Neutral Citation Number: [2024] EWFC 2 (B)

Case No: ZW23C50245

IN THE FAMILY COURT AT WEST LONDON

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

Date: 3 January 2024

Before :

HIS HONOUR JUDGE WILLANS

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Between :

THE LONDON BOROUGH OF [ ] **Applicant**

- and -

(1) J **Respondents**
(2) M
(3) N (through his Children's Guardian)

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Christopher Archer (instructed by HBB Law) for the Applicant
Nicholas Stonor KC and Hanisha Patel (instructed by Reena Ghai Solicitors) for the First Respondent
Clive Newton KC and Tor Alloway (instructed by Fort & Co Solicitors for the Second Respondent
Rachel Chan (instructed by McCormacks solicitors) for the third Respondent

Hearing dates: 6, 8 & 11-14 December 2023

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JUDGMENT

His Honour Judge Willans:

Summary of Findings

1. *I am satisfied N suffered an inflicted head injury which was likely caused by a shaking mechanism.*
2. *I am satisfied M was responsible for the infliction of this injury. On balance I consider it likely this arose out of a single incident in which M acting without intention to cause harm, and during a temporary loss of control shook N.*
3. *I find J was neither present when the incident occurred, nor was she aware of it having taken place. I have though made a finding against her of delay in seeking medical assistance and I do make some observations as to her approach to the issues in the case. I do not find this amounts to a failure to protect N or that she colluded with M after the injury was occasioned.*

Introductory Observations

4. This judgment follows a 6-day fact find hearing. I have regard to the documents contained within the hearing bundle (together with a limited number of documents forwarded to me after the completion of the bundle); the live evidence of the medical experts[1], J and M; and the written and oral submissions of counsel for each party. In this judgment I will refer to the first respondent mother as J, the second respondent father as M and the third respondent child as N. This is how they were referred to during the hearing and no discourtesy is intended by using their forenames. I will not reference all of the evidence put before me but will focus on that information which has been central to my decision making. I have kept all of the evidence in mind.

5. The hearing proceeded on a remote basis during the expert part of the evidence and was attended thereafter. I am very grateful to the professional and courteous manner in which this case was conducted by counsel. The issues were by their very nature sensitive and highly emotive. I am also grateful for the professionalism of the interpreters who assisted each parent. An effective hearing would not have been possible without their hard work.

Background

6. M and J are aged 45 and 35 years respectively. They are both [X] Nationals. Both parents have children from previous relationships who continue to live with their other parent in [X]. The mother recounts a difficult childhood in [X], being abused and growing up in a children's home between around age 8 to 20. J has not had contact with her child from the previous relationship since that child was aged 2 (she is now 15). M had a long term relationship in [X] which ended in 2017. His children out of that relationship were aged 14 and 20 at the time of his first statement. He remains in contact with his children.

[1] Dr Fionnan Williams (Neuroradiologist); Mr Abdul-Jabbar Ghauri (Consultant Ophthamologist); Mr Jayaratnam Jayamohan (Consultant Neurosurgeon), and Dr Nicola Cleghorn (Consulant in Community Paediatrics and Forensic Paediatrics)

7. The parents met through mutual friends online in around 2020. They moved in together and were engaged (and remain so) in 2021. I understand they planned a child but J suffered pregnancy complications and had a termination. Between April and August 2022 they separated and for at least part of this time J was in a relationship with R. The parents had lived in a shared household with him and a number of other individuals when they first lived together in this country. In August 2022 the parents resumed their relationship and shortly after this J fell pregnant with N. He was born on 27 April 2023 at gestation week 37/3. It seems there were no complications although he was a relatively small baby. He came home with J, and M took a week off work to help. In the early days he suffered with Jaundice but there were no significant concerns.

8. On 28 May 2023 N was admitted to the [X] Hospital with a history of vomiting and irritability. It appears there was an early concern as to meningitis. However, following further investigations bleeding on the brain was discovered and N was transferred to Great Ormond Street Hospital (GOSH). Whilst at GOSH further investigations were undertaken leading to a concern that N may have suffered an inflicted head trauma. In the course of his admission extensive checks were undertaken to ascertain whether N had any underlying conditions or disorders that might explain his presentation. An overall account is given on 20 July 2023:

> *Taken together, the consensus of the clinical multi-disciplinary team is that N has co-occurring cerebral venous sinus thrombosis and subdural/extra-axial and intraventricular haemorrhage. We have found it difficult to link these findings in terms of underlying cause and will not be able to say definitively whether the two processes are related. So far, we have not found a medical explanation for either finding. The MRI changes indicate bleeding caused by traumatic head injury and the retinal haemorrhages found on Ophthalmology examination are consistent with traumatic head injury. It is important that medical disorders are excluded as far as possible and for completeness we await the final enzyme test for glutaric aciduria (skin biopsy result), a rare condition associated with bleeding tendency. If this test is negative, the medical consensus is that the intracranial and retinal haemorrhages are most likely to be due to a non-accidental injury.*
>
> *N's medically complex case has been discussed extensively and on multiple occasions with the Neurology and Neuroradiology multidisciplinary team and other clinical colleagues, as is standard practice to support clinical care. There was consensus on the conclusions stated in this report.*

9. Consequent upon the above child protection measures were undertaken and these proceedings commenced on 15 June 2023.

The proceedings

10. On 20 June 2023 the child was placed into the care of the applicant under an interim care order. DNA testing was directed and appropriate directions were given to the case management hearing (CMH). On 7 July 2023 I conducted the CMH. I gave directions for the each of the expert assessments; gave appropriate additional directions and listed both a Pre Trial Review (PTR) and this fact find hearing (FFH). I modified the timetable by a consent order on 3 October 2023.

