Neutral Citation Number: [2018] EWHC 1211 (Fam)

Case No: CM17C05369

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/05/2018

Before :

MR JUSTICE NEWTON

- -

Between :

Essex County Council	**Applicant**
- and -	
P	**1st Respondent**
- and -	
K	**2nd Respondent**
- and -	
A	**3rd Respondent**

- -

Ronan O'Donovan (instructed by **Essex County Council**) for the **Applicant**
Cyrus Larizadeh QC and Charlotte Baker (instructed by **Michaels and Co Law Ltd**) for the **First Respondent**
Frances Judd QC and Richard Beddoe (instructed by **Galbraith Branley Solicitors**) for the **Second Respondent**
Mary-Jane Taylor and Stella Young (instructed by **Jefferies Law**) for the **Third Respondent**

Hearing dates: 12 - 27 March 2018

- -

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.

.....

MR JUSTICE NEWTON

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Newton:

1. This hearing has been an investigation into the circumstances surrounding the death of A on 15 August 2017, who, together with her surviving twin brother, B, was born on 6 June 2017. No natural cause for her death has been identified and post mortem examinations identified several injuries which are without explanation. Both parents were arrested. Ultimately the father has been released without charge and is a prosecution witness. The mother now stands indicted for murder and child cruelty. The Police took immediate protective measures in relation to B, and the local authority issued proceedings, the first interim care order being made on 2 August 2017.

2. I wish at the outset to record the Court's indebtedness to all counsel for their tireless assistance in what has been inevitably a difficult hearing. Such investigations always produce a vast amount of paperwork, and this case is no different. The full bundles exceed 15,000 pages. I have of course received a considerable number of additional documents, position statements and final submissions from each party, as well as supplementary materials. Mr Larizadeh QC also produced and relies on a number of Research papers that are contained in a separate bundle. The hearing has spanned 12 days.

The Law

3. In determining the issues at this fact finding hearing I apply the following well established legal principles. These are helpfully summarised by Baker J in A Local Authority v M and F, and L and M [2013] EWHC 1569 (Fam).

    i) The burden of proof lies with the Local Authority. It is the Local Authority which brings the proceedings, and identifies the findings that they invite the Court to make. The burden of proving the assertions rests with them. (Whilst much recent legal debate has centred on the expression "nothing else will do"; see for example Re B [2013] UKSC 33 and Re BS [2013] EWCA Civ 1146 and Re R [2014] EWCA Civ 1625), in this case it is not suggested that the relationship between B and his father should be severed. I nonetheless bear in mind that the burden is on the Local Authority and not on either parent. Those cases reinforce the importance of reaching proper findings based on proper facts; the principles are the same whatever the proposed outcome. Here, there is, as in many cases, a risk of a shift in the burden to the parents to explain occasions when injuries might have occurred. Whilst that can be an important component for the medical experts, it is not for the parents to explain but for the authority to establish. There is no pseudo burden as Mostyn J put it in Lancashire VR 2013 EWHC 3064 (Fam). As HHJ Bellamy put it in Re FM (A Clinical Fractures: Bone Density): [2015] EWFC B26.

> "Where … there is a degree of medical uncertainty and credible evidence of a possible, alternative explanation to that contended for by the local authority, the question for the Court is not "has that alternative explanation been proved" but rather … "in the light of that possible alternative explanation can the Court be satisfied that the local authority has proved its case on the simple balance of probability."

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

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

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

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

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

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

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

v) The evidence received in this case includes medical evidence from a variety of specialists. I pay appropriate attention to the opinion of the medical experts, which need to be considered in the context of all the other evidence. The roles of the Court and the expert are of course entirely distinct. Only the Court is in a position to weigh up the evidence against all the other evidence (see A County Council v K, D and L [2005] EWHC 1444, [2005] 1 FLR 851 and A County Council v M, F and XYZ [2005] EWHC 31, [2005] 2 FLR 129. There may well be instances if the medical opinion is that there is nothing diagnostic of a particular non-accidental injury but where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts, that is on the balance of probability, there has been non-accidental injury or human agency established.

