuously rejects L's account that he (F) was downstairs. This, he maintains, is entirely wrong.

**23.** DC H explained that she has, in her current lead role as the local Police's lead on "Specialist Victim and Witness Interview Capabilities," recently designed and delivered enhanced training to child interviewers within GMP regarding the pre-interview assessment of children and vulnerable adults (PIPPA) which is researched based and is being evaluated academically. DC H told me that in the light of her pre-interview assessment of L she considered that an ABE interview was indicated. She told me that she communicated this view to the investigating team, but no action was taken on it. Accordingly, the contemporaneous but not entirely verbatim account, recorded by DC H's colleague at MGM's home is the only record of what L has said to the police:

> L*: He fell off the bed*
> *DC H: Did you see that?*
> *L: I saw it when he was on the floor.*
> *DC H: Who else was there?*
> *L: K*
> *DC H : Who else?*
> *L: Me*
> *DC H: Who else?*
> *L: No-one*
> *DC H: Who else was in the house?*
> *L: Dad*
> *DC H: Where was Dad?*
> *L: Downstairs getting some pants.*
> *DC H: Did you see N fall?*
> *L: No*
> *DC H: Why didn't you see N fall?*
> *L: Because I was playing on my laptop.*
> *….*
> *DC H: How did you know N fell?*
> *L: I heard a big bang.*
> *L used plastic figures to show where everyone was.*
> *DC H: Where was N on the floor?*
> *L: N had his back on the floor.*
> ..

*L: I heard dad come upstairs. Dad brung N downstairs and put him on the rug.*

*..*

*R: Dad was sad and a little bit mad because he thought K had pushed N.*

*…*

*L: He shouted at K*
*DC H: What did dad do?*
*L: Why did you push N off the bunkbed*
*DC H: Did K push N?*
*L: No because K was still on the bed.*

**24.** The day before this discussion L had been spoken to by his teacher, Ms G. Ms G initiated the conversation. She told me in her evidence that things were being said about N in the classroom and that L, a characteristically reserved child, had his *"head down"* and was obviously sad. Ms G took him out of class and asked him if he was alright. He responded without giving any detail, that N had fallen off the bed. Ms G asked *"Were you there?'* and he replied *"Yes, I was playing on my game and I heard a bang."* He said that he had turned round and saw N on the floor. He said dad came in and picked him up. Ms G asked *"Where had he fallen from"* and he said, *"the bed"*. Ms G recalls asking, *"was daddy not in the room?"* and L replied, *"daddy was ironing and he put N on the bed with K as he was ironing, he (daddy) had no trousers so he had gone downstairs for some trousers."*

**25.** *L* said his father ran in to pick N up, he told L to stay upstairs and his dad went downstairs with N. Ms G did not consider L's blunt account, with its striking lack of detail as being in anyway out of character for this particular boy. She described how, though L could be fulsome and enthusiastic when engaged, he was rarely instinctively forthcoming. She observed that whilst other children would spontaneously volunteer lots of information to her when they arrived at school, L would merely say "morning" and move on to his desk. I have a strong sense that Ms G liked L, whose school work was of *"good quality"*, whose manners she saw as faultless and whose appearance she described as *"always immaculate."* She later shared with him that she too had lost a sibling when she was 7 years old. She told L that he could come and talk to her about his loss whenever he wanted. L did not take her up on that offer. He had little opportunity to do so as he moved to junior school at the end of the academic year. Ms G described L as *"a very black and white concrete thinker."* She said that L lacked intuitive imaginative skills and drew from that a conclusion that L must be telling the truth. It is important to signal, as I did to Ms G, that L's credibility is not in issue here. It is important to listen carefully to what he is reported as having said and to evaluate that in the broad canvas of the wider evidence. It requires to be emphasised that L does not recount seeing any fall and has never done so at any stage. I stress this because there are frequent references to "what L saw," which has, on a few occasions, elided in to a misapprehension that he has said that he saw N fall from the bunk bed. He has not.

**26.** The police have interrogated L's laptop and confirmed that there was activity under 'user account L' in relation to a computer game between 19:20:44 and 19:39:48 on 25th June 2019. There were no indicators of activity after this time on that date. Counsel are agreed that these timings do not necessarily mean that L was engaged in using the game but only that it was awake on the laptop.

**27.** On 27th June 2019 Professor Philip Lumb, Forensic Pathologist on the Home Office register, visited the family home. Also present was Dr Panasa, Consultant Paediatrician, Detective Chief Inspector D and Ms JMG, Crime Scene Manager. In his report, dated 8th January 2020, Professor Lumb describes the property as *"a detached house," "very well kept and generally clean and tidy."* Professor Lumb makes the following observations in respect of the "upstairs bedroom where the incident reportedly happened":

> *"There was a bunk bed, up against the wall. At one end of the bunk bed, towards the room's doorway was the bunk bed ladder. Tied to the railing of the upper bunk was a helium filled balloon which was still floating. The upper bunk had a mattress and bedding upon it. The bedroom carpet was moderately soft. There was obvious carpet underlay.*
>
> *At my request, following my attendance at the scene, scaled images of the bunk bed were made these images have subsequently been provided to me and they show that at the foot of the bunk bed, where the ladders meet the upper bunk, the drop to the floor from the mattress was 1.34 metres from the top of railing, in the region of the balloon, the drop to the floor was 1.53m" (4ft 7inches).*

**28.** On 28th June 2019 Professor Lumb conducted the post-mortem examination along with Dr Melanie Newbould, Consultant Paediatric Histopathologist, XY Children's Hospital. Somewhat surprisingly, to my mind, notwithstanding the extant post-mortem investigations, on 2nd July 2019 F was informed that the police did not intend to take any further action.

## The Legal Framework

**29.** At the commencement of these proceedings the Local Authority's stated position was that it wished to investigate the evidence before advancing a positive case. By this I understood the situation to be that they intended to analyse the two competing hypotheses i.e. a fall or a shaking injury, before determining which they considered to be more likely, having heard all the evidence. Somewhat to my surprise, I am told that the Local Authority has been unable to resolve its dilemma and, at the conclusion of the case, is no further advanced in its thinking. Ms Heaton QC, on behalf of the Local Authority tells me that her clients remain securely pivoted "on the fence". She has told me, twice, that she is "instructed" to advance a neutral position. Ms Walker, on behalf of the Children tells me that the Guardian is in the same position. For completeness, I record that the father contends this was an accident. The mother continues to support the father's case. Manifestly, this puts the Court in an invidious position. Ms Heaton submitted that, notwithstanding the Local Authority's inability to reach a conclusion, the Court could, nonetheless, properly determine that the injuries leading to N's death arose in consequence of shaking and impact. Mr Vine QC, on behalf of F, submitted that the Local Authority's position, when properly scrutinised, is that it cannot maintain that the "threshold criteria," pursuant to Section 31(2) Children Act 1989, can be met on the basis of a shaking and impact injury. Sitting on the fence, Mr Vine contends, can only mean that the Local Authority, on its own

account, has not established this aspect of their case to the requisite standard i.e. the balance of probabilities. I agree with Mr Vine.

**30.** Ms Heaton's riposte is to suggest that the threshold criteria is nonetheless met on the basis of the father's own case. By this she means that F's action in leaving a 9-month-old baby on the top of a bunk bed falls within the Section 31 (2) criteria. Logically, this is the only case she can actively advance.

**31.** In the course of discussion, Mr Vine recognised two important points. I am careful not to characterise these as concessions but rather as a correct understanding of the applicable legal framework. Mr Vine recognises that it is intrinsic to the Article 8 rights of both these subject children, that the central factual dispute at the heart of this hearing should, if possible, be resolved one way or the other. He also, responsibly acknowledges, that such an approach does not compromise F's Article 6 rights to a fair hearing, F having been aware of the allegation he faced and having had extensive opportunity to challenge the evidence both by the instruction of experts and in cross examination, presented by leading counsel.

**32.** Ms Heaton does not seek leave to withdraw her application. Thus, it seems to me, that in this investigative, non-adversarial, sui generis jurisdiction it remains open to me to make such findings as my analysis of the evidence requires. For the avoidance of any ambiguity, this includes findings other than those contended for by the parties. Each of the advocates supports this approach. It is not a comfortable position for the Judge to be placed in and in my view reflects an incomplete understanding of the approach of the court when weighing, assessing and generally evaluating the evidence at fact finding hearings. Logically, the Local Authority's forensic approach should seek to foreshadow the court's approach. It strikes me as necessary to consider the scope and ambit of the applicable law in greater detail than I had originally contemplated.

**33.** It is axiomatic that it is judges and not experts who determine cases. The conclusions of well-reasoned, carefully assessed expert evidence, free from dogmatism or defensive protection of amour propre, will always weigh significantly in the Court's evaluation of the evidence as a whole. However, it will rarely, if ever, be determinative. Developments in medicine and imaging technology, most strikingly in the last 20 years, have displaced shibboleths and perceived orthodoxies across a range of clinical understandings and practice. Developments in neuro imaging, in particular, have enhanced understanding of the impact on the brain of a wide variety of organic illnesses and both accidental and non-accidental injuries. This progress has, or at very least should have, caused both the professionals and interested members of the public, to recognise that today's mainstream prevailing professional consensus may, in the future, be disproved or refuted.

**34.** However, whilst the Court should always be alert to the expanding horizons of medical knowledge and be prepared fully to engage with presentations which may be uncommon, anomalous, irregular or atypical to a conventional diagnosis, it should never permit itself to become a platform for professional debate or a forum to resolve competing professional theories or ideologies. That is, most decidedly, not the function of this court.

**35.** The judge's task is to consider the accounts given by the parents, any family members and, generally, any lay evidence which is thought to be relevant. Alongside this the medical evidence which, where it is disputed, must be appropriately put to the assay

in cross examination, will be considered. There is no assumption that medical evidence will, automatically, be of greater weight than any other. The Court will also look for extraneous, independent observations or identifiable facts, which may indicate that one explanation is, on balance, more probable than another. Though these precepts are relatively easy to state, they can be challenging to apply in a complex matrix of evidence, emanating from a variety of professional disciplines and other sources. What emerges is a broad canvas of evidence which must be viewed as a whole alongside the examination of its individual components.

**36.** That the Court must take into account all the evidence and consider each piece of it in context, is an approach first articulated by Dame Elizabeth Butler-Sloss, President, in **Re U, Re B (Serious Injuries: Standard of Proof) [2004] EWCA Civ.567** where she recognised that the Court "invariably surveys a wide canvas." In **Re T [2004] EWCA Civ 558, [2004] 2FLR 838** at paragraph 33 she developed the point thus:

> *"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 the other evidence and to exercises an overview of the totality of the evidence in order to come to the conclusion of whether the case put forward by the Local Authority has been made out to the appropriate standard of proof."*

**37.** An extensive exegesis of the development of the applicable law is unnecessary here but it is, I consider, helpful to restate some of the key principles. In **Re S [2009] EWHC 2115 (Fam)**, at para 254, Eleanor King J (as she then was) emphasised the importance of experts recognising the parameters of their own expertise:

> *"Cases involving an allegation of shaking are, inevitably, and necessarily, multi-disciplinary in their approach. It is therefore crucial that each expert keeps within the bounds of their own expertise and works in a collaborative way with the other experts in order to see if a diagnosis/cause can be reached. This means that each expert must defer to the expertise of others more qualified to comment on certain areas such deferral must be made not grudgingly or reluctantly, but in ready acknowledgment of the greater expertise and knowledge that the other specialists may have in relation to certain aspects of the case."*

**38.** In **Re B (Care: Expert Witnesses) [1996] 1Flr 667** Ward LJ, foreshadowing some of my observations above, observed:

> *"the expert advises but the judge decides. The judge decides on the evidence… there is, however, no rule that the judge suspends judicial belief simply because the evidence is given by an expert."*

**39.** In **Re W (Children) [2009] EWCA Civ 59, [2009] 1 FLR 1378** at para 206, Wilson LJ (as he then was) concluded his judgment with the following caution:

> *"The moral which I draw from this case and will never forget is that a hypothesis in relation to the causation of a child's injuries must not be dismissed only because such causation would be highly unusual and that, where his history contains a demonstrably rare feature, the*

*possible nexus between that feature and his injuries must be the subject of specialist appraisal at an early stage."*

**40.** It is important to emphasise both facets of Wilson LJ's reasoning in the above paragraph. A court should not dismiss a ***"highly unusual"*** hypothesis merely because it is rarely seen. However, there must be some ***"demonstrably rare feature"*** that establishes a possible ***'nexus'*** between that feature and the injury, and which should be the subject of ***"specialist appraisal at an early stage"***. The emphasis above is mine. It seems to me that these words have particular resonance in this case. By parity of analysis, a free-standing hypothesis that cannot root itself within, or gain any traction from the available evidence, becomes mere speculation. It may be that such speculation has a range of plausibility from 'possible' to 'highly unlikely' but to achieve evidential weight it must, in some way, be connected to reliable identifiable evidence. That may be within the wider medical interdisciplinary material but need not be confined to that and may be rooted in lay evidence, where that is found to be credible.