Findings sought & Response

11. The applicant seeks the following findings:

Physical Harm

1. *When presenting to …Hospital on 28 May 2023 N was found to have the following conditions:*
   - a. *Cerebral venous sinus thromboses*
   - b. *Subdural haemorrhages - multifocal seen over each cerebral convexity, within the interhemispheric fissure and in the posterior fossa*
   - c.. *Thrombosed subdural bridging veins*
   - d. *Traumatic subdural effusions*
   - e. *Intraventricular haemorrhage*
   - f. *Retroclival blood*
   - g. *Encephalopathy*
   - h. *Bilateral asymmetric retinal haemorrhages with*
     - i. *In his right eye, one clear "dot and blot" intraretinal haemorrhage and a few (<10) possible additional intraretinal haemorrhages*
     - ii. *In his left eye, multiple (too numerous to count) "dot and blot" intraretinal haemorrhages, possible "flame-shaped" intra-retinal nerve fibre layer haemorrhages, and pre-retinal haemorrhages*
2. *The conditions in 1 were sustained between 23 May 2023 and 28 May 2023*
3. *The cause of the condition in 1 was abusive head trauma and*
   - a. *There was most likely just one episode of such trauma but the possibility of "more than one occurring over a limited time period" cannot be excluded*
   - b. *The trauma took the form of a shaking mechanism, although "a co-existent impact against a softer more yielding surface cannot be excluded."*
   - c. *"The force required to cause these injuries is unknown but would be high and clearly inappropriate for N"*
4. *The abusive head trauma was inflicted by one or both of the parents*
5. *There was a failure by each parent to seek prompt medical attention for N such that:*
   - a. *N's pain and suffering was extended, and/or;*
   - b. *The optimal treatment for N's injuries was delayed.*
6. *There was a failure by the inflicting parent to be open with the medical staff, such that:*
   - a. *N's pain and suffering was extended, and/or;*
   - b. *The optimal treatment for N's injuries was delayed, and/or;*
   - c. *N received unnecessary medical treatment.*

Emotional Harm

7. *The infliction of abusive head trauma by one or both of his carers would have caused emotional harm to N.*
8. *N was at risk of emotional harm through exposure to domestic abuse in his parents 'relationship:*
   - a. *The mother suffered psychological abuse from the father. She was grabbed by him on occasions; by her hair, by her clothes or her hand. He would also be verbally abusive;*
   - b. *The father was at times controlling of the mother, checking where she was going, checking her phone or messages;*
   - c. *The last incident was when the father grabbed the mother at the beginning of her pregnancy, when he had doubts about whether he was the father of N. On this occasion, he smashed a TV that he had bought and then grabbed her by her hand and tried to remove her from the property*
   - d. *In June 2023, the police shared information that neighbours of the parents "reported hearing frequent shouting and banging coming from their address and that a female (which it is assumed was the mother) was heard to be shouting in an angry rather than a scared way."*
9. *By virtue of the aforesaid, at the relevant date N was suffering and was likely to suffer significant harm, that harm and likelihood of harm being attributable to the care given to him, and likely to be given to him if an order were not made, not being what it would be reasonable to expect a parent to give to him.*

12. By closing submissions the applicant asked me to find M responsible; to find both parents responsible for delay in seeking medical assistance, and to make possible findings against J.

13. J accepted N had suffered an abusive head trauma but denied she was responsible. She accepted domestic abuse in the relationship and accepted she had delayed in seeking medical assistance.

14. M did not accept N had suffered an abusive head trauma and denied being responsible in any event. He accepted there had been domestic abuse in the relationship. He did not accept delay in seeking medical assistance.

15. The children's guardian probed the evidence but did not take a positive case as to the issues in dispute.

16. *When considering whether I can or should make the findings I proceed from the basis that it is for the applicant to prove each of the allegations and it is not for either parent to bear a responsibility to disprove any of the same. The applicant will prove an allegation if they establish it on the balance of probabilities, namely by proving it to be more likely than not.*

17. *In assessing the truth of an allegation I should bear in mind all of the evidence received in a holistic manner and not within separate compartments. I should avoid a linear approach and should give regard to the wide range of evidence. It will always be important to give close scrutiny to the evidence given by the central participants, here the parents.*

18. *When assessing the evidence given I can have regard to the manner in which it was given but I should be particularly alive to what is said and whether it is both internally and externally consistent with other evidence. I can have regard to the inherent probability of an event likely to have taken place but I must caution myself that whilst an action might be felt to be generically unlikely I must not lose sight of the specific circumstances of the case.*