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

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

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

b) ([ ])

c) Particular caution is necessary where medical experts disagree.

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

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

ix) It is not uncommon for witnesses in such enquiries, particularly concerning child abuse, to tell untruths and lies in the course of the investigation and indeed in the hearing. The Court bears in mind that individuals may lie for many reasons such as shame, panic, fear and distress, potential criminal proceedings, or some other less than creditable conduct (all of which arise in a particularly highly charged case such as this) and the fact that a witness has lied about anything does not mean that he has lied about everything. Nor, as R v Lucas [1981] 3 WLR 120 makes clear does it mean that the other evidence is unreliable, nor does it mean that the lies are to be equated necessarily with "guilt". If lies are established I do not apply Lucas in a mechanical way but stand back and weigh their actions and evidence in the round. I bear in mind too the passage from the judgment of Jackson J (as he then was) in Lancashire County Council v C, M and F (2014) EWFC3 referring to "story creep".

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

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

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

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

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

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

4. Strongly submitted and I bear in mind, is the need to avoid speculation or jumping to a particular conclusion from an unknown cause: E v Harris 2005 EWCA Crim 1980 (in relation to the triad of head injuries); Re R, Cannings and R v Henderson all demonstrate situations where the "triad" could give rise to errant findings of the Court, especially where there may be (as here), naturally occurring conditions that have caused or contributed to, or might have done, the medical findings.

5. I have in mind Re R [2011] EWHC 1715 (Fam), [2011] 2 FLR 1384, as Hedley J stated:

> "A temptation described is ever present in Family proceedings and in my judgment should be as firmly resisted as the Courts are required to resist it in the Criminal law. In other words there has to be factored into every case which concerns a discrete aetiology giving rise to significant harm, a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities … a conclusion of unknown aetiology in respect of an infant represents neither a provision of professional or forensic failure. "

6. Finally when seeking to identify a perpetrator of a non-accidental injury the test as to whether a particular person is in the pool of possible perpetrators is when there is a likelihood or real possibility that he or she was the perpetrator (see North Yorkshire County Council v SA [2003] 2 FLR 849). In order to make a finding that a particular person was the perpetrator of non-accidental injury the Court must be satisfied on the balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interests of

the child, although where it is impossible for a judge to find on the balance of probabilities that for example parent X rather than parent Y caused the injury then neither of them can be excluded from the pool and the judge should not strain to do so and should say so (Re D [2009] 2 FLR 668 and Re SB (children) [2010] 1FLR 1161).

The Background

7. A and B, who were born prematurely at 36 weeks, had very different trajectories. B was able to be discharged home, but A had significant special needs and spent the first months of her life in hospital. On birth A demonstrated significant respiratory distress. She had (inter alia) atresia of the oesophagus with tracheoesophageal fistula, apnoea, jaundice, suspected sepsis, hypoglycaemia, hypernatremia, gastro-oesophageal reflux, an anastomotic leak and food intolerance. Self-evidently she was a most unwell baby, requiring not just surgery but intensive care within the neonatal unit. She was prescribed very many drugs and only finally discharged from Addenbrookes Hospital to a local hospital on 18 April 2017 and thence to the care of her parents on 15 May 2017. A, however, was slow to thrive and required very considerable and continuing additional care and medical input (for example "stretch surgery" on 25 July 2017). She and her parents received assistance from over a dozen health care professionals. Her severe reflux and feeding difficulties continued, indeed the records demonstrate (for example the health records at G226 for 31 July 2017) how very difficult this was.

8. The parents additionally had relationship difficulties, the mother alleging domestic abuse (some very serious), over the previous 7 years. On 5 August 2017, both parents contacted the police; the mother made criminal allegations to the police, the father left the family home. He did not see A alive again. From the moment of separation the mother had sole care of both children.

9. At 9.30am on Monday 14 August 2017 the mother was visited by the health worker and the children's social worker. No concerns were raised. At midday a district nurse attended to reposition the nasogastric feeding tube which had been removed by A. In the evening, at 7.30pm, the mother reported that A was fed and put to bed in the moses basket.