**41.** In **Cumbria County Council v KW [2016] EWHC 26 (Fam)** I indicated that whilst it is *"entirely right that experts should stimulate full professional enquiry"* this should not be regarded as a licence *"to indulge in professional debate on controversial issues."* I considered, for the reasons set out in that judgment, that in his wish to emphasise the importance of factoring in *"unknown causes"* into the diagnostic process, the expert had strayed into the *"tendentious"* and away from the *"professionally objective."* I do not consider the medical evidence I have heard in this case to have been tendentious. The central question is whether an accidental injury as opposed to an inflicted one can be supported by identifiable evidence as opposed to a purely theoretical analysis.

**42.** It is necessary to restate the Practice Direction concerning **the duties of an expert and the content of the expert's report: PD 25B, para 9.1.** I would emphasise the following:

> ***'9.1***
>
> ***The expert's report shall be addressed to the court and prepared and filed in accordance with the court's timetable and must –***
>
> ***(f) in expressing an opinion to the court –***
>
> *(ii) describe the expert's own professional risk assessment process and process of differential diagnosis, highlighting factual assumptions, deductions from the factual assumptions, and any unusual, contradictory or inconsistent features of the case;*
>
> *(iii) indicate whether any proposition in the report is an hypothesis (in particular a controversial hypothesis), or an opinion deduced in accordance with peer-reviewed and tested technique, research and experience accepted as a consensus in the scientific community;*
>
> *(iv) indicate whether the opinion is provisional (or qualified, as the case may be), stating the qualification and the reason for it, and identifying what further information is required to give an opinion without qualification;*
>
> ***(g) where there is a range of opinion on any question to be answered by the expert –***

> *(i) summarise the range of opinion;*
> *(ii) identify and explain, within the range of opinions, any 'unknown cause', whether arising from the facts of the case (for example, because there is too little information to form a scientific opinion) or from limited experience or lack of research, peer review or support in the relevant field of expertise;*
> *(iii) give reasons for any opinion expressed: the use of a balance sheet approach to the factors that support or undermine an opinion can be of great assistance to the court;"*

**43.** This Practice Direction is expressed in clear language. Its importance is highlighted in every standard letter of instruction to an expert in family proceedings. It underscores the importance, when expressing an opinion to the court, of following the "process of differential diagnosis." It also signals, inter alia, and again in clear and prescriptive language, that such a process requires factual assumptions to be highlighted as well as any deductions drawn from them. In the court room, just as in the hospital, competing diagnoses or working conclusions do not exist in a vacuum, they require to be linked to the given history, the reliability of which will always need to be considered where one of the competing diagnostic hypotheses is non-accidental injury. Forensic medicine and clinical practice share the same professional rules.

**44.** Cases involving shaking injury to babies have, understandably, excited concern and anxiety within the medical and legal professions and amongst the public more generally. In **R v Henderson [2011] 1 FLR 547**, Moses LJ confronted some of the challenges these cases present:

> *"[1] There are few types of case which arouse greater anxiety and controversy than those in which it is alleged that a baby has died as a result of being shaken. It is of note that when the Attorney-General undertook a review of 297 cases over a 10-year period following the case of R v Cannings [2004] EWCA Crim 1, [2004] 1 WLR 2607, 97 were cases of what is known as 'shaken baby syndrome'. The controversy to which such cases gives rise should come as no surprise. A young baby dies whilst under the sole care of a parent or childminder. That child can give no clue to clinicians as to what has happened. Experts, prosecuting authorities and juries must reconstruct as best they can what has happened. There remains a temptation to believe that it is always possible to identify the cause of injury to a child. Where the prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative cause, it is tempting to conclude that the prosecution has proved its case. Such a temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude, beyond reasonable doubt, an unknown cause. As R v Cannings, para [177] teaches, even where on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown.*
> *[2] This court has heard, over a period of 3 weeks, three appeals concerning three babies, two of whom died, whilst in the care of a single adult. During the course of the trials a large number of medical experts were called. In two of the appeals what was asserted to be 'fresh' medical expert evidence was called. These three cases*

> *highlight a particular feature of cases where it is alleged a baby has been shaken in the care of a single adult. The evidence to prove guilt may consist only of expert evidence. It must never be forgotten that that expert evidence is relied upon to prove that the individual defendant is lying in the account he gives, either at the time or at trial. The correct management of such evidence is, therefore, of crucial importance in cases such as these. The correct approach to such evidence must be identified. If a conviction is to be based merely on the evidence of experts then that conviction can only be regarded as safe if the case proceeds on a logically justifiable basis. That entails a logically justifiable basis for accepting or rejecting the expert evidence (see R v Kai-Whitewind [2005] EWCA Civ 1092, [2006] Crim LR 349, para [90]). Hearing these three appeals in succession affords an opportunity to make observations on the correct approach and the management of such expert evidence."*

**45.** Mr Vine highlights the observation of Munby LJ in **Re R 1 FLR 1250**, (as approved in *Re TG* [2013]) Munby LJ:

> " *In my judgment, a conclusion of unknown aetiology in respect of an infant represents neither professional nor forensic failure. It simply recognises that we still have much to learn and it also recognises that it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism. Maybe it simply represents a general acknowledgement that we are fearfully and wonderfully made'."*

**46.** King LJ describes the scope and objectives of fact-finding hearings in family proceedings in enviably clear language in **Re A [2020] EWCA Civ 1230**:"

> *"29. Judges are well used to conducting finding of fact hearings in which arriving at findings substantially relies upon the judge piecing together strands of evidence, both expert and lay, direct and circumstantial. By way of example, only rarely will there be a witness to a baby being shaken. That does not, however, mean that at the conclusion of a trial, having considered all the evidence, a judge is prevented from making findings on the balance of probabilities, that the cause of death was shaking, and to identify the unseen perpetrator. In reaching such conclusions, a judge will rightly have looked at all the evidence, contemporary, written and oral.*
>
> *30. Inevitably in such cases, the oral evidence of the key protagonists, most often the mother and her partner, is highly significant. The case law has developed in a way designed to ensure that, whilst there is recognition of the fact that the oral evidence of lay parties is often critical, it also has its limitations; there are dangers in an over reliance by the judge on either demeanour, or upon the fact that a witness has told demonstrable lies.*
>
> *30. The case of R v Lucas [1981] QB 720 is routinely quoted, as it was here at [15] of the judge's judgment, as a reminder to the court that people lie for all sorts of reasons; the fact that a person lies*

*about one specific thing does not necessarily mean that they have lied about another matter.*

*31. I have in mind the guidance given by Baker J (as he then was) in Gloucestershire CC v RH and others [2012] EWHC 1370 (Fam) and in particular at [42] his point 7:*

*"Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them (see Re W and another (Non- accidental injury) [2003] FCR 346)."*

**47.** As King LJ averted to above, the Court will keep in mind the warning in R v Lucas [1981] QB 720:

> *"If a court concludes that a witness has lied about a matter it does not follow that he has lied about everything. A witness may lie for many reasons for example how to shame, humiliation, misplaced loyalty, panic, fear, distress, confusion and emotional pressure."*

**48.** In the context of shaking injury to a child, I would add to the above, the importance of recognising that these injuries paradigmatically occur in the context of parents under great stress. The incident itself will last only a few seconds with potentially traumatic consequences that may resonate for a lifetime. In order to manage this unbearable tragedy, it has often struck me and others, that some of those who have caused injuries of this kind may simply blank out those awful few seconds of loss of control and construct a narrative which they can more easily cope with psychologically. In this sense the lie becomes an unconscious one and, perhaps because of this, more convincing.

**49.** In **Re BR (Proof of Facts), Re [2015] EWFC 41** Jackson J (as he then was) made the following observations:

> "*6. The burden of proving a fact rests on the person who asserts it.*
>
> *7. The standard of proof is the balance of probabilities: Is it more likely than not that the event occurred? Neither the seriousness of the allegation, nor the seriousness of the consequences, nor the inherent probabilities alters this.*
>
> *(1) Where an allegation is a serious one, there is no requirement that the evidence must be of a special quality. The court will consider grave allegations with proper care, but evidence is evidence and the approach to analysing it remains the same in every case. In my view, statements of principle (some relied on in this case) that suggest that an enhanced level of evidential cogency or clarity is required in order to prove a very serious allegation do not assist and may lead a fact-finder into error. Despite all disclaimers, reference to qualitative concepts such as cogency and clarity may wrongly be taken to imply that some elevated standard of proof is called for.*

*(2) Nor does the seriousness of the consequences of a finding of fact affect the standard to which it must be proved. Whether a man was in a London street at a particular time might be of no great consequence if the issue is whether he was rightly issued with a parking ticket, but it might be of huge consequence if he has been charged with a murder that occurred that day in Paris. The evidential standard to which his presence in the street must be proved is nonetheless the same.*

*(3) The court takes account of any inherent probability or improbability of an event having occurred as part of a natural process of reasoning. But the fact that an event is a very common one does not lower the standard of probability to which it must be proved. Nor does the fact that an event is very uncommon raise the standard of proof that must be satisfied before it can be said to have occurred.*

*(4) Similarly, the frequency or infrequency with which an event generally occurs cannot divert attention from the question of whether it actually occurred. As Mr Rowley QC and Ms Bannon felicitously observe:*

*"Improbable events occur all the time. Probability itself is a weak prognosticator of occurrence in any given case. Unlikely, even highly unlikely things, do happen. Somebody wins the lottery most weeks; children are struck by lightning. The individual probability of any given person enjoying or suffering either fate is extremely low."*

*I agree. 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. Clearly, in this and every case, the answer is not to be found in the inherent probabilities but in the evidence, and it is when analysing the evidence that the court takes account of the probabilities.*

*8. Each piece of evidence must be considered in the context of the whole. The medical evidence is important, and the court must assess it carefully, but it is not the only evidence. The evidence of the parents is of the utmost importance and the court must form a clear view of their reliability and credibility.*

*9. When assessing alternative possible explanations for a medical finding, the court will consider each possibility on its merits. There is no hierarchy of possibilities to be taken in sequence as part of a process of elimination. If there are three possibilities, possibility C is not proved merely because possibilities A and B are unlikely, nor because C is less unlikely than A and/or B. Possibility C is only proved if, on consideration of all the evidence, it is more likely than not to be the true explanation for the medical findings. So, in a case of this kind, the court will not conclude that an injury has been inflicted merely because known or unknown medical conditions are improbable: that conclusion will only be reached if the entire evidence shows that inflicted injury is more likely than not to be the explanation for the medical findings.*

> *10. Lastly, where there is a genuine dispute about the origin of a medical finding, the court should not assume that it is always possible to know the answer. It should give due consideration to the possibility that the cause is unknown or that the doctors have missed something or that the medical finding is the result of a condition that has not yet been discovered. These possibilities must be held in mind to whatever extent is appropriate in the individual case."*

**50.** I note Jackson J's assertion in paragraph 6 (above) and I am acutely aware that whilst a shaking and impact injury have been placed before the court no party, on a proper construction of their positions, may be described accurately as submitting that it can be supported by evidence which is founded on the balance of probabilities. I have addressed this at para 6 above. Nonetheless, I highlight these passages by Jackson J because they strike me as very helpfully illustrative of the court's approach to analysing evidence in cases such as these.