19. *Whilst I can have regard to lies told by a party as being probative to the truth or otherwise of the issues in dispute before me I should proceed with caution as people may lie for all sorts of reason, including embarrassment and shame. There is a clear structure I should take when I approach such a suggestion. I should first identify the lie on which a party relies; I should then identify the significant issue to which it relates before questioning on what basis it can be determined that the only explanation for the lie is the guilt of that party.*

The Medical Evidence

20. I benefitted from four experienced and highly professional witnesses. I am most grateful for the assistance they each gave the Court. Proceedings of this sort cannot function without a community of clinicians and experts prepared to investigate our cases in a fair, professional manner and without fear of challenge. The experts in this case listened with care to the points put and gave appropriate consideration to alternative propositions. Where they disagreed they did so in a respectful manner providing clear explanations as to why they could not agree. They made appropriate concessions where they felt the same were justified. They did not stray outside their area of expertise and identified where it was appropriate to defer to other witnesses. They were measured in their approach and appropriately distinguished between degrees of confidence in a manner that was helpful to my assessment.

21. At both the start and end of their evidence the experts maintained a unified position under which the most likely cause of the presentation was abusive head trauma with the most likely mechanism being shaking and with the forces being incapable of exact calculation but outside the boundaries of normal handling such that an objective bystander would consider the same inappropriate. As to timing, the experts could not determine whether the presentation was as a result of a single episode or not. The most significant evidence as to timing came from Mr Jayamohan and Dr Cleghorn. They narrowed down the sentinel event leading to admission to being on 27 May 2023 having regard to the child's encephalopathic presentation and the presence of effusions. They were clear that one was looking to identify when the child was last found to be presenting in a manner normal for that child and to date the event to after that point.

22. In reaching a conclusion in this regard the following matters were noted:

- The presence of asymmetric retinal haemorrhages in both eyes which were too numerous to count and involved multiple layers of the left eye (Mr G)

- Evidence of widespread subdural bleeding seen over each cerebral convexity, in the interhemispheric tissue and in the posterior fossa which equated to multifocal, multi-site subdural bleeding. In addition there were tears in the arachnoid membrane leading to subdural effusions. The presence of thrombosed subdural bridging veins were noted which are seen in trauma where there is anterior-posterior head shaking motion (Dr W)

- The presence of venous sinus thrombosis, subdural haemorrhage including postfossa subdural blood that cannot be associated with the thrombosis, subdural effusions arising due to an acute process which would be either trauma or severe bacterial infection (which was not present), intraventricular haemorrhage, retroclival blood which is trauma related unless there is a bleeding disorder (which was not present) together with an encephalopathic presentation more consistent with post trauma than after a non-fully occlusive sinus thrombosis (Mr J)

- There were extensive investigations completed and no other investigations are recommended. No concerns were raised as to clotting disorders or the presence of infection on admission. Other rare conditions leading to bleeding disorders can be ruled out. N was extensively investigated during his admission and no other clinical concerns were raised. The intracranial findings, retinal haemorrhages and encephalopathy are more likely the result of trauma (Dr C)

23. When probed on behalf of M they provided the following additional evidence:

i) **Timing:** The acute blood meant these injuries did not date back to birth (Dr W). Encephalopathic presentation is brain dysfunction with an altered

presentation which can be seen as irritability, drowsiness, seizures, vomiting and floppiness or stiffness. N presented in this manner on admission, he was irritable and jittery, he had a high heart rate and there was an initial concern as to a brain infection, then he had seizures. This fits with clinical encephalopathy (Mr J). If N was acting in a normal manner at midday on the preceding day then it is likely the sentinel event occurred thereafter. It is not likely he would have the injuries and then have interacted with others in a normal manner to the point no-one thought there was a problem. Whilst one can have a deterioration one would not have a lucid period although the deterioration might be masked whilst the child was asleep. Whilst this might differ with the severity of the injury N progressed rapidly, he stopped breathing and there was a fear of meningitis. It should not be misunderstood how sick he was. The presence of effusions and the clinical presentation indicated the sentinel event happened on 27 May 2023 (Mr J). Changes would occur fairly quickly. N was at the higher end of severity in this case. He was significantly unwell and had to go into intensive care (Dr C).

ii) **Thrombosis:** The venous sinus thrombosis (VST) was non-occlusive with blood continuing to flow. This could not have caused the other findings. It was likely a secondary factor (secondary to dehydration linked to vomiting which followed from the encehaplopathy) rather than the primary driver of the symptoms seen in N. The trauma led to the VST not the other way around. In any event it was in the wrong area. If the VST was the primary driver then the Court would have to take the view the imaging was very unusual (Dr W and Mr J)

iii) **Infection:** A history of ear wax issues in the child would not suggest an infection based cause. There is a separation of the inner ear and the ear drum and N on scanning had a pristine middle ear (Dr W). There was nothing on the scan to suggest ear infection and the clot in question was in a different part of the venous system to the ear (Mr J). N had a complete screening for infections. It is unlikely he had an undetected infection. He did not behave like a child with sepsis (Dr C).