10. In summary, at about midnight on 15 August 2017 A was reported to have had her last feed, which took about half an hour; she took a while to settle. B was also fed. During that time A began coughing and was described as "wriggling" intently. About 15 minutes later the mother reports being woken: A was coughing and struggling to breathe. She noted coffee ground coloured vomit around A's mouth and nose; she noted a brown liquid oozing from both. She contacted the emergency services at 2.55am and was instructed to carry out chest compressions. I have listened to the recording of the 999 call and advices being given to the mother over the telephone. The operator's approach and advice was impressive. Paramedics arrived who instigated emergency procedures. A remained in asystole. It was clear in fact that she was already dead. She was blue lighted to hospital where CPR continued. Death was certified at 4am.

11. On 18 August 2017 a skeletal scan occurred. The results demonstrated multiple fractures to the skull, ribs and a fracture to the leg.

12. Further post mortem examinations revealed

    i) multiple bruising to the head

    ii) traumatic brain injury with subdural haematoma, subarachnoid haematoma and focal axonal injury and

    iii) multiple retinal haemorrhages in all regions of the retina, at all locations, as well as bleeding in the optic nerve, scleral junction, optic nerve sheath bleeding and orbital bleeding.

The Expert Evidence

13. I have heard from very highly experienced and respected medical experts, clinicians and pathologists. I review their evidence in accordance with the schedule of identified injuries.

1. Traumatic brain injury with subdural haematoma, subarachnoid haematoma and focal axonal injury.

14. Professor Al-Sarraj reported evidence of traumatic brain injury. Some of the features are consistent with an old traumatic brain injury of several days to weeks' duration. This could be due to one or several episodes of traumatic brain injury in this period. There was also evidence of recent injury which was of one to a few hours duration. He found at least two subdural haemorrhages and two subarachnoid haemorrhages, suggesting two or even more incidents, both individually suggesting traumatic origin, but together powerful indicators of traumatic brain injury. A would have become immediately unwell after the trauma. A's brain showed no evidence of disease (which if present could explain some of the neurological findings, though not all of them); he considered that the delay (between death and post mortem examination of 9 days) would have had no effect on the identification of the subdural injuries. He did not consider that cranial rebleeding played any part here (or in many cases where he considered that it frequently, was completely misinterpreted and misunderstood in many Court cases). The degree of force might not necessarily be hard, but the skull fractures and bruises might suggest otherwise.

15. He did not support fuller neurological testing, which could he said otherwise be endless, with no foundation and to no effect; there must be pathological or clinical evidence to support such a course. There was a need to focus. The discussion needed to concentrate on the context of the case, neuropathy being only one part of the jigsaw. There was no evidence to show EDS. The Professor was a powerful, confident, clear and convincing witness.

16. Dr Ward, commenting on this area, looking at everything together, said that A had suffered a catastrophic brain injury which had occurred shortly before the 999 call. Essentially, the brain injury would have led to cardio respiratory arrest (which was why CPR was so essential); she would not have expected survival for longer than 12 hours. She commented authoritatively upon research in America, in particular a pattern of minor shakes (which can apparently quieten a child), but becoming more serious. She was also asked about an occasion (on 22/7/17) when A had become floppy. She was clear that whatever the cause, whether it be spasm of the larynx,

viral infection or previous inflicted injury, it was unrelated to the serious injuries which precipitated A's collapse. She went on to consider these injuries in the context of the eye injuries which I review later.

2 and 3 – Complete fractures to the right and left parietal bone.

17. Professor Mangham stated that the skull fractures showed signs of occurring within 2 and 12 hours of death, and were likely caused by significant blunt force or impact.

18. Dr Halliday agreed, stating that the bilateral skull fractures were likely caused by a blow to the head. They could not have been self inflicted, although could have occurred at the same time if an object had fallen onto the skull. Each could have occurred by a fall of less than a metre (although obviously there would have had to have been two falls, two incidents). It was unlikely that either of the fractures were caused by someone "gripping" the skull. She dismissed any idea that the fractures might be sutures - both from their position and their appearance, and simply because the pathologist found a fracture.