**51.** Finally, I conclude my summary of the law in this sphere with the key passages of Baroness Hale's judgment in **Re B (Care Proceeding: Standard of Proof) [2008] UKHL**:

> *"70. My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under section 31(2) or the welfare considerations in section 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies…*
>
> *72. As to the seriousness of the allegation, there is no logical or necessary connection between seriousness and probability. Some seriously harmful behaviour, such as murder, is sufficiently rare to be inherently improbable in most circumstances. Even then there are circumstances, such as a body with its throat cut and no weapon to hand, where it is not at all improbable. Other seriously harmful behaviour, such as alcohol or drug abuse, is regrettably all too common and not at all improbable. Nor are serious allegations made in a vacuum. Consider the famous example of the animal seen in Regent's Park. If it is seen outside the zoo on a stretch of greensward regularly used for walking dogs, then of course it is more likely to be a dog than a lion. If it is seen in the zoo next to the lions' enclosure when the door is open, then it may well be more likely to be a lion than a dog."*

**The Medical Evidence**

**52.** Examination in life, radiological scanning and post-mortem examination revealed the following injuries:

> **HEAD**

> a. Bilateral acute subdural haemorrhage at several different sites. [i.e. over the convexity of the brain covering the frontal regions on both sides, worse on the right than the left, and between the two halves of the brain, and in the posterior
> fossa].
>
> b. Acute subarachnoid bleeding. [i.e. over the superior aspects of both cerebral hemispheres and in the interpeduncular cistern.] The CT scan taken following N's admission to hospital revealed evidence of acute (i.e. recent) subdural bleeding at several different sites, acute sub arachnoid bleeding and very extensive hypoxic-ischaemic brain injury.
>
> d. Seen at post-mortem, but not radiologically, a 2.4 cm hairline fracture on the left frontal bone with associated subaponeurotic liquid blood.
>
> e. Brain swelling. (encephalopathy)
>
> **SPINE**
>
> Spinal subarachnoid blood, nerve root bleeds and axonal bleeds and limited axonal injury in the pyramidal tract in the lower brainstem [medulla].
>
> **EYES**
>
> Numerous multi-layer bilateral retinal haemorrhages and perimacular folds at 15.10 hours on 26th June 2020 and confirmed at autopsy.

**53.** There is no dispute in this case as to the very strong association between traumatic hypoxic-ischaemic brain injury; widespread intracranial haemorrhages; diffuse and multi-layered retinal haemorrhages; perimacular folds and shaking and/or shaking impact injury, involving rotational, accelerative and decelerative forces. It is also recognised by all and importantly by Mr Vine, on behalf of F and Ms Connolly QC, on behalf of M, that the degree and extent of this ophthalmic and neurological damage has no recognised association with accidental falls from the height posited in this case.

**54.** In discussion with counsel at the conclusion of the evidence but before filing of written submissions, it was possible to identify two further areas of common ground. It is agreed that raised intravascular pressure and raised intracranial pressure may have resulted in some extra bleeding to the eyes but if that had occurred it could not have been the cause of the presentation of the eyes and in any event was not associated with the perimacular folds. It was also agreed that raised intracranial pressure would not have exacerbated or "confounded" the intracranial bleeding.

**55.** It will be immediately clear from the above that the ophthalmological findings are of great significance in this case. It will be recalled (see paragraph 9) that both Dr S and Ms A (Consultant Paediatric Ophthalmologist) were concerned from the very beginning of the medical investigations in this case that these were indicative of non-

accidental injury. Professor Ian Christopher Lloyd, Consultant Ophthalmic Surgeon and Paediatric Ophthalmologist at the Great Ormond Street Hospital for Children, was instructed to provide an independent report. For much of his distinguished career Professor Lloyd has held a special interest in the ocular features of cases of suspected non-accidental injury. He is a member of the Ophthalmic non-accidental injury working party, convened under the aegis of the Royal College of Ophthalmologists which published the guidance in this area. It is also pertinent to note that Professor Lloyd was a member of the Child Protection Ophthalmology Injury Group which critically surveyed and appraised the Ophthalmic literature concerning shaking injuries. In his report dated 9th June 2020, Professor Lloyd reports having examined over 170 infants suspected of suffering non-accidental injury since 1991.

**56.** The Eye Histology report, prepared for the post mortem by Dr Roger Gibbs states:

> "*The eye pathology findings in this case can be summarised as showing severe, bilateral, numerous, multilayered retinal haemorrhages, associated with bilateral optic sheath haemorrhage. Haemorrhagic subILM macular cysts/retinoschisis cavities contained within ring-like retinal folds are present at the posterior poles of both eyes associated with focal sub-retinal haemorrhage. Haemorrhage at the optic nerve/scleral junction is also seen bilaterally."*

**57.** Professor Lloyd is measured and careful in the way he explains the association between subdural haemorrhage (and other intracranial injury), and retinal haemorrhages. He described the association as "strong". In his oral evidence he was careful to identify that the statistics do not reveal the association of the two to be "diagnostic" or "pathognomonic". Indeed, Professor Lloyd did not consider that there was anything in the field of ophthalmology which could properly be termed pathognomonic. He highlights, in his report, that retinal haemorrhages are noted to be bilateral (as here) in 83% of abusive head injury cases as compared with 8.3% of those due to accidental head trauma. Professor Lloyd also notes that retinal haemorrhages tend to be numerous and bilateral (again, as here) in abusive head trauma. He emphasises that this is not "invariable".

**58.** For reasons which require no explanation the exact mechanisms causing retinal haemorrhaging in infants suffering traumatic head injury are, and are likely to remain, unclear. Professor Lloyd analyses the mechanisms that are thought most likely to be contributory in this way:

> *"(a). Direct tractional forces from movement of the vitreous body (gel) within the eye during waves of acceleration/deceleration. This causes traction on the attachments of the retina to the vitreous (vitreo-retinal interface) and results in shearing forces which in turn cause bleeding from small blood vessels within the retina.*
>
> *(b). Raised intra vascular pressure (transmitted from raised intra-thoracic blood pressure) causing forcible*

> *extravasation of blood from retinal blood vessels. It is postulated that this could occur if the infant's chest*
> */thorax was forcibly gripped and that it would be more likely to lead to posterior pole bleeding (adjacent to the optic nerve). A had no evidence of grip or pressure marks on his chest and no radiological signs of rib fractures. This mechanism thus appears unlikely in this case.*
>
> *(c). Raised intracranial pressure (particularly if of sudden onset and/or massive in nature) has been cited as*
> *a cause for retinal bleeding. This clinical situation is known as Terson's syndrome and is well described (if rare) in adults. However, Terson's Syndrome is thought to be unusual in young children and infants because of the open fontanelle in young infants."*

**59.** Engaging directly with the alternative hypothesis i.e. that the retinal haemorrhages could have been caused by a fall from the top bunk, Professor Lloyd readily agreed that it is possible for retinal haemorrhages to arise in consequence of what he considers can here properly be characterised as a *"short distance fall"*. However, he emphasises that bilateral haemorrhaging to this degree is entirely atypical in the context of a fall. Usually retinal haemorrhages following a fall are minor, unilateral (this he stresses as significant) and occur on the same side as a co-existent intracranial haemorrhage. Additionally, they are characteristically constrained to the posterior pole of the eye. Retinal haemorrhages in such cases are usually mild and do not extend to the peripheral retina. There is complete agreement amongst all the doctors that A's injuries are *"at the most serious end of the spectrum"*. N exhibited very extensive and severe retinal bleeding in both eyes with perimacular folds again, in both eyes. Optic imaging revealed evidence of tractional retinal forces.

**60.** There can be no doubt that Professor Lloyd was prepared fully to engage with the competing hypothesis. His evidence struck me both as entirely free from dogmatism and well rooted in a lifetime of professional experience in this particular field. It is common ground that the hypothesised fall from the upper bunk would have had to involve rotational acceleration/deceleration forces (oscillation) and that these would have to have been both "significant" and "angular".

**61.** Dr Du Plessis, Consultant Neuro Pathologist, carried out a neuropathological examination of N's brain and spinal cord for the post mortem. The conclusion in his report, dated 8th December 2019, requires to be set out in full:

> *"In conclusion, from a scientific/statistical perspective an exercise in judging whether an explanation should be favoured or discounted on balance of probability relying on previously creditable and reliable pathological evidence might become meaningless if other potentially contradictory novel variables/additional non-pathological information of a reliable nature (if accepted by investigators and the Court as such) is introduced in addition to the pathological evidence. To put it another way, if we as clinicians and pathologists regard our findings as near incontrovertible to incontrovertible evidence of a non-accidental event based on sound prior shared and agreed experience such a position nevertheless needs to be*

> *reconsidered when supplemented by additional evidence seriously challenging such a position. For example, if CCTV imaging is obtained confirming an accidental injury event previously regarded as implausible, the whole equation changes – to insist that a non-accidental injury event remains on balance the most likely explanation might still be valid as a general rule, but becomes untenable in the particular case under scrutiny. Should the relevant circumstantial evidence obtained in this case prove credible to any Court I would have to accept that father's account is true. The specifics of the accidental scenario under consideration in this case might further be an exceptional explanation for the fatal outcome and full injury profile obtained, but in my opinion such specifics (height and possible manner of fall and impact) introduces a reasonable prospect of causing a fatal head injury, allowing me to reconcile the account provided with the tragic fatal outcome."*

**62.** In the prefacing sentences above, Dr Du Plessis is, if I may say so, not merely 'pushing at an open door' but facing an aperture where the doors have already been blasted off their hinges. Nobody, in this case, is suggesting that a conclusion should be predicated on a *"scientific statistical perspective"* to the exclusion of other *"potentially contradictory novel variables and non-pathological information of a reliable nature"*. The approach, which I have laboured to set out, is quite the opposite. I consider that Dr Du Plessis is here signalling in forceful language what I have said above i.e. that a contrary hypothesis in the context of these injuries must always be carefully evaluated recognising that uncommon events do occur uncommonly.

**63.** Dr Du Plessis told me that he had, in recent years, become increasingly interested in the biodynamics of injuries of this kind. He was careful, and appropriately so, not to advance himself as an expert in that sphere. Neuropathology involves the diagnosis of natural and unnatural diseases of the nervous system by analysing tissue obtained either during life or post mortem. Dr Du Plessis and Dr Melanie Newbould both comprehensively exclude disease, which is not identified as a factor which requires to be considered in this case. Biodynamics manifestly, fall outwith Dr Du Plessis's expertise but he was keen to tell me that the final position in a fall does not indicate the nature and dynamic of the fall. He told me that he had little difficulty in contemplating some accelerative/decelerative forces on impact and perhaps during the course of the fall postulated on behalf of F. Dr Du Plessis balanced this opinion with his clear recognition that, *"so called low level accidental falls with a fatal outcome are vanishingly rare in the paediatric age group"*.

**64.** I sensed that Dr Du Plessis is highly motivated to guard against the so-called 'triad' of injuries as establishing a too easy assumption that they must always, and in every case, arise in consequence of non-accidental injury. This court and all involved in this case, have that point well in mind. Nonetheless I consider that Dr Du Plessis is entirely right to underscore the ever-present need for robust forensic rigour.

**65.** In his report Dr Du Plessis constructed the following scenario, drawn from the presence of a helium balloon tied to N's bed:

> *"If [N] was reaching up to grab the balloon tethered to the railing, the level of his head above the ground may well have exceeded 5 or*

> *even 6 feet (his crown-heel height was 2.5 feet). He could further have toppled over the railing, introducing a rotational/angular component to the momentum of his fall. Were his forehead to have struck the floor first (an entirely plausible proposition given the height involved which would have permitted a headlong plunge downwards with the whole of [N's] bodyweight kg of over 10 kg bearing down on the impact site) substantial force may have been applied to the head on impact. Such a fall could have accounted for a skull fracture (which cannot be dismissed in this case given Dr Lumb's post mortem observations), an independent form of verification of substantial force exerted on the head and therefore on the brain. Such an impact could further have caused considerable and sudden whiplash related strain on the upper neck/lower brainstem."*

**66.** At an experts meeting, conducted on 17th July 2020, Dr Du Plessis amplified the hypothesis thus:

> *"Apart from static/crush-related head injuries, nearly all other head injuries involve some component of acceleration/deceleration force, with a subset involving rotational or angular movement in the process. The distinctive injury profile observed in this case (involving the eyes, brain and spine) most likely relates to a particular form of angular acceleration/deceleration, namely one involving oscillatory movement with at least an initial crescendo/amplifying rather than dampening effect (such as may be caused by forceful shaking, but also any other oscillatory movement with rapid and forceful reversal of head acceleration, a possibility which could also exist with a head impact resulting in a forceful to-and-fro whiplash-type movement of the head due to rebound phenomena."*

**67.** This is the high-water mark of the countervailing hypothesis. It must be deconstructed a little. The toppling over the railing would require N to have propped himself up against it in order to achieve the crown-heel height posited. This cannot be reconciled with anything I have heard about N's level of development from any of the family. He could not sit up unaided nor could he move other than by what has been called a "commando shuffle". He was not "cruising", by which is meant holding on to objects to help propel himself around. In any event, in the light of the wider evidence, this is unlikely to be a significant point.