iv) **Blood moving between areas:** Whilst there can be anatomical variation generally this does not permit flow of blood between the areas seen. It was unlikely blood moved between sectors of the brain (Dr W). In this case the spaces were in completely different loci. The expert had never seen a leakage of this type and could not understand how it could happen. Intracranial pressure could not cause blood to move around. Surgical intervention is planned on the basis of scans and the blood is found where it is suggested to be by the scan. Whilst some movement is possible it doesn't move around as suggested (Mr J).

v) **Spontaneous subdural haemorrhaging**: In one area would be unusual; to have on two sides would be more unusual; to have in multiple sites would be most unlikely.

vi) **Spontaneous intracranial hypotension:** Had never seen this in 20 years practice. It is not in the textbooks and there are no concerning disorders. Plus this would have had to have occurred spontaneously at the same time as he presented with encephalopathy (Mr J).

vii) **Seizures:** It is common for clinicians to see children experiencing violent seizures but these do not lead to subdural haemorrhages or effusions. From experience clinicians treating seizures with anti-seizure medication do not see these symptoms as a result (Dr W). It is not likely a seizure could cause the eye haemorrhages seen in this case as it was most unlikely a child of this age would be able to exhibit the necessary movements through seizure that would be required to cause what is seen. We would expect to see different features if hypertension were the cause with a cluster of haemorrhages around the optic nerve. Here they are present through the retina itself (Mr G). Varying intracranial pressure is not a likely cause of the bleeds. The changes in pressure for N were intended by the treatment plan in operation and were not an unexpected change. It was not pathological in origin. Some of the symptoms were not explicable by seizure in any event (Mr J). An EEG was carried out and there were no signs of epilepsy syndrome. There was unusual brainwave activity but this was related to the areas of the brain where there was identified brain abnormality. This suggested the seizures were likely related to the brain injury he had suffered. It would be very unusual to have an underlying epilepsy syndrome that only presented with encephalopathy several weeks down the line. One would expect to see this in the first days of life. The EEG does not support this suggestion (Dr C).

viii) **Birth as explanation:** There is a significant level of subdural haemorrhages found in new borns and the cause for the same is unexplained. However this could not be used as an explanation for what is found in this case. These haemorrhages resolve and are non-symptomatic by this point. If they did not resolve then we would be seeing a population of children with increasing head circumference which we do not. It is unlikely a birth related situation might predispose the child to later subdural haemorrhages (Dr W). New born babies do present with retinal haemorrhages but there are no inherent factors which predispose an ordinary infant to retinal haemorrhage (Mr G). For there to be a predisposition would suggest a re-bleed yet N did not have the necessary membranes for this to be the case (Mr J).

ix) **A lucid interval:** This is unlikely. There would be a more significant change at the time of trauma, there would be a sentinel event and the information suggests this was close to the point of presentation. It is likely the incident causing the trauma will have happened at a point after the child was last seen to be behaving in a manner normal for that child (Dr W). In cases of this sort the children present quickly (in hours) (Dr C).

x) **Unidentified Causes**: It appeared the necessary tests had been undertaken The circumstances did not suggest a haematological cause. Other known disorders are not relevant in this case (Dr W). It was difficult to think of a non-traumatic explanation that could encompass all the symptoms seen in this case

(Mr J). N had comprehensive screening for metabolic conditions (Dr C). The pattern of haemorrhages in both eyes and with those in the left being both extensive in number and multi-layered was supportive of a conclusion of inflicted injury with there being nothing in the medical evidence suggestive of an alternative explanation (Mr G).

24. *In approaching the medical evidence I need to keep in mind their role is as advisor to the Court on medical issues but the ultimate decision making process must lie with the Court. The Judge has the crucial advantage over the expert of hearing all the evidence and being able to make findings of fact and being able to assess the inherent credibility of the witnesses.*

25. *I must also keep in mind the well understood principle that science is not stationary and that developments in science do occur (sometimes rapidly) making that which was previous inconceivable a later dominant paradigm. The Court has to pay due respect to the reality that there is much that remains unknown or uncertain including in the clinical arena. The Court must be cautious when considering the dogmatic expert and must ensure each expert carefully keeps to their own area of specialism. The Court must bear in mind, to the extent appropriate in each case the possibility of an unknown cause.*

26. *The medical evidence is only part of the complete picture placed before the Court. It has no priority over other evidence and must be assessed together with the broad canvas of available evidence.*

The parental evidence / the wide canvas of evidence

27. In many ways M and J were open and frank in their evidence. M at times spoke with a degree of openness whilst exposing to the Court significant emotional challenges he has faced in his life. He made clear he is quite a closed person and I have no doubt he found it very difficult to give his evidence as he did. In significant part he made material concessions as to domestic violence, challenging mental health at times and resort to alcohol to self soothe. I was impressed by his openness. It is clear I do not agree with all he told me but I sense not all of this flows from conscious evasion or deception on his part. I sense his perception of matters is somewhat out of kilter with the reality to the objective viewer but I don't think this means he does not genuinely see matters in the way he told me.