19. Dr Randall stated that it was possible to differentiate between suture lines and fractures. Here, they look like fractures because they were fractures.

4. Multiple retinal haemorrhages in all regions of the retina, at all locations, as well as bleeding in the optic nerve scleral junction, optic nerve sheath bleeding and orbital bleeding.

10a Previous bleeding in the right eye

11 Older haemorrhage in the left eye (likely associated with 5a below).

20. Dr Bonsheck stated that most of the bleeding seen in the retina, orbits and optic nerve sheaths was of recent origin, but there was evidence for earlier haemorrhage in the left eye – most of the bleeding appeared fresh, with little or no tissue reaction. However, there were also areas especially in the right eye in which there was widespread focal acute inflammatory cell infiltrate indicating bleeding of onset at least 12, and more likely 24 hours prior to death (microscopically extensive and widespread bruising). The presence of haemosiderin indicates bleeding of greater than 2 to 3 days prior to death. Haemosiderin may persist in the tissues following bleeding for several months or longer.

21. He considered that the multiple retinal haemorrhages in all regions of the retina at all locations as well as bleeding and orbital bleeding, was highly suggestive of traumatic causation and in particular non-accidental injury, with likely more than one episode.

22. In evidence he reiterated his opinion that there had been at least two to three, or even more separate incidents causing bleeding to the eyes, in particular the right eye and an older one in the left. He did not consider that the delay between death and examination made any difference to his findings. He was taken through several other possible causes (e.g. birth related) giving reasons why he did not consider they were relevant here.

23. Dr Randall's findings concurred with Dr Bonsheck's specialist advices.

24. Dr Ward considered that there were "shaking" injuries. The older haemorrhage could be anything from a few days to a few weeks old, it is likely to be associated with the older subdural and subarachnoid haemorrhage and focal axonal injury (at 5a).

5, External skull periosteal hematoma without fracture on left parietal bone, indicating an area of traumatic injury.

25. Professor Mangham concluded that bruises to the bone surface had occurred between 3 and 7 days prior to death and would have been caused by a significant blunt force or object.

5a Subdural haematoma, subarachnoid haemorrhage and focal axonal injury.

26. Professor Al-Sarraj said these injuries had been caused by an impact related trauma occurring several days to a few weeks before death. I have already noted that Dr Ward considered such findings were consistent with shaking and impact.

6 Three posterior rib fractures; to the right fifth, right ninth & right twelfth ribs

7 Three anterior rib fractures to right ten, right eleventh & right twelfth ribs

27. Professor Mangham concluded that the appearance of all the rib fractures was consistent with having occurred between 12 and 48 hours prior to death. He was asked whether they could have occurred as a result of CPR, but differentiating between the front and back, concurred with Dr Ward who considered that such injuries whilst possible, were rare, and if caused by standard CPR (i.e. lying flat) were incredibly rare.

28. He concluded that the posterior rib fractures were especially indicative of side to side compression of the wall of the chest. Whereas the anterior rib fractures indicated compression of the thoracic cage.

29. Dr Ward stated that anyone present at the time of the fracture would realise the child was injured. A would likely have immediately cried in pain and for some minutes, possibly up to half an hour.

8 Proximal left tibial classic metaphyseal lesion involving the medial third of the metaphyseal osteocartilagenous junction

30. Professor Mangham concluded that the features of the fracture indicated having occurred between 3 and 7 days prior to death, Dr Halliday concluding at least 10 days prior to death, but deferred to Professor Mangham. Both considered the injury was caused by a pulling or traction and twisting action. It was not considered that the injury could have occurred through any medical intervention.

9 A row of three faint bruises over an area 3.5 x 1.5 cm on the left side of the forehead. A further row of three faint blue bruises in the left frontoparietal region

31. Dr Randall described them in evidence and their position. She considered they were consistent with fingertip pressure, hours or days before death – such marking would not be expected through normal handling.