**68.** A rotational/angular component to the momentum of the fall, with the forehead striking the floor first is considered, by Dr Du Plessis, to be "plausible". Given N's body weight, which is in excess of 10kg (around 23 pounds) he considered it to be "feasible" that substantial force may have been applied to the head which could account for the hairline fracture, seen by Professor Lumb, at the autopsy but invisible on the neuro radiology. I accept the feasibility of the hypothesis.

**69.** This theory, however, must be evaluated in the context of the wider panoply of evidence, as Professor Lloyd unhesitatingly recognised. Having regard to the height involved in the alleged fall, on even the most ambitious measurement, Professor

Lloyd could not account for the very significant number of retinal haemorrhages observed bilaterally and the presence of perimacular folds, *"I am comfortable in saying this is likely to have been a shaking/impact injury"* he concluded.

**70.** Dr Roger Malcolmson, Consultant Paediatric and Perinatal Pathologist at the Leicester Royal Infirmary, provided a report in these proceedings dated 10th October 2019. He attended at court in person (i.e. not by video conferencing platform). In his oral evidence and in his report, he stressed that the eye pathology should be correlated with the wider investigation, especially the full autopsy findings and the findings of the radiological, osteoarticular, brain and spinal cord examinations. Additionally, he highlighted that consideration should also be given to the opinion of appropriate clinical experts, in particular in relation to the eyes: a paediatric ophthalmologist. This succinct summary of the approach to the medical evidence I regard as having been agreed by all the doctors involved.

**71.** Dr Malcolmson summarises the pattern of the eye injuries as *"showing severe bilateral, numerous, multi-layer retinal haemorrhages associated with bilateral optic nerve sheath haemorrhage"*. He considered the possible explanations:

> *"The differential diagnosis of such a pattern of bleeding within and around the eyes with retinal folding is essentially restricted to abusive trauma, high energy impact trauma (e.g. a road traffic accident, fall from significant height), severe crush head injury or Terson syndrome (catastrophic intracranial haemorrhage associated with ocular haemorrhages in the context of sudden rupture of a large calibre intracranial aneurysm or intracranial arteriovenous malformation). Birth related head injury is not a credible explanation for the recent haemorrhages present.*
>
> *Bilateral, multi-layered confluent retinal haemorrhages may rarely occur in the context of severe (high energy) accidental trauma but the retinal haemorrhages in such a context, when present, are much more often said to be unilateral, localised to the posterior pole and few in number (Maguire et al, 2013 Eye; 27; 28-36 – systematic literature review). This latter pattern is not the pattern of retinal bleeding seen in this case.*
>
> *According to Binenbaum and Forbes (Paediatr. Radiol. 2014; 44:S571-77), the incidence of retinal haemorrhages in accidental injury is less than 4% and in most studies the incidence is zero, especially when due to short falls. Typically, the history provided is that of an unambiguous high energy incident such as motor vehicle incident or very high level fall with other injuries matching the traumatic mechanism. Binenbaum and Forbes state that the retinal haemorrhages found in such accidents are confined to the posterior pole, few in number and are rarely subretinal."*

**72.** For completeness I should recall that Dr Malcolmson considered a range of isolated potential causes e.g. leukaemia, meningococcal meningitis, streptococcal meningitis, severe meningococcal septicaemia with disseminated coagulation and pneumococcal septicaemia in the context of a glycosylation disorder but discounted all these

conditions as having been excluded by consideration of the clinical findings and at autopsy. I include this merely to show the extent of the investigations and record that nobody takes issue with this conclusion.

**73.** Dr Malcolmson concluded that the appearances in the eyes were typical of those seen in abusive head trauma (a term which encompasses shaking and shaking with impact) in an infant and consistent with an incident occurring around 2 days prior to death. Again, he signalled that the findings presented his report should be correlated with those from the autopsy, neuropathology and other information available from the wider death investigation.

**74.** In the course of his evidence Dr Malcolmson stated that he would expect *"an extremely high energy event, comparable to a high energy or high velocity road traffic accident to have caused the findings in the eye"*. He was unable to reconcile the pattern of injury with *"less energy and complexity"*. In common with every other doctor in the case, excluding Dr Cartlidge, Dr Malcolmson stated that he had never encountered these findings in a fall from this kind of height. When pressed as to whether he considered the hypothesis to be possible he responded that he considered it to be *"remote, if indeed possible at all"*. Even if the extent and location of the retinal haemorrhages could be reconciled with a fall, a scenario with which he plainly struggled, he was unable to accommodate the presence of the perimacular folds.

**75.** Dr Malcolmson also made an observation, which struck me as relevant, not least because it is not highlighted, at least to any great degree, in either the experts meeting or within the reports, namely that *"[F's account]… is unusual from the start… for a 9-month-old baby to be unsupervised on top of a bunk bed"*. This resonates with the evidence of Ms KB, Paramedic, who, during the course of her safeguarding report, told the operative (as recorded) that her safeguarding instincts were triggered from the outset by the fact that *"a 9-month-old baby was on the top bunk bed in the first place"*. It should be noted that this observation occurs in the context of a very sympathetic response to the distress of both parents. I refer to it here because I consider it to underscore that which can be easily lost sight of in the complexities of the medical debate i.e. the factual circumstances in which it is said the fall took place are themselves both alarming and unusual; the constellation of injuries caused by the fall are atypical to a degree which has never been seen before by the doctors. Thus, the completed hypothesis of the fall, requires the coupling of two inherently unlikely scenarios.

**76.** I heard evidence, via video conferencing platform, from Dr Neil Stoodley, Consultant Neuroradiologist employed by the North Bristol NHS Trust. Dr Stoodley's area of expertise lies in the interpretation of imaging investigations of the brain and spinal cord. He has a specific expertise in the neuroimaging of children. In the context of the neurological evidence he contributes a perspective of experience from a specialist regularly evaluating paediatric head injury in children, the majority of whom survive their injuries. Self-evidently, this is a very different perspective from that of the pathologist whose experience, by definition, must concentrate on the examination of patients who have died from various pathological processes. Dr Stoodley considers the neuroradiology of a whole range of treatments referred for imaging in a wide spectrum of head injuries from a variety of causes across the spectrum of severity.

**77.** In response to Mr Vine's careful and well-crafted questions Dr Stoodley was clear that if he were to see subdural bleeding consequent on a fall, he would expect to see it

"at the point of impact, not at various different sites (as here)". He added to this that in the context of domestic injury it is, in itself, unusual to see injury to the brain. The central hypothesis, as I have foreshadowed, put to Dr Stoodley and to Professor Lloyd, is that the angular mechanism of the fall might have mimicked flection/extension of the kind seen in shaking cases. It was suggested that some whiplash reaction to the fall could contribute to the mimicking of the neurological and ophthalmological signs. Dr Stoodley made, what I consider to be, a real attempt to reconcile this hypothesis with the neuroradiology. He was clear that a consultant in this sphere should *"never say never"* but his approach was to seek to contextualise the possibility of a fall by reference to the totality of the imaging and from that perspective he concluded that if the court found that a fall from the bed had occurred as described, he regarded it as very unlikely that any injury sustained from such an episode could be reconciled with or unify the scan features. In response to Mr Vine's direct question, Dr Stoodley stated *"I don't feel I can reasonably explain the constellation of imaging findings as an impact injury; even where short distant falls give rise to fatality the imaging is very different."* Dr Stoodley agreed with Mr Vine that "every fall is different" but insisted that in the context of a domestic head trauma he would *"not expect to see brain injuries, particularly bleeding in the spinal canal"* and, further, that *"in the range of trauma he has seen"* he had not *"seen anything like this"*. By contrast, he noted that spinal bleeding should be regarded as strongly associated with shaking and not conflated with trauma in general.

**78.** In his report Dr Stoodley sets out his review of the neuroimaging. At risk of overburdening this judgment I consider it necessary to set his observations out in full. Understanding these passages requires an explanation of the terminology. With considerable diffidence I distil, what Dr Stoodley says in his report.

**79.** The whole surface of the brain is covered by a very fine membrane. The brain with its pial covering (the pia mater) lies within a covering of another fine membrane (the arachnoid mater); a much tougher and thicker membrane lies between the arachnoid and the inner aspect of the skull (the dura). Fluid between the pia and arachnoid membranes (i.e. in the sub arachnoid space) Dr Stoodley says is "normal and entirely innocent". Fluid in the subdural space (which is really a potential space in the absence of fluid) is always due to a pathological cause i.e. trauma or infection.

**80.** The appearance of blood on CT and MR scans varies, most particularly reflecting the time interval between the bleed and the scan being performed. Fresh, or at least relatively fresh blood on the CT scans is said to be of "high attenuation" i.e. showing more brightly than the underlying brain. The older the blood, the less bright it becomes until such point (which can be between one to three weeks) as it returns to the same attenuation as the underlying brain, before deteriorating to 'lower attenuation' (darker than the underlying brain).

**81.** On the MR scans the appearance of the blood becomes more difficult to interpret. The appearance is no longer confined to the passage of time between the bleed and the scan but now also incorporates *"the specific scan sequences used"* and other factors e.g. "dilution of blood into a pre-existing fluid collection" or cerebrospinal fluid (CSF), which may have leaked into the subdural space, having found a route, in consequence of damage to the arachnoid membrane. Manifestly, these variables render the task of assessing the length of time blood has been present on a head scan, very difficult indeed.

**82.** Dr Stoodley records his observations:

> *"CT head and cervical spine 25 June 2019 at 2320hrs*
>
> *There is evidence of high attenuation (bright) material on both sides of the interhemispheric fissure throughout its length and over both frontal convexities. A small amount of similar further bright material is seen in the posterior fossa. All of this bright material is acute (recent) subdural blood. It is not possible to assess accurately the age of the blood on the basis of the scan appearances alone as acute blood can appear bright on CT from soon after an episode of bleeding for up to around 7-10 days.*
>
> *Further acute blood is seen over the superior aspects of both cerebral hemispheres but this has a more linear, spiculated appearance and represents acute blood in the subarachnoid space. The peripheral distribution of this blood is consistent with it having a traumatic cause. Acute subarachnoid blood is also seen in the interpeduncular cistern.*
>
> *No focal intraparenchymal lesion such as a contusion or tear is seen but there are widespread parenchymal abnormalities in that there is evidence of extensive low attenuation change throughout both cerebral hemispheres with reduced grey-white differentiation, the right cerebral hemisphere being slightly more affected than the left. These appearances are of widespread established hypoxic-ischaemic brain injury. Despite the extent of the hypoxic-ischaemic injury, the lateral ventricles and basal cisterns are still visible, although small suggesting a degree of developing generalised cerebral swelling.*
>
> *Although there are marked changes in the cerebral hemispheres, no reversal sign is present. The reversal sign is the radiological appearance whereby the cerebellum appears artefactually bright when seen adjacent to cerebral hemispheres which are of pathologically low attenuation. Given the extent of the changes in the cerebral hemispheres, the lack of a reversal sign suggests that the cerebellum is also of lower attenuation than normal and is involved in the hypoxic-ischaemic injury. This is a marker of the severity of the hypoxic injury overall. The fourth ventricle is distorted suggesting a degree of developing cerebellar swelling. The cerebellar tonsils are at the level of the foramen magnum but have not protruded through and there is no distortion or compression of the brain stem, i.e. coning has not occurred at the time of this scan. It is necessary to remember that the scan gives a "snapshot" of the appearances at the time of the scan and this is an evolving acute pathological process which is likely to progress.*
>
> *Given the extent and distribution of the hypoxic-ischaemic changes seen on this scan, in my view there is likely to have been a major change in N's neurological state at the time of the causative event and he would not have behaved in any way normally after the*

*causative event.*

**83.** Dr Stoodley also examined the scans in an attempt to identify the fracture:

> *Looking at the scan on bone windows I can see no evidence of a fracture. There is no evidence of any soft tissue swelling that might suggest a recent impact injury against a hard or unyielding surface. There is a very short linear lucency just off the midline to the left which appears continuous with the line of the sagittal suture which it appears to join. The margins of the lucency appear sclerotic and there is no associated soft tissue swelling. On radiological grounds the appearances would be most in keeping with an unfused portion of the metopic suture. Radiologically I cannot identify features to suggest a fracture in the area highlighted by Professor Lumb. The 3D reconstruction of the bone images does not suggest a fracture to be present at this or any other site. The cranial sutures are not widened at the time of this examination.*
>
> *Imaging of the cervical spine shows normal alignment and the calibre of the canal is adequate throughout. No focal bone injury is seen."*

**84.** In conclusion Dr Stoodley was clear that the abnormalities seen on N's scan were most likely to be due to an episode of abusive head trauma involving a shaking mechanism.