28. J like M has faced a very challenging life and I have done my best to empathise with her plight. As with M there were levels of significant honesty around questions of alcohol and domestic abuse. My sense of her was that she was far too accepting of some behaviours and I judge this is a consequence of her upbringing and to an extent the culture that has surrounded it. She did show some insight.

29. Whilst both struggled at times in answering questions and had to be brought back to the point under examination I did not sense they were deliberately evading an answer or obfuscating. I did sense there was a degree of detail being lost in translation. I make this point without intending any criticism of the interpreters.

30. Ultimately my assessment is more an evaluation of what they actually said and did not say rather than the manner in which they said it. Still I consider it important to recognise my assessment of each of them as individuals who appeared before me.

31. There were a number of key factors which were the focus of their examination. In order I will deal with: (a) domestic abuse; (b) alcohol consumption; (c) Paternity/R; (d) the events of May 27. I will set out a number of other points which appear to me to be aspects of the wide canvas and which deserve to be recorded. I would though note that there was a high level of agreement as to much of the above that allows me to provide a focused summary of these matters.

Domestic Abuse

32. J recorded what can only be understood to be a pattern of domestic abuse during the relationship associated with alcohol consumption and controlling behaviour on the part of M. He would regularly express jealousy as to her actions and would regularly check her phone contents. Particularly, when affected by alcohol he became belligerent and would not be happy if she did not engage with him. There were a number of episodes where he grabbed her arms/hand and/or hair. He did not actually hit her and she was not scared of him but this was physically abusive on any objective assessment. She described M as a match that would 'explode' and said this happened on around 5-6 occasions. In addition to the above there was abusive language and messaging and she was called a 'whore' and other names. The sense was that this behaviour was present throughout most of the relationship although matters appeared to have quietened in recent times.

33. M accepted much of this but wished to make clear he could control himself and had never actually hit J. He essentially agreed the forms of abuse set out above although I had the sense he would have described slightly fewer incidents. He agreed he was jealous and I had a sense of him ruminating on issues. He agreed alcohol was part of the problem and agreed he was jealous about what J was doing. Both parents spoke of heart to heart conversations around changing the relationship (particularly following the TV incident detailed below and around the time of N's birth).

34. In contrast to the above both viewed the other's engagement with N as being loving and tender. There was good evidence of M being involved in N's care to include bathing and nursing him. Both were clear the other loved N very much. It was clear from the evidence he was a wanted baby.

35. I heard about a particular incident in the parents' bedroom when J was in the early stages of pregnancy (late 2022). When the isue of R arose M wanted to continue a conversation and was under the influence of alcohol. J was ignoring him and watching television. In frustration and anger M pushed/pulled the television off of the unit it was sitting on causing it to fall on the bed close to J. Both accept it did not hit her. I note it was a large 75" television. Then M grabbed J by the arm and hair and tried to remove her from the property. I accept this account of the incident. I do not believe the television was thrown.

36. There were reports of loud shouting coming from the property.

37. M seemed to accept a relatively high level of impulsivity in his behaviour. When frustrated he would act in the manner suggested. Whilst he did not actually agree to this description as impulsive, this was the very strong sense of his evidence.

38. It appeared to me the parents view of and attitude around domestic abuse was somewhat outdated with a focus on abuse being hitting rather than other forms of behaviour. I bear in mind they come from a very different culture and note it was not so long ago that such a viewpoint held significant purchase in this jurisdiction. They cannot perhaps be blamed for holding to this view but whilst this may explain how they have responded to the presence of the same (by accepting it) this does not change the nature of the behaviour.

Alcohol

39. J does not drink alcohol. M does. M has consumed alcohol at a problematic level for a number of years and his problematic consumption clearly predates the relationship. He gave some indications of background factors that have led to this state of affairs and gave me the very strong sense that he relies on alcohol to soothe himself at times of stress and when he is feeling overwhelmed. He particularly references strong feelings of despair when the couple lost an ectopic pregnancy in around 2021. He turns to alcohol and it is the classic crutch on which he has come to rely.

40. It is clear he has some understanding that it is an issue for him and has previously sought help including via AA. He has on a number of occasions during the period under consideration sought to reduce or abstain from alcohol use. On the evidence at this time he has once again stopped drinking (since seeing J's final statement in November 2023). Yet it is clear he has struggled to remain abstinent or to control his consumption when times have been difficult. Both parents agree he would work hard and long hours and would mainly drink at the weekends, although he would on occasion come home having drunk after work. He would drink beer or vodka and during certain periods would be drinking 1L a day or on his own case in around April-August 2022 up to around 2.5L of vodka per weekend (this is 100 units a weekend). When drinking his behaviour would become impulsive (see the TV incident).

41. M was quite clear as to his personality. He is not a particularly social man and would find comfort in drinking and playing his computer console. He would keep his feelings close and was not open in sharing his feelings. My sense was of his feelings being bottled up and of him ruminating until this was no longer possible and the feelings would explode out.