12 Non-displaced diaphyseal tibial and fibular fracture

32. Professor Mangham concluded that the tibial and fibular fracture occurred at least 4 weeks prior to death and likely more than 6 weeks prior. In evidence he described it as a blow fracture, a "pretty severe" fracture. Dr Halliday, although deferring to Professor Mangham, considered the fracture to the tibia to be less than 4 weeks old. She did not consider that the fracture could have been caused by medical interventions or ordinary handling. Dr Halliday considered the injury would have been caused by a twisting force. Dr Randall confirmed the fracture but could not comment on causation. Dr Ward agreeing, stated that the fracture was at an unusual site, and would have been more obvious than the metaphyseal fracture. All the evidence she considered pointed to trauma in early July 2017. Anyone unaware of the cause would have noticed that A was in pain and exhibited reduced movement. The father noticed both and caused A to be medically examined. Dr Featherstone, who examined her as a result, did not identify the injury. Dr Ward, agreeing with Dr Halliday, did not consider the fracture could have been caused by medical interventions.

33. Taking all the findings together Professor Mangham concluded that whilst there was some evidence of underlying and explained bone disease, there was no histological evidence of an underlying disease that would make the bones more susceptible to fracture. The fractures which were present by virtue of their number, type and occurrence at different times indicate that they were caused by significant trauma and, in the absence of any plausible event or explanations, are indicative of non-accidental injury.

34. Dr Ward similarly reviewing the injuries to the head concluded that a skull fracture is normally suggestive by a history of a remarkable event, the child's response and subsequent examination. Anyone present when the injury occurred would know the child was injured by the child crying or screaming in pain, or by their altered behaviour (which might include drowsiness, altered behaviour or even loss of consciousness).

35. A demonstrated extensive injury to her head. Whilst a substantial skull fracture could lead to subdural and subarachnoid haemorrhage and hypoxic brain injury, the same constellation of injuries is also seen in children who have experienced an acceleration/deceleration injury, a shaking injury. She concluded that A's injuries were consistent with such a mechanism. There was additionally localised soft tissue and bony injury suggesting impact trauma. She concluded the evidence supported a shaking and impact before the ambulance was called in the early hours of the morning of 15 August 2017.

36. Dr Ward (in common with the other experts in relation to further testing) both in relation to EDS or genetic testing observed that here the Court has radiological and pathological evidence too, if there were metabolic or skeletal disease she would expect to see radiological or pathological abnormalities. The ultimate evidence she concluded was post mortem, all of which fell on the side of traumatic brain injury.

37. A similar line was taken by Professor Al-Sarraj who did not consider neuroradiological survey would have made any difference to his assessment, though his evidence in relation to genetic testing was different.

38. Professor Mangham too, having regard to the absence of multiple small micro fractures stated that further enquiry was unjustified, there being no evidence of disease sufficient to weaken the bones. In respect of genetic testing he stated that the presence or absence of a mutation gene does not necessarily mean mutation is manifest in the protein level or that the bone is structurally weak. He had looked for evidence of structural weakness, without clinical, radiological or histopathological evidence to support that enquiry, it would mean that the particular gene does not produce a result in the bone.

39. I shall return to the issues of whether further enquiry is necessary later in this judgment.

The evidence of the parents

The father

40. The father was an impressive individual and witness. He described the parents' early married lives and their journey through IVF. It was known before birth that one of the twins was not developing as well as the other and so it proved on birth that A required medical, surgical attention and special care. Despite holding responsible employment he would travel the considerable distance after work to spend time with A almost every day during the long period she was detained in hospital. On discharge that closeness continued, concerned for her health and feeding. In July he felt she was exhibiting pain in her leg, he asked the GP about it; she was ultimately examined by Dr Featherstone who could discover nothing of concern.