**85.** At the experts meeting and in his evidence Professor Lumb was entirely clear that what he examined at the autopsy was a 2.4cm long vertical linear fracture which he described as located just to the left of the midline, in the frontal bone, extending into the frontal suture. He was certain that what he was examining was not a suture but a fracture which extended marginally into the suture line (0.5cm), which was lacerated. Professor Lumb also observed that the line contained haemorrhage which identified it as a fracture. The haemorrhage extended along the suture line for a further 2cm. Dr Stoodley, entirely correctly in my judgement, yielded to Professor Lumb's naked eye observation, recognising that the anatomical detail seen by Professor Lumb was entirely consistent with the fracture.

**86.** In my review of the medical evidence I have not found it necessary to analyse the contribution of each and every doctor assisting Professor Lumb in his post mortem investigation. The parameters of the dispute in this case have become, as is clear from the above, confined to a central dispute as to whether the ophthalmic and neurological signs strongly associated with shaking/shaking impact injury could have been mimicked by a fall from the height described. It is however necessary for me to conclude this review by reference to the evidence of Dr P H T Cartlidge and Dr Tim Lawrence, Consultant Paediatric Neurosurgeon.

**87.** Dr Cartlidge was a Consultant Paediatrician from 1990 until his retirement in 2017. He is an Associate Editor of Archives of Disease in Childhood. Dr Cartlidge described himself as having "got off the fence". He told me that "if he were N's doctor" he would consider that the injuries were caused by a single traumatic event, of which a fall from the bunk bed is the most likely cause. Dr Cartlidge said, in evidence, that he "deferred to the ophthalmologists and pathologist". I consider that

this meant, at least in the case of Professor Lloyd's evidence, that he accepted the description of the ophthalmic findings. Manifestly, he was not agreeing with Professor Lloyd's conclusions. Dr Cartlidge stated in his evidence that he had been involved in low level falls with retinal haemorrhages in practice and, during the course of his evidence, tried to find in his records examples of such cases and to assess how serious they were. It was not a fruitful enquiry.

**88.** I repeat, the professional consensus in this case is that retinal haemorrhages, as numerous and as diffuse as those seen here, have not been encountered professionally by any of the doctors, in the context of low-level falls. Neither does the extensive research that I have been referred to establish that they may occur in such a context. Again, I emphasise loudly and unambiguously that none of this drives me, automatically, to exclude this possibility. Dr Cartlidge considered that if N fell onto his head, in 'free fall', that might have been a sufficiently high energy impact to explain the neurological and ophthalmological signs. I am inclined to accept Dr Cartlidge's view that N was not at a sufficient stage of development to be able automatically to break his own fall. I do not understand any other witness to take issue with this. I note that, in his report dated 15th September 2020, Dr Cartlidge recognised that on his interpretation this was a 'statistically unusual case', but he perceived it to be unusual in any event for *"a 9 month old infant to free fall such a distance"*. I interpret that to mean the distance is considered by Dr Cartlidge to be the unusual feature rather than the "free fall" mechanism. It would seem to me to follow from Dr Cartlidge's reasoning, that any infant of this age, of normal development, would be unable to break a fall instinctively.

**89.** I enquired of Dr Cartlidge what he meant when he prefaced his conclusions by his remark *"if I were N's doctor"*. He was not surprised to be confronted by this question and told me that he considered he had made a "clumsy" observation which he immediately recognised to be unhelpful. I hope Dr Cartlidge will not think me in anyway discourteous, but I considered his remark, in fact, to be illuminating rather than clumsy. Doctors in clinical practice must of necessity evaluate the reliability of the account given to them in order to factor it in to a differential diagnosis. Doctors by and large assume their patients are being truthful if not always entirely accurate. Lawyers do not start with that same assumption. Whether F's account is reliable is a matter for the court to assess, having had the benefit of evidence across a wide range of medical and factual issues. Dr Cartildge's conclusion is inextricably linked to his assumption that because he can reconcile the clinical features with the 'proffered history' F's account becomes the most likely cause. Whether there was a fall or not is a matter to be determined by this court.

**90.** Mr Tim Lawrence is a Consultant Paediatric Neuro Surgeon based in Oxford, with sub-specialty interest in trauma and cranio facial surgery. He is presently the Clinical Lead for Paediatric Major Trauma at the Oxford Major Trauma Centre (MTC) and Thames Valley Trauma Network (TVTN). He is Honorary Senior Lecturer in Clinical Neurosciences, University of Oxford. He concluded:

> *"In my opinion, on the balance of probability, the type and distribution of brain injuries seen on N's scan, and at post-mortem, were consistent with a shaking mechanism, with or without impact. However, an impact trauma, following a fall from the top bunk of a bunk bed cannot be entirely ruled out as an unlikely, but possible, explanation for the injuries. There is no evidence of any organic*

*cause for the injuries seen."*

**91.** Mr Lawrence observed that spinal subdural haemorrhage was likely to have occurred at the time of injury due to bleeding within the spinal subdural space. He added *"There is some evidence to suggest that spinal subdural haemorrhage is more likely to occur in non-accidental injury rather than accidental trauma. Although the spinal subdural blood could theoretically have trickled down from the intracranial compartment (with which the spinal compartment communicates) after the injury had occurred, this does not explain the nerve root injury."*

**92.** Mr Lawrence concluded that N's injuries were a result of trauma which occurred *"in the minutes leading up to the presentation"*. He considered there were two possible mechanisms which he analysed in his report and require to be set out here:

> *"**Shaking trauma,** with or without a degree of impact, resulting in rapid forwards and backwards movement of the head and spine, is a possible mechanism for the combination of injuries seen. As an infant's head is unsupported and large, relative to their body, the head moves rapidly from the extremes of range, forwards and backwards. Veins bridging the subdural spaces and subarachnoid spaces may then rupture resulting in widespread, multi-compartmental, acute subdural and subarachnoid bleeding. Rapid, forceful, movement of the spine and limbs, during shaking could cause damage to the nerve roots with evidence of bleeding and damage to the nerve tissue as seen in N. The act of shaking would require the perpetrator to grasp the infant around the chest. Bruising might be expected to occur at the points where the infant was held. There was no evidence of bruising to N's body recorded. None the less shaking remains a likely mechanism to cause the combination of injuries seen."*

**93.** The alternative hypothesis is also addressed in detail:

> *"**Impact trauma,** resulting from N's head making forceful contact with an unyielding object, with additional rotational movement of the body, following a fall from approximately one and a half meters would be unlikely to cause the constellation of injuries seen. With such a mechanism, one would expect there to be external evidence of injury in the form of soft tissue swelling over the site of impact, skin abrasions, bruising or lacerations. However, it is possible for infants to suffer intracranial injury without soft tissue swelling. A skull fracture might be expected but it is also possible that a skull fracture could be absent following impact trauma causing intracranial injury in an infant. The presence of a skull fracture and scalp swelling is disputed in this case and it is for the court to decide on the presence or absence of a frontal fracture beneath an area of scalp swelling that was seen at post-mortem but not on clinical examination. A fall from a height of approximately one and a half meters onto a carpeted floor would be sufficient to cause a traumatic brain injury. The severity of the traumatic brain injury suffered by N is considerably more severe than would be expected following a fall*

> *from such a height. The distribution of injuries is also inconsistent with an impact trauma where a predominance for one side over the other might be expected, causing more localised traumatic lesions. There is evidence that low level falls can cause significant, life-threatening brain injuries in infants. Plunkett performed a retrospective review of falls in infants and children and found 18 cases of death following low level falls. However, the specific pattern and anatomical location of injuries seen on N's scan and at post-mortem would be unusual following impact trauma. The spinal and nerve root injuries seen at post-mortem are more difficult to explain following an impact trauma compared with a shaking trauma. Rotational movement of the body at the point of impact would be required if the fall was the sole cause of the injuries. Death in infants following a fall from one and a half meters is extremely rare, therefore, robust evidence from post-mortem studies does not exist that might help us understand whether such spinal and nerve root injuries, suffered by N, are an expected or recognised finding.* ***MRI is becoming more common following various different mechanisms of trauma, and it is evident that spinal subdural blood is not a frequent finding following accidental trauma. The spinal and nerve root injuries identified at post-mortem may also not be evident on clinical imaging in children who have survived the injury. Consequently, it may be appropriate to state that the injuries suffered by N are unlikely, on the balance of probability, to have occurred following the fall, but insufficient evidence exists to safely state that it is not possible for the injuries to occur following the mechanism described." (my emphasis)***

**94.** There is extensive medical evidence in this case from a range of disciplines, but I think it correct to note that far from there being significant differences of opinion or approach there has emerged a wide measure of agreement. I do not want in any way to shrink the scope and ambit of the medical evidence that I have heard, but I do consider it necessary to identify a clear consensus to the effect that whilst a shaking/impact injury most readily explains the key medical evidence, it does not exclude the theoretical possibility of it having been caused by a fall from the upper bunk, if that fall mimicked the rotational/accelerative/decelerative forces more commonly seen in shaking/impact injury. There are shades of difference between the experts as to how likely "the fall" explanation is but all agree that the starting point is that it is unlikely. I should record that Dr Cartlidge did not seem to agree this enthusiastically, perhaps not at all. On this I reject his view as unsustainable for all the reasons set out in the opinions of the other experts.

**The lay evidence**

**95.** Both Mr Vine and Ms Connolly have emphasised the wealth of evidence pointing to the good qualities of these parents. There is no doubt that each of the children was loved and very well cared for. L's teacher spoke fulsomely of his abilities, his confident but quiet personality and his immaculate presentation at school (see para 25 above). It is obvious that both parents wanted to provide each of their children with the opportunity to flourish to their full potential.

**96.** M and F met when they were both very young. M was 17 years and F was 20. Within 4 months of their meeting, M became pregnant with L. Some might consider this to be immature and rash behaviour but though L was not planned there is no doubt that his birth was very much welcomed by both parents and, it seems, their wider respective families. M told me in her evidence that there was a tradition of having three children in her family which was a pattern she was very keen to follow.

**97.** F was a good provider. He had gained solid respectably remunerated employment as a tradesman in which, it struck me, he is obviously thriving. It is work, I sensed, that he feels suits him. He is a careful, fastidious and well organised man. Throughout the hearing the couple have also been immaculately and unostentatiously dressed. They have each displayed emotional restraint and conducted themselves with instinctive good manners. F recognised that he had developed a capacity to "put things in boxes" emotionally when he felt unable to address them now. He kept his emotions in check throughout the entirety of the hearing. I do not think for a moment that this means that he is not sad, grieving or struggling considerably with the aftermath of the events of 25th June 2019. On the contrary, I think his grief is deep and profound though perhaps displaced and concealed.

**98.** M listened as carefully as she could to the evidence. At times tears ran down her face for many minutes, though she remained silent. I agree with Ms Walker that her grief was visceral and almost palpable in the court room. It was distressing to watch and thrown into stark relief by the strict social distancing required generally and rigorously observed in the court room. It was difficult for others to console her. Her family were not at court. The social workers were attending remotely.