42. The evidence as to drinking patterns through the relationship was considered in some detail however I found it difficult to establish a clear delineation between respective periods with some blurring of the boundaries between periods and a degree of contradiction between the suggested drinking levels at a given time and other evidence in the case. I do not think I was being misled in this regard and I sense it is difficult for the parents to provide a clear and accurate history given the range of challenges they have faced. However, it seems clear alcohol has been a consistent issue in the relationship and a source of regular difficulty.

Paternity / R

43. I have recorded M's jealous attitude towards J around men. In their first property there were a number of other adults including 7 men. This caused M some problems given his jealous feelings. One of the men was R. It seems R and M would have known each other but only to a limited level. In April 2022 J and M separated and she commenced a relationship with R. The exact quality of the relationship is not entirely clear but it was an intimate relationship of which M was aware. During this period M and J remained in contact and it was at this time that M was drinking to a very high level. In August 2022 M and J resumed their relationship. She appears to have fallen pregnant around the same time.

44. It is clear M developed a concern that R might be the father of the child and the parents discussed DNA testing although this was never done (until within proceedings when DNA confirmation of M's paternity was obtained) due it seems to financial issues. There is no doubt this prayed on M's mind and it is clear it was a source of ongoing conflict between the couple. Even after N was born M went onto Facebook and found a picture of R and sent it to J alongside one of N commenting as to their likeness. Having heard the evidence I was unclear whether M was actually making a genuine point or was just being spiteful. The parents agree this led to a conversation and to M expressing regret.

45. I note the evidence of M that none of this impacted on his feelings for N as N was not to blame for anything that had happened. i accept M genuinely holds this feeling. I am not clear M did in fact become reconciled to being N's biological father until the DNA test results were obtained. I make this observation given the live evidence of M that the parents spoke and agreed he would be N's father whether or not he was his biological parent. This suggests continuing uncertainty.

The events of May 27

46. This was not the first time M had cared for N when J was at work however he would normally do so for an hour or so whereas on this occasion J was gone from around 12 noon to around 8pm.

47. M does not enjoy good sleep and was up late the previous night. N was on a three-hour feeding cycle. Neither parent notes anything out of the ordinary on that morning and it seems N fed as normal. Neither parent provides a history of any meaningful incident or accident in the preceding days that might explain the subsequent findings.

48. J prepared a bottle for M and left for work. The evidence of that day is given by M although there is some confirmation in other communications between the parents during the course of the day. M gives an account of N being largely sleeping during the day when not being fed. Whilst N was sleeping M also slept, played on his console or watched television. There appeared to be very limited engagement with N aside from feeding although M explained he did play with N for a period and N interacted by pulling his hair (beard). He seems to have fed him at around 12 noon, 3pm and 6pm although the 6pm feed was slightly unusual in that N struggled to feed and was 'fussy'. The feeding took twice as long as usual. N had been crying for around 10 minutes in

an increasingly escalating manner whilst waiting for the feed. A sense of how this was is given in police interview when M refers to N being 'angry'. At around this time M noted two scratches to the side of N's face but put this down to the child scratching himself. At around this time M and J spoke and M told her about the 'fussy' behaviour and the scratches.

49. J returned at around 8.30pm and kissed N who was sleeping. Shortly after this M prepared a baby bath for N and J prepared a bottle whilst holding N and undressed him for the bath. M bathed N with J present. N did not engage with his bath as he normally would but was crying throughout and not settling. After the bath the parents noticed N exhibiting 'weird' jerking movements to his head. They explain there had been previous 'twitching' to the arms, legs and chin but not this movement and not on this day. N took his bottle but shortly after vomited and brought up a large quantity of milk (either 1 (M) or 3 bottles (J)). J was concerned and phoned a friend which settled her. The parents resolved to monitor the situation that night. N continued to be sick during the night feeds although he took a morning feed without doing so. He then vomited after his next feed whereupon J transported him to hospital where he was admitted and the investigations commenced.

50. There was questioning as to the delay in proceeding to hospital. J said she had first been comforted by the friend's advice but later she could not travel due to not having the money to book a taxi. She therefore had to wait to the morning. In the morning she left after N was sick. M gave evidence which appeared to contradict in saying J had access to his card and an 'app' in his phone for booking taxis. However, he did not say whether his card had funds on it to permit the same. The tone of J's evidence was that finances were very tight at this point. M agreed to an extent in that he had not been working for a period after N's birth. I consider it is likely that financial constraints impacted on sensible decision making at this time.

Other matters

51. There were a number of points raised by J which the applicant notes and asks the Court to comment upon. These relate to explanations offered by her as being possibly probative as to the cause of the symptoms. I heard about:

- An alleged fall when pregnant and cleaning. J was cleaning a cooker hood and standing on a combination of the work surface and vacuum cleaner when she slipped and fell on her side. She did not seek medical treatment.

- The suggestion of N being 'jittery' on occasion. It seems the applicant considers this feature has been exaggerated so as to permit the argument of a pre-existing seizure condition when it is not justified on the evidence received including the initial evidence of the movements stopping when held (inconsistent with seizure).

- Inconsistency as to M's drinking in telling the police he had been abstinent for 12-18 months prior to the police interview when this was plainly not true.

- Epilepsy within her family. It is contended this was not mentioned by J to the treating team as might have been expected. The suggestion is that it has been raised falsely later to give an explanation for N's presentation.

- A scan close to the end of the pregnancy when J was concerned as to lack of movement. Both she and M recorded being told the foetus had hypoxic brain cells. It is said there is no basis for such an account in the medical records.

- The failure of J to join up the 'pieces of the jigsaw'. On her case she accepts the medical evidence and agrees N suffered an abusive head trauma. She agrees that only she or M could be responsible and is clear she is not. Yet she does not positively accept he must be responsible.

Wide canvas points

52. I have noted the evidence of loving and tender care exhibited on occasions by both parents. Both M and J speak of the other in such terms. Neither has given an account of the other expressing any anger or regret with respect to N. It is clear N was a wanted baby. The parents had tried previously and that had sadly ended with an ectopic pregnancy but N was very much wanted.

53. There is no evidence of substance use/abuse on the part of J.

54. Both parents have children from previous relationships. M prays in aid a significant role as a father to his two children. Neither have any convictions directly relevant or suggestive of a propensity to cause harm to a child.

55. In giving evidence it was clear both parents are emotionally attached to N and love him.

56. Whilst there is some evidence of financial challenge in broad terms both parents were working and it seems able to meet their needs.

57. *In considering what has happened the Court must have regard to the wide canvas of available evidence and should not approach the evidence in a compartmentalised form. Evidence relating to the parents' broader life and behaviour is likely to be highly valuable when the Court carries out its final analysis.*

58. *If a lie is found to have been told then this cannot be taken to prove guilt in respect of the issue under consideration in contrast the Court has to be satisfied that the only explanation for the lie is the guilt of the person.*

My analysis and findings

Abusive head trauma or other cause / unexplained cause?

59. Having balanced all the evidence in a holistic manner and having considered the wide canvas including all the evidence (medical and lay) I am satisfied that on balance I am concerned with a case of abusive head trauma.

60. The medical evidence is unified and clear. In this case there are a host of different presenting features which taken in totality can only be explained by there having been such an event. Whilst isolated matters might be extracted and subjected to close examination leading to agreement as to possible other causes this misses the point that the same would come nowhere near providing an explanation for the constellation of other symptoms. These symptoms taken together are well recognised to be associated with abusive head trauma and shaking in particular.

61. I have summarised the medical position at the outset of that section. It is a compelling explanatory basis for reaching conclusions in this case. Importantly there are no other accidental explanations that might provide an alternative understanding. Further there have been extensive investigations that can rule out those less common conditions and disorders that can be found in conjunction with bleeding of this sort.

62. The areas of enquiry raised by M were fully and comprehensively answered in a clear and authoritative manner. They left no room for real doubt. I appreciate at many points the experts accepted the possibility of certain scenarios. However at no point was any possibility felt to be a 'real' possibility so far as explanation was concerned. As the experts pointed out one can never say never. However, this is far from a safe basis on which to reach conclusions absent some foundation for doing so.

63. This was not a case in which the lay evidence was such as to cast doubt on the medical explanation. Indeed, within the wide canvas there were far more worries than positives to bring into the account. This was a case in which the wide canvas lent support to the medical evidence rather than undermining it.

64. It was clear there were many stressors in the family unit through the relevant time period. There were issues of alcohol abuse, stress and difficulty in the relationship, domestic disharmony and abuse. Conflicts as to paternity and questions of partner fidelity. To an extent there were financial difficulties and the normal challenges of a new baby in the home with associated loss of sleep and new responsibilities.

65. I am satisfied the likely mechanism of the trauma was a shaking motion. On the evidence available to me it seems likely this was a single event given the relatively concentrated time period under consideration. Whilst, absent an admission I cannot form an absolutely clear understanding of what happened I am satisfied the applicant is correct to put its case not on the basis of a malicious or conscious wish to inflict harm (which would not fit with the wide canvas of evidence) but a more likely loss of control over a short period during a period/moment of stress or frustration (which is consistent with the wide canvas). I accept the other parent was not present when this happened and medically there is no basis on which that parent could have been aware of what had taken place in their absence. As to the extent of the shake it will have been a motion which any bystander would have considered excessive but it may well have been a limited (and possibly highly limited) number of anterior/posterior motions. In simple terms this could have been one shake which was over in a second or two.

Identified perpetrator or pool finding?

66. *In attempting to identify who was responsible for this trauma I should simply apply the standard balance of probability. It is not for me to 'strain' to find a perpetrator although that is not to say there is not significance in being able to identify if possible the individual responsible for what happened.*

67. On my assessment the evidence in this case points clearly to M as being the likely perpetrator of the injuries found. This flows with a high level of confidence from a combination of the medical, lay and wide canvas evidence.