**99.** Both parents have worked hard. F left for work at 6.30am every morning, returning at around 5pm. He would frequently undertake overtime on Saturdays but would, he told me, be careful to build this around the plans for the children. His employers were sufficiently flexible to accommodate this. M is an instinctive home maker. She enjoys being at home with her children. She told me, and I accept, that she much preferred this to socialising or going to the pub. M's sister (NX) gave evidence before me. She told me that F got on very well with their side of the family and that she considered M and F to be "the perfect couple".

**100.** This was an aspirational family. They were able to purchase their own home by way of mortgage. They enjoyed foreign travel. They were invested in the appearance of their home as well as themselves and their children. F particularly liked everything to be tidy and organised. M was rather more relaxed. This was reflected in their different parenting styles. NX described M's style as much more casual, she perceived an unrestrained easy-going approach to parenting. F, she described as the one *"who would do the shouting"*. She told me this without my sensing any criticism of either approach but merely advancing a neutral observation of the difference between the two. In her evidence, M recognised these features of her personality and her parenting style, as described by her sister. I assess this to be a genuine recognition though I have noticed that M is predisposed to agree with what others say and sense that she struggles to assert her own opinion.

**101.** In addition to caring for the children, M was working at a local supermarket. She told me she enjoyed this as it gave her a bit of time to herself and she got along well with the people she worked with. She has worked there for a number of years, save for maternity leave and, on average, as I understand her evidence, has worked three

evening shifts per week, usually between 6 to 11pm. There was some flexibility as to the days she worked but invariably it would include one of the weekend days. F would take over the care of the children on these occasions, which would have involved bathing them and getting them to bed. M had usually provided a meal for the children before she left.

**102.** Self-evidently, this was a challenging routine for both parents. It would inevitably have been hard for F after a long day but, similarly, it would be tiring for M who would be going out to work having been on the go all of the day. M told me that sometimes, apart from bank holidays etc, it would be quiet in the evening at work and, though she was not supposed to take her mobile phone on to the shop floor, she and the others would usually do so. M told me that she would frequently message or snapchat F and that he would return her messages.

**103.** M took 9 months maternity leave following the birth of N. NX told me that her sister was absolutely delighted by N. All seemed to agree that N was a baby whom M was particularly close to. NX suggested that this might have been because N was M's last child and that there was no plan for any more. M now had the three children she had hoped for. The evidence before me made it clear that M was almost unable to prevent herself photographing and taking short videos of N, often many times a day. He was an extraordinarily well photographed little boy.

**104.** Listening to F's evidence and re-reading his statements, I am struck by the extent to which he understands the nature, temperament and personality of each of his boys. He is described by M and by her sister NX as "a hands-on dad". He had no difficulty in caring for them or nappy changing. He recalled how K was tongue-tied. He related how K started to sleep through the night at about 12 weeks old and moved into his own bedroom and cot at 6 months. In his statement he recounts how K moved into L's bedroom and how initially he would "top and tail" with L. I note that F recalled that they still had "a bed guard". F told me how K was a "rough and tumble boy" especially with L but always gentle with N. He relates in his statement how "on occasion" K pulled N's legs if he saw him crawling towards his toys. F said there was "nothing of concern" but I inferred that he was vigilant to his children's safety. This is consistent with the wider evidence as to how he parented his children.

**105.** When M was at work, L and K would be bathed by F every other night. I formed a clear impression that F ran quite a tight ship at bedtime. Before N was born the boys would go to bed "at about 8pm". They often had their iPads "for a bit before falling to sleep". F told me he would "do other things around the house" when the boys were in bed. He gave examples of doing the washing up, ironing, generally tidying, the cleaning and emptying the bins. I have not the slightest doubt that all this is accurate. It is clear that cleanliness, tidiness and order was and is very important to F. I am left with an equally clear impression that M regarded this as not entirely a blessing. F did not feel that M was as invested in such domestic order as he was. Both unhesitatingly remembered a row where F complained that M had left the inside of the car too messy. There was another big row a few weeks before 25th June which both spontaneously recalled, and which had "lingered longer than usual" on M's account.

**106.** This row arose in consequence of F's own father shouting at K in a way that M considered to be excessive. It was sparked by K either leaving the kitchen cupboard doors open or banging them too loudly. F clearly took his father's side and did not speak to M for a number of days after the row. This habit of silent sulking, M told me,

had become something of a pattern. M made it very clear that it was always she who had to break the silence and apologise. These little vignettes of domestic life may be relatively insignificant in themselves, but they do build a picture cumulatively.

**107.** It was striking that in their evidence both M and F identified the same incidents when forced to address any difficulties in their relationship. Both the language they used and the incidents they alight upon have a striking similarity. I considered that F seemed to display little, if any, insight into the impact of some of his more fastidious traits on M's general sense of well-being. As I have said, both parents identified the example of an argument which arose because of F's displeasure with untidiness in the car. It did not seem to occur to F that a mother with three children under 7 might be permitted some latitude when it came to keeping the inside of a car clean. Nor did M seem entirely to grasp that it might be F rather than herself at fault in this situation.

**108.** Throughout the investigation M has never expressed any other view other than that N's death was a terrible accident. Even the arrival of Professor Lloyd's report did not, it seems, awaken any doubt in her. Her identification of what I find to be underlying stresses in her relationship with F, however, was both spontaneous honest, entirely free from vindictiveness and was not, in my assessment in anyway designed to undermine his case. Paradoxically, this only serves to make her evidence about the difficulties in the relationship all the more compelling. I sensed that M was too tired, too overwhelmed by her grief even to sense that some of Ms Heaton's questions on these issues were guided to identifying any dynamics within the parent's relationship which might indicate heightened levels of stress within the household which might have elevated N's vulnerability.

**109.** It came as rather a surprise to me to discover that throughout much of what we have come to know as lockdown, F has been visiting M and the children at the family home for over three hours per day most days of the week. The contact is supervised by the maternal grandmother (MGM). It is obvious from what everybody has said that F and MGM hold each other in some esteem. I am sure the social workers consider that MGM must have sufficient objectivity about the issues in the case and the risk F must be deemed to present, to be able to exercise authoritative and independent supervision. I have not heard from MGM but the evidence I have heard has not reassured me on this point.

**110.** Contact at this frequency plainly became unbearable for M. She told me how F would be critical of what I summarise as her general tidiness and standard of house-keeping. Without F's considerable input, I have no difficulty in understanding why 'standards' may have slipped a little in F's perception. It was obviously a recurrent theme. It played a significant part in her decision finally to separate from F. Though M asserted that she and F were happy prior to 25th June 2019, my impression was that their differences in parenting style and their approach to general standards and routines around the home was longstanding. I have taken some care, in the passages above, to place this in context.

**111.** I was concerned that M had not felt able to voice her distress surrounding the contact arrangements either to the social workers, to the Guardian or to her own mother. In August 2020 M left the family home. I am confident that she recognised that this move would be unsettling for the boys. I am equally clear that she appreciated that by taking them to live with her mother they were moving to less than ideal circumstances. She told me, in a way that I found to be utterly convincing that

*"anything was better than being at that house"*. She was pressed as to whether she left in order to put a barrier between the children and the father. This she flatly rejected. Her response *"I wanted to put a barrier between the father and me"* was again spontaneous, authentic and it related again to his criticisms of her.

**112.** M returned to work on 10th June 2019. On that day she worked between 6 and 11pm, a shift repeated on both the 13th and 14th of June. On Sunday 16th June M worked between 1 and 5pm. On the 18th and 19th June she returned to the 6-11pm shift. On Sunday 23rd June she worked between 12 and 5pm. On 25th June the planned shift was, once again, 6-11pm. The couple are young, fit and generally healthy. Both value material goods. They are house proud. They both told me that the money from M's work, whilst not essential, was important to them. I accept that M enjoyed the change of scene and adult company at work. Nonetheless, the daily routine is obviously a hard one.

**113.** The 25th June 2019 was M's 26th birthday. F left for work early that morning, as usual, at approximately 6.30am. Earlier in the week F had checked with NX as to which perfume M would like for her birthday. It was a Japanese brand. He told me that he also bought a voucher for a spa day. F left the gifts, when he went to work, so that L could give them to his mum. F returned home between 4.30 and 5pm. The couple had at best, 45 minutes or so together before M left for work. F had described this routine as often feeling like "ships which pass in the night". The supermarket is only ten minutes away, but M left at 5.30pm. Both the parents explained that she sometimes did this because of the delay at traffic lights. M and F told me that there had been no problems between them that day. Neither expressed themselves to be under stress due to the pace of their lives or their respective workloads. Though N was teething at the time, both parents said this had caused no trouble or extra burden to either of them. Neither expressed having experienced any continuing stress following N having become unwell on 20th June 2019 and suffering a febrile convulsion on the 21st June. This necessitated A being taken to hospital by ambulance. This was the couple's third child, they were by now experienced parents and I do not consider M would have called for the ambulance without being really anxious. For two nights M kept N with her and F slept downstairs on the sofa.

**114.** Also, at this time, F had been suffering from an inflamed tendon, following the discovery of a tear. As Ms Heaton solicited in cross-examination, F had become very much invested in a steroid injection to his heel which he had been led to believe would very significantly relieve his pain and discomfort. In fact, he plainly believed that the injection would get rid of his problem completely. Unfortunately, the injection, which was to have been given on 20th June 2019 could not go ahead. F accepted, in response to questions from Ms Heaton, that he was sometimes in pain during the day, particularly when he had been standing. He had been prescribed Naproxen, an anti-inflammatory. Ms Heaton explored with F the nature of his work on the 25th June. F volunteered that it was an undemanding contract involving relatively straight forward replacement of light fittings. Ms Heaton observed that this had involved F going up and down ladders all day with an inflamed foot and suggested that must have been difficult for him. My impression of F's evidence was that, at least to some degree, he accepted that.

**115.** When M left for work N was in his baby walker, K was playing in the sitting room and L was upstairs in his bedroom playing on his computer. I have been told that when he is on his computer, playing games, L is "fixed" in his concentration.

**116.** F gives the following account of what happened that evening, in his statement dated 7th August 2019, which follows on from his interview to the police on 26th June 2019. I extract the relevant parts though it is necessary to set it out at some length:

> *"On Tuesday 25th June 2019 I was at work between 7am and 4.30pm. [M] sent me a video via snap chat of [N] and [K] at 13.50. [N] had just woken up and had some food. [M] had already given the boys their tea when I got home. We had a quick chat about our days before [M] went to get ready for work. [M] left to go to work at 5.30pm. [L] was in his bedroom. [K] was playing with his toys… [N] was moving around in his walker between the kitchen and living room while I was cooking and eating my tea and popping between the two rooms keeping an eye on [N] and [K]. [L] remained upstairs with [N] and [K] with me downstairs. I watched a bit of television and gave [N] a baby snack he likes. I washed and sterilized [N's] bottles and it was then bath time. By this time bath and bedtime routine had changed a little. [M] had been back at work for about 2 weeks. It was more difficult to try and bath all 3 boys at the same time and so I tended to bath [N] only on the nights [M] was at work. We then bathed all 3 boys together when we were both home and [M] was not working.*
>
> *I got [N] in the bath at roughly 7.10pm. I know this as I took a photo of [N] in the bath and sent this to [M] at 19.14 via snap chat. It was [M's] birthday and so I sent her a picture saying 'happy birthday mummy'. While [N] was in the bath [L] and [K] were in their bedroom. [N] was in the bath for about 10 minutes. I washed his hair and body and then got him out and took him into our bedroom and got him ready for bed on our bed. I then picked [N] up and took him to the boys bedroom to ask [L] to put his pyjamas on while I got [K] ready for bed. I put [N] on the top bunkbed at the pillow end and gave him a dinosaur balloon of [K's] to play with while I did this. [N] had done this before and liked to play with the balloon. After he put his pyjamas on [L] was sat at his desk playing a game on his lap top... After I had put [K's] pyjamas on he climbed on to the top bunk bed with [N]. I then started to get the boys clothes ready for the next day like I usually did.*
>
> *First I got [L] and [K's] clothes from their wardrobes and ironed them. The ironing board was set up on the landing. The door to the boys bedroom was open and I could see into the room so I could keep an eye on them. After the clothes were ironed I would hang them on the bannister on the landing. While I was doing this I was popping in and out of the bedroom and checking on the boys. At one point I heard [K] take the balloon off [N] and so I went in and tied the balloon to the bed near [N] so [K] could not take it off him. [N] was hitting the balloon and laughing. I saw [L] get up a couple of times and climb up on to the top of the bunk bed to kiss [N] before getting down. I think I saw him do this at least 2 times. I then briefly popped into [N's] room to get his clothes to iron them. While I was on the landing I then heard a thud. I would say that the scenario of*