68. The medical evidence clearly positions the event on May 27 and having regard to the parental evidence after 12 noon on that day. That morning N had been normal and this would in my assessment of the evidence have been inconsistent with an already existing injury. At the point at which J left for work he was well. Evidence of his normality can be found in the limited evidence from M of N interacting with him in a small way during the day and taking his first two feeds without incident.

69. Thereafter on the lay evidence there is very little if any opportunity for J to have subsequently caused the injury. One would be looking to place it within the very few minutes of time when M was running the bath and she was making the bottle and undressing N. However, the evidence of the surrounding circumstances and her presentation at that time make this a vanishingly small likelihood and this is fortified by the fact that there is within the lay evidence prior irritability on the part of N surrounding the 6pm feed. Shortly after the bath N was seen to be showing head jerks which I find are associated with the developing encephalopathy. I doubt these presentations would have presented quite so rapidly as a result of a pre-bath shake. They are more consistent with a developing situation over the prior 2-3 hours. Further I would have expected there to have been something of note which M would have seen or heard or sensed had there been a shake during the pre-bath period.

70. In my assessment this is further supported by the wide canvas of evidence. There is clear evidence of M being anxious and stressed and impulsive in his behaviour. He was I find still concerned about the relationship with R and had only days earlier sent the picture. I struggle to find him reconciled to the situation. On this day he was caring for N for the full day for the first time and of course J was out of the house all day. This would likely have been playing on M's mind. There is evidence of N becoming very upset and crying and of M suffering without sleep and being somewhat distracted by his gaming. Whilst I do not find evidence of alcohol consumption on the day in question it may well be that an inability to soothe by reference to alcohol may have left M more, not less on edge.

71. Frankly, there is a constellation of features which support a conclusion that of the two parents M was far more likely to act impulsively and inappropriately. It was he who had the opportunity and responsibility for N during that day. On the evidence available N was well when J left for work and unwell when she returned.

Failure to Protect?

72. *I must guard against this being a 'bolt-on' finding or falling into the trap of concluding that just because the person shared a home with the perpetrator that they must have*

failed to protect. Nearly all parents are imperfect and many houses operate under circumstances of stress. That does not mean that for that reason the person has failed to protect by allowing a partner to remain within the home.

73. I am not persuaded in this regard. I accept there are a series of features of the relationship that cause concern yet I am also conscious of the evidence of M being warm and loving to N. I can readily see J distinguishing between his attitude to her and to the child. The problematic signs (alcohol and domestic abuse in particular) have been a central part of my analysis and are relevant but I do not consider this is sufficient to find that J in failing to act and protect N prior to May 27 has contributed to what happened.

74. I am though concerned as to her general attitude which is part minimisation and part lack of reflection as to the reality of the situation. She appears to have closed her eyes to the reality and in doing so created a worry as to her ability to be a safeguarding parent into the future. This will of course be for the welfare stage. But I am concerned as to her lack of curiosity and the failure to take obvious points to their logical conclusion. She appears to have prioritised the question of the ongoing relationship over a real scrutiny of what the evidence suggested. I should not be thought to be suggesting what she should now do and I leave open the role that M may in due course play in N's life but I agree with the applicant that this will be a matter requiring close consideration.

75. I do not entirely agree with all the points put by the applicant. I draw nothing from the account of the fall or the occasion of the scan. The former may well have happened and the latter may simply be a matter of language confusion. It is the sort of evidence which parents will often grasp for when seeking an innocent explanation of what happened. I take a similar view as to the seizures and twitching. This is not probative evidence as to dishonesty but likely evidence of a natural wish to find an explanation even if this requires the facts to be reshaped to permit the same. To an extent this is human nature in action.

76. I accept there was delay in presentation and make the finding sought. I understand J accepted this in any event. On balance I consider the delay was occasioned by a balance between worry and the financial challenges and unfamiliarity in a somewhat foreign system. There will be many parents faced by such a dilemma who act without delay and rush to hospital. But I can also empathise with parents in far more challenging circumstances who are forced to weigh a series of countervailing features and come to act with less haste. This tells me nothing as to J's understanding as to causation at this time.

Conclusions

77. I find the threshold made out as to the injuries sustained although I find this occurred on May 27. I find the trauma was inflicted by M, that there was a failure to seek prompt medical care and that M was not open with medical staff as alleged. As set out here I find allegations 1-6 proven.

78. I find this will have caused emotional harm to N [7] and that he was at risk of emotional harm arising out of the domestic abuse in the parents relationship [8(a)-(c)] I do not find (d) established as a finding of fact although I accept information was shared as alleged.

79. Consequent on the above [9] follows and the threshold in section 31 is crossed.

80. I will send this judgment to counsel. It can be shared with their clients (both lay and professional). Can I have any corrections or requests for clarification by 4pm on 22 December 2023? I will hand this down at a short hearing in the first week in the New Year on a date to be agreed. I have emailed in this regard and would ask counsel to liaise to provide a date by 22 December as above. I would like a draft order in advance of the hearing. I release counsel from the handing down so long as the parties are represented at that hearing.

His Honour Judge Willans