> *getting the boys pyjamas on and getting the clothes ready for the next day was going on for about 15 minutes at this point.*
>
> *When I heard the thud I immediately went into the boys bedroom. I saw [N] on the floor on his front facing the ladder of the bunk bed. He had his arms at his side and was lifting his head up. He was crying. I know that you should not pick babies up if you don't know the injuries as it could make them worse but my instinct was to pick him up which I did straightaway. I held him under his arms facing me so I could look at him. I saw blood on his mouth and then his eyes started to roll back, his head lolled back and he went floppy. I was worried he was going to have another fit. The hospital had told us if he did we should lie him on his side. I told the boys to stay in their room and took [N] straight downstairs holding [N's] body against my chest. I cannot remember if I supported his head or not. I put [N] on the living room rug on his side. I saw blood in his mouth and he was struggling to breath at this point. I therefore rang 999 and asked for an ambulance. I think that this was at about 7.40pm. From this point I stayed on the phone to the 999 operator. I remember that she was asking for lots of details such as [N's] date of birth and all I wanted was an ambulance to come. At some point I think the boys had come downstairs as I remember they were there when the ambulance arrived… I have read in the papers that it is said I asked [K] if he had pushed [N]. I do not remember asking this or thinking this."*

**117.** Most striking in this account is F's contention that he placed his 9-month-old son on the top bunk of the boy's bunk beds and then left him inadequately unsupervised. The length of the period in which F says N was "out of his sight" has varied from between 30 seconds to 3 minutes. The hospital notes record the period as "30 seconds", though in his oral evidence F expanded the time (*"possibly 3 minutes"*). He also told the police in interview *"it could be 3 minutes"*. On the account given by F, the actual time period strikes me as far less significant than the act itself. F is an experienced "hands on dad", as all agree. N is his third child. Nobody, most particularly M or her sister NX, has ever known him do anything even remotely dangerous or irresponsible towards any of his children. There is an interesting example, recounted by F (see paragraph 104 above), where he instinctively describes how L and K, when they were younger, would "top and tail" on a single bed "with a guard". There are other casual examples revealing F's vigilance to his children's safety (see para 104 above). NX was asked whether she would ever have thought that F would cause a serious shaking/impact injury to N. She told me she would never have believed it. She was then asked whether she would ever have believed that F would have placed N on the top of a bunk bed in the way he has described. With equal force she told me that she would never have believed this either.

**118.** Mr Vine has suggested that for a loving parent to cause the shaking and the impact injuries sustained by N it should accurately be described as "inherently improbable". I agree. However, I also consider that what Miss Walker correctly, in my view, described as a "dangerously reckless decision" to leave a 9-month-old child unattended on the top bunk bed would, for this father, also be "inherently improbable". It requires me somehow to assume that for no apparent reason and entirely out of character he put his son's safety in manifest and obvious peril. I am

bound to say that I find it very hard indeed to think why this man, who I find to be loving to his children, actively involved in their care and so in tune with their respective personalities would behave as he claims to have done. Had the account involved being temporarily distracted by a phone call, a spilled drink, an emergency with another child, it might well have been more credible. There was no such explanation, F said he left N on the top bunk because *"N was happy and so I didn't put him to bed"*. I interpolate at this point my observation that "happy" is precisely the word used by L in his explanation of these events.

**119.** In his interview F characterised his actions in these terms *"I know it was stupid of me leaving him on the bunk bed but… its just a stupid thing, isn't it, though?"* later he said, *"it's just stupid how it's happened, init?".* F said that he told M that *"he put [N] on the… bed… I probably said, like a dick head,… and he's fell off and he's banged his bed"*. I find these descriptions fall considerably short of accurately reflecting the degree of parental failure involved. They trivialise the tragedy they purport to describe. The language is not consonant with the event. It simply lacks the grief, guilt and despair that would consume any parent in such a situation. As I have noted, Ms KB, Paramedic, was instantly alerted to safeguarding issues on these related facts alone. It strikes me that if this had truly been the mechanism by which N came by his fatal injuries F would not have described them in this manner. In the intense focus on the competing medical hypothesis, these simple realities have been lost sight of. F is describing an accident which involves him acting entirely out of character, for no apparent reason and describing the event in language which is incongruent and jarring.

**120.** Ms Walker submits that *"the Guardian is not satisfied that a full account of events on the tragic night of 25th June has been given by the father and is conscious that the issues of his credibility will be central to the court's determination as to what is likely to have happened to N."* I agree with the Guardian both that a full account of that night has not been given and that, inevitably, F's credibility is central to my findings.

**121.** In his police interview F has described N as having been found *"faced down with his head towards the steps [of the bunk bed]. On his belly with his, crying with his head up. Urm, but if he had gone… head forward, I don't know how he would have landed on his belly but that is, that is how I found him, like, in that position"*. In the interview room F demonstrated this physically, lying on the floor by way of illustration. He also drew a plan. I asked him, in the witness box, whether he had, since his interview, developed any idea of any manner of fall that could have led to N landing in this position. He told me that he could not. I am bound to say neither can I, nor has anybody else suggested how landing in this position might have occurred. Mr Vine's riposte to this is to draw from the medical evidence the undoubted fact that the position in which the body lands is not an indicator of the mechanics or nature of the fall. This I accept but, with respect to him, that is a different point. Whether a fall involves the accelerative/decelerative features that might mimic a shaking injury is a different question from the simple enquiry as to how, whatever the nature of the fall itself, N's body could have landed face down at the bottom of the ladders.

**122.** F told me that he had placed his mobile telephone (there is no landline) on charge in his bedroom. He says that he picked up N's body and went downstairs to conceal N's obviously very serious condition from his brothers. He placed N's body on the rug. F then claims to have realised that he needed the mobile phone and called L to bring it downstairs. None of this sounds particularly coherent but I, of course, accept that

people do not behave rationally in acute distress. What I do find to be significant is that F told the ambulance service at a time when he correctly appreciated that his son was dying that *"oh he sort fell off bunk bed…" "he fell off his bunk bed high up, he's only 9 month old, oh my god I can't believe it!".* A little later he is recorded as saying *"He was with my youngest son on… well either way he's [?] the bed while I was just getting a towel he's just fell off"*. F completely denies the accuracy of this though, as it is recorded, he accepts he said it. He has no explanation as to why he might have said it. It is not reconcilable either with the account he gives to this court or that which he gave to the police in interview.

**123.** It is however consistent with what NP the first Paramedic at the scene records as her history taken from the father. The history she records states "he had fallen off a bunk bed. *"I asked if it was a top bunk bed to which he replied yes. I do not remember the exact dialogue, but he implied he had only left him for a few seconds, as he had been distracted by another child who was in the bathroom and needed assistance."* Ms P was confronted with a baby on the sitting room floor with a small amount of blood around his mouth but with no other visible markings. He was unresponsive and making poor respiratory effort, breathing at two respirations per minute. It was obvious that this baby was in real difficulty. It is perhaps hardly surprising that N was Ms P's, focus rather than noting the exact dialogue. However, Ms KB who was the last paramedic to arrive at the scene noted what was said, filed a statement in these proceedings and gave evidence. A transcript of her safeguarding referral, made shortly after N had been taken by ambulance to hospital, has been filed in these proceedings. The following extract is relevant:

> *"O: I don't envy you having to go to things like this. Its like we take it on the phone and that's bad enough sometimes*
>
> *KB: I mean they are few and far between, thankfully*
>
> *O: But when you do get them they are quite harrowing aren't they?*
>
> *KB: yes. It's not nice, its not nice.*
>
> *O: It never is. OK so two other children in the house.*
>
> *KB: there were. Dad said… basically Mum had been at work, she worked in a shop somewhere not far away, but she was at work. F was minding the children and he was bathing the other 2. And I think he's gone to get the child out, one of the child, er, children out of the bath and he's put [N] on the top bunk. I don't know why, but he's put [N] on the top bunk. I don't know whether [N] was asleep or whether he was awake, I'm not sure, because we couldn't really get like a proper, he was too distraught dad, to sort of get much out of him so I don't know whether he's asleep or he's awake when he's put on the top bunk. But he's gone to get the other child out of the bath and then he's come back in. I don't know if he's heard him fall or whether he's gone in and found him on the floor. I'm not sure.*
>
> *O: Ok so he was bathing the other two children*
>
> *KB: Yes*

*O: and placed [N] on the top of the bunk bed*

*KB: Yes*

*O: to go and get another child out of the bath*

*KB: Yes, something like that. He was getting, the child, a child, I don't know, I'm not sure, a child out the bath, erm and when he's come back in, [N] was on the floor. Like I said I don't know if he's heard him fall or just gone in and found him, I don't know."*

**124.** Ms B is reporting what NP told her. Her evidence has therefore to be identified as hearsay. It is of course admissible in these proceedings but must always be treated with appropriate caution. Ms B has a strikingly clear and detailed recollection of that evening, which may not appear obvious from the transcript of the call but is much clearer in the recording, to which I have listened (at Ms Heaton's request) and in her evidence. N is clearly a patient who has stayed in her mind. She was absolutely clear that NP told her that F reported that he was bathing the children and had put N on the top bunk. She was clear that Ms P said, *"he's gone to get the other child out of the bath and then he's come back in. I don't know if he's heard him fall or whether he's gone in and found him on the floor. I'm not sure".* The substance of being distracted by another child in the bath, I am satisfied, is entirely accurately recorded. I note that she also recorded with accuracy M's situation on the day i.e. working in a shop not far away.

**125.** The referral Ms B makes is concerned, thoughtful and, in my judgement, suffused with sympathy towards F. The tenor of the call reflects Ms B's nagging anxiety and general feeling that a safeguarding report should be made. She is in every way an impressive witness and I accept her evidence. Ms P was also entirely proper in recognising and acknowledging that her own recollection of what F said was incomplete. As Ms Walker notes F's response to Ms P's evidence was that she was "making it up". He later moderated this but, so that he is clear on reading this judgment, I reject his suggestion.

**126.** When he was confronted with these inconsistencies F preferred to rely on what he had told the police. He said, "I told the police the truth", that was, I consider, an unguarded expression and I draw nothing from it. By it I understood F to insist that he was ironing on the landing when the fall took place, out of his sight. There is no doubt that, at some point, F had been doing some ironing on the landing because NX tells me that she switched the iron off when she attended at the house.

**127.** I have already referred to the account of that evening given by L to DC H. Much thought has been given to considering whether evidence should be taken from L at this hearing. Arguments for a hearing, pursuant to **Re W (Children) [2012] UKSC 12**, were filed but in due course all the parties agreed it would not be appropriate. L's discomfort, first observed by DC H, has not diminished with the passing months. When the Guardian endeavoured to speak with him, via a video conferencing platform, he hid from her and refused to engage. I have been told that his behaviour has generally deteriorated and is causing some concern. Most importantly however, it

is clear that L does not want to give evidence and the parties, entirely correctly in my judgement, have concluded that it would be wrong to compel him to do so.

**128.** F is keen to rely on the fact that L reports having heard "a thud" and his assertion that N fell from the bunk bed. It is common ground that L has at no point talked of seeing N fall. I have very much in mind Ms G's assessment of her pupil as being "a concrete thinker" and "lacking imaginative skills". It is important to identify that whilst F seeks to rely on L's description of *"a fall… a big bang…" "I saw dad ironing"* and his assertion that he did not see N fall *"because I was playing on my laptop"*, F nonetheless rejects the accuracy of other aspects of L's account. When L says F was *"downstairs getting some pants"*, F disputes that. When L was asked *"where was dad before N fell?"* he responds *"he was downstairs with N. He doesn't leave N…"*. This is also refuted by F.

**129.** There are further aspects of L's account which F disputes. L describes N as *"messing with things on my bed…" "N was getting closer to the edge…"* when asked *"where was dad?"* at that point he responded, *"dad was downstairs".* DC H pressed this *"How do you know he was downstairs?" L* responded, *"I know because I went outside my room and dad wasn't there"*. Later, L describes F as *"coming upstairs"*. He describes F as *"sad and a little bit mad… because he thought K had pushed N"*. L says F shouted at K asking, *"why did you push N off the bunk bed"* DC H asked if this was true L said, *"No because K was still on the bed".*

**130.** For all the reasons identified above it is obvious that I must treat L's account with great care. F has, I consider, largely accepted that it is likely that L overheard at least part of his call to the ambulance service and thus perhaps aspects of his account of a fall. In any event I consider it likely that L will have heard the call. It is also clear that R may well have overheard discussions within the family about a fall. The grandfather is reported as urging the family to *"keep it down"* when discussing what had happened in order not to be heard by the children. This occurred after N had been taken to hospital on the night of the 25th June 2019. If, as is contended, L was "fixed to his computer" and did not see a fall, it seems to me likely that he would have accepted F's account as he overheard it. As his teacher said, he is a concrete thinker, somewhat lacking in imaginative capacity. He would have had no reason to disbelieve his father. It would not have occurred to him that F might not be telling the truth.

**131.** I note that F relates, in his statement, how earlier that evening, L had been upstairs on his iPad alone whilst he and N were downstairs with K. L's assertion to DC H to the effect that F was downstairs with A.. *"before [N] fell"* is strenuously contested as inaccurate by F. It strikes me that it may be that L has conflated his own lived experience with his attempt to absorb F's account. Certainly, there was a point when L was upstairs alone.

**132.** A further area of dispute relates to L's response when he was asked where N was on the floor (after the fall), he responded *"[N] had his back on the floor"*. This is irreconcilable with F's account of having found N face down.

**133.** It is also important to consider the following passages in F's police interview:

*"DC PD: Did you consider that he could have—*

F*: [Inaudible 01:11:44] like—*

*DC PD: —moved off that top bunk?*

*F: I did, er, to be honest, I didn't… I didn't think he could be, get out that little gap. Everywhere else is surrounded, do you know what I mean? I-I don't know…*

*[sighs] obviously it's stupid to put him up there n-now that it's happened but… it's too late, init? But—*

*DC PD: I think what I'm asking you is—*

*F: [Sighs]*

*DC PD: —is it something that you considered and then you just, you just said to me then that, well, you didn't think he could get out. Did you actually, at the time—*

F*: I didn't think he was gonna fall, no, I didn't, I didn't… I didn't think about him falling out, no.*

*DC PD: Right.*

F*: Er, like, [inaudible 01:12:17]… I should've given him his bottle first, to be honest, but… what's done is done, innit?*

*DC PD: Is it something that you've done before?*

F*: Play with the balloon with him? Yeah.*

*DC PD: Put him on the top bunk there?*

F*: Yeah.*

***DC PD: And it's something you've done before where you've put him on the top bunk and then left the room for—***
***F: [Inaudible 01:12:32] well, just while I, while I've ironed, yeah.***
***DC PD: Okay. How often have you done that?***
***F: Er, I'd say, er, once, just once before.*** (my emphasis)

*DC PD: Right."*

**134.** A little later in the interview DC D returns to the point:

*"DC PD: And on any of the occasions, sorry, how many times have you done it before?*

*F:* ***Just once****.*

*DC PD: Once before?*
*F: [Inaudible 01:12:50].*

*DC PD: When you say just once, that one time or one previous occasion?*

F*: Well, and the one, er, yeah, that time and then the one before that.*

*DC PD: And on the previous occasion—*

*F: L* ***would have been there, yeah.****"*

**135.** The emphasis in the above extracts is mine, to assist in contrasting L's own responses to DC H. During his "preliminary interview" L volunteered, apropos of nothing,: *"Dad has put N on top of the bunk bed before"*. As is clear from the above, this is said by F to have happened on only one previous occasion. F volunteers in his interview: *"[L] would have been there"*. I note that F does not say "L was there". I also note that F was not describing anything remarkable, merely having placed his son on the top bunk on a previous occasion when absolutely nothing happened. Accordingly, I can see no reason why L would even have noticed this, let alone remembered it and, entirely uncharacteristically, volunteered it in interview. I was struck by how Ms G was so clear that L was rarely forthcoming in ordinary social exchanges and I remind myself again that she described how L would never volunteer anything to her unless she probed it by questioning. She told me that when she did ask L about e.g. what he had done over the weekends he would happily tell her. Left to himself he would simply say "morning" and move on. I have already recorded DC H's observations relating to L finding it easier to respond to closed questions (see para 21). When I consider the notes of DC H's interview it is striking that apart from the above L rarely, if at all, volunteers' information which is not in direct response to the specific and usually closed question asked. Virtually the only piece of information spontaneously volunteered in the interview is this line: *"Dad has put N on top of the bunk bed before"*. This was a response to a different question namely: *"How was Dad before [N] fell?"*. R's response to the question, proffered at the very end of the interview, does not strike me as authentic, it is far more consistent with the delivery of a message that L feels he is required to. I do not know whether L is repeating something he has heard or whether he has been coached by F. I am satisfied that L is unlikely to be relating his own recollection.

**136.** In her evidence M told me that she did not think it was appropriate to speak with L about events surrounding N's death. However, she unexpectedly volunteered, during the course of cross examination, that as long ago as October 2019, L had spoken to her about that night and told her that N was going to the *"edge of the bed"*, and so he went to find F who said, *"just a minute"*. M told me that she confronted F about this. She considered it to be so important that she waited outside the house in order to avoid being overheard by the children. As Ms Heaton points out this is not significantly different to what L had told DC H. It is difficult to see what emphasis M was placing on it and why she felt it necessary to confront F outside, in the way she tells me she did. She created the very clear impression that she had been troubled by what L had said and was unhappy, even angry, with F. On M's account F seemed equally troubled by what M told him. Despite M's attempt to keep this from the children, she told me that F went inside the home and went straight upstairs to confront L about it. NX, who was in the house at the time, manifestly thought his behaviour was inappropriate and said to him words to the effect of *"you shouldn't be doing this".* There is no doubt that this was a significant confrontation but the dissonance between what is reported to have been said and the reaction of the adults is striking. I infer that something far more troubling than I have been told was related that day. NX of course, was entirely right in her admonishment of F. He should not

have been talking to L about the events of that night. This, I assume, was one of the reasons NX was there to supervise F's contact and to ensure that L was protected from such questioning. It is equally clear that F went upstairs with the purpose of straightening out L's recollection and that by acting in such a hasty way against the advice of his partner and her sister his interests in speaking to L were his own and not his sons. All this serves to enhance my concern, set out above, relating to the authenticity of some of L's observations to DC H.

**137.** As Ms Heaton points out, nothing of this October confrontation was included in M's second statement, dated 11th February 2020. Neither was anything mentioned by F in his evidence. It only came to light in M's oral evidence. F subsequently confirmed, through Mr Vine, that M's account was accurate.

**138.** The above has served to cause me doubts about M's ability and/or willingness to cooperate entirely openly and honestly with this investigation. I am also concerned that at the hospital M was asked by the police not to forewarn F that they were investigating a shaking injury. M ignored that warning completely and revealed it to him at what must have been the first opportunity she had. She told me that she did so because she *"needed to know for herself"*.

**139.** After the paramedics had placed N in the ambulance on the 25th June 2019, F telephoned M to break the terrible news to her. He described her, both in his interview and in his oral evidence, as having "hung up" on him. There is no doubt that he was intending to convey his distress at this response. He addresses this in his police interview:

> *"DS VW: Okay, how did she come to find out about the baby being unwell?*
>
> F*: I rang her after… the paramedics took, er, took the baby and shut the door. I rang her then—*
>
> *DS VW: So you rang her?*
>
> F: *—and then she's, she just left work straight away and got home.*
>
> *DS VW: Right. Tell me about that conversation.*
>
> F*: Er, [pause] I was, like, "[M], [N's] fell off, I've put him on the double bed," I p, I've probably said, like a dickhead, erm, "and he's fell off and he's banged his*
> *bed," erm, "and I've rang the ambulance and they're here now" and she, she hung up on me.*
>
> *DS VW: Did you say double bed then?*
> *F: On the bunk bed.*
> *DS VW: Bunk bed, right, okay.*
>
> F*: Not the… erm, and she hung up on me and I think that's when she's come, she come home. I did try ringing her loads, she weren't answering her phone.*

> *DS VW: And at what time when we were talking before, during everything that's happened, at what point have you rung her?*
>
> F*: After the paramedics had took [N] into the van and they've then shut the door and they wouldn't let me in, they said they didn't want me to see anything so I've rang her then—*
>
> *DS VW: At that point you rang her?*
>
> F*: —cos I needed, I was thinking, "Oh, I need to go to hospital with him but I need someone to get here with the kids."*

In these passages F describes M as having "hung up" on him and stresses that he tried to telephone her "loads of times" afterwards. M said that she did not look at her phone, she just concentrated on getting home. Once again, this aspect of her evidence I find to be troubling.

**140.** Though the couple would, M says, regularly exchange messages whilst M was at work, M did not respond to F's photo message of R in the bath earlier that evening. It was, of course, M's birthday. Given that the couple had barely spent any time together that day, M's lack of response seems odd. Similarly, given the horrific news F communicated to M after the ambulance had arrived, the reasons M gives for failure to respond to F's subsequent phone calls, does not strike me as convincing. This was plainly an emergency. Additionally, the couple rarely communicate, I was told, by telephone but prefer to send SMS messages and snapchat. I am bound to say that I would have expected M to have had the phone close to her and, given that she responded to F's original call, I cannot see that she would have put her phone on silent mode. I emphasise that M has not said that she put her phone on silent, she insists that she had only one priority, namely to get home. Accordingly, I am asked to accept that she drove home listening to her phone ring out and declining to answer it. Again, I understand entirely the instinct M articulates, nonetheless I struggle to understand why, in such extremis, she did not respond at all to F's insistent calls.

**141.** Paradigmatically, people "hang up" on others if they are annoyed or upset with them. Equally commonly they may choose not to answer the immediate follow up calls, usually while they try to recover some composure. There is all manner of reasons why one would have expected M to answer the phone in the heat of such a crisis… most obviously F might have been telling her to go directly to the hospital. On his account, which M does not dispute, F told her, on that short phone call, that the ambulance was already there when he was calling her. Both parents have denied that there was any argument or upset between them that evening, but I am unable to rely on the disavowal of either. I am left with the impression that, for whatever reason, neither parent was happy that day.

**142.** It is facile to assume that at a fact-finding hearing, such as this, the judge or the advocates can reconstruct, with accuracy, how a child came to be injured, in circumstances where only the adult who was present can really know. Once the court comes to the conclusion, as here, that the adult's account cannot be relied upon, it is driven back to the wider evidential canvas which, inevitably, can only be constructed from the available thread. The task of the court remains: to identify such facts as it can; to evaluate each of the expert opinions; to identify reliable evidence from which

inferences may reasonably be drawn. The court will then weigh this evidence to arrive at such conclusions as it can, on the balance of probabilities.

**143.** As I have stated, neither the Guardian nor the Local Authority has advanced a case in respect of the two competing hypotheses placed before me. In fact, on reading Ms Heaton and Ms Walker's closing submissions, it strikes me that they do not, ultimately, follow the logic of their own reasoning to its inevitable conclusion. Both cast significant doubt on F's reliability as a witness. On the evidence that I have identified they were, in my judgement, bound to. Ms Walker correctly identifies that an assessment of F's credibility is intrinsically linked to the plausibility of F's account of the fall. It follows that if F is himself implausible, as a witness, the account he advances is also weakened. It does not follow, automatically, that as I am unable to rely on F's evidence his explanation of a fall must be discounted. I have reminded myself that individuals in such circumstances may lie for a variety of reasons. I considered L's evidence with particular care to see whether it can lend real credence to the explanation F advances. For all the reasons analysed above I have come to the conclusion that L's evidence does not provide such support and not merely because he has never given any account of seeing a fall.

**144.** In all these circumstances the extensive retinal haemorrhages and neurological injury remains most cogently explained by N having sustained a shaking and impact injury. As N was in his father's sole care at the time, I find that he was the perpetrator of the injuries.