41. Relations deteriorated on 5 August 2017, both he and his wife called the police. It was that day, but he had noticed it in July, that he remarked on his wife's impatience with A, "tapping" her or "smacking her bottom", she being "frustrated" that A was not progressing at the same rate as B. She said "why is she not learning more quickly". "I felt my wife needed time and space; my wife was a good mother, just impatient (about A's development) and a bit detached with her and never had the patience to feed her". She had just had twins and A had been in hospital for a significant period – she was more attached to B. On 5 August the Police were interested in his wife's allegations against him, they were not interested in his concerns about his wife, "I expected the police to help and give my wife some advice".

42. He spoke powerfully about B, and about the pressing need to regularise his care. Overall I found the father an impressive witness, the marital relationship was not always stable, although until these events they each had a traditional (and constant) view of the other. I do not condemn the father for failing to take more action when his wife's behaviour and condition was deteriorating. This was a traditional couple, until early August, endeavouring to sort out their private domestic lives themselves. The father was overwhelmingly and obviously, a truthful witness.

The mother

43. The mother was at once a very different witness. I make full allowance for the circumstances, not just what happened in August, but giving evidence in a strange environment, and additionally having only recently also been charged with murder, and for a short while detained in custody. Nonetheless, her evidence had a most unusual quality. The mother portrayed an idealised picture of family life which I simply do not accept as accurate. "I was excellent, I never, ever, once felt stressed or tired, I'd waited 7 years for that (the birth), I knew I was having two babies, it was not a surprise, so I was prepared for that".

44. The mother spoke of the separation on 5 August and her perspectives on that. "On 14 August I was feeling lonely and I had a feeling something bad was going to happen. A was fine although had a slight temperature and a cold and cough. I was coping. I changed her nappy at about 11.30pm, fed A first and then B, then we all went to sleep. After about 10 minutes A was coughing (because of the reflux), I rubbed her chest and back, and she went back to sleep as did I. Sometime later I saw A was struggling to breath, wriggling and coughing, I'd seen that before on a couple of occasions in July. I rang 999. The lady kept asking lots of questions. I did not pick A up. I did not place her on the floor. I was holding B".

45. The mother's rather curious idealised perspective became much more evident in cross examination. Not just that she maintained that she was not struggling, stressed or unhappy (although the evidence is otherwise), but that because she had always wanted a daughter, they had a "special relationship". Her action in relation to her family and others seemed to me telling, rebuffing suggestions that she had kept A's condition from them, portraying them as the perfect family: "I really just didn't want to talk about it – she will be better, she was getting better". She denied being frustrated or losing touch with reality, although in truth it was clear that both were true. She denied what her husband said (and what was the fact), that the twins were developing at different rates: "no, they were both the same". As she was pushed, appropriately in cross-examination, more and more by Mr O'Donovan, her brittleness and vulnerability became sadly more obvious. The mother did not agree with the comments of others that she was "overwhelmed by her situation", or struggling, though clearly she was.

46. A more genuine picture was portrayed by the mother herself when she was interviewed by the police (I/3863).

> "I don't know about that day ("inaudible due to crying"). I used to feel bad for myself , I couldn't., I was struggling for myself, ("sounds like") I couldn't stop myself, why am I struggling today. Why it happened, it never happened before, why I am struggling. I used to feel something is going to happen something is going not good, something bad is going to happen. And whenever I used to hear this ambulance sound because I can hear lots of ambulance because one side is Princess Alexander and the other side is Whipps Cross. Why can I hear this ambulance sound? Something bad is going to happen today. And to be honest I really wanted my husband back because I don't know why I was sitting before going to

> bed also I was going everywhere and running everywhere inside our house. Checking that the cooker is switched off or the fridge is properly closed or the heater. That the door is properly closed. I really don't know why I was doing that."

47. Even more unusual were the mother's replies to Ms Judd QC, denying with more vehemence that she was impatient, saying "I didn't have the right to hold her for 4 ½ months", and subsequently to Ms Taylor, her evidence increasingly bearing little resemblance to reality.

48. As the mother described the events of that night she became distressed, blurting out "I never expected to see this, I didn't think she was going to die".

49. She was asked to explain why she had not followed the very clear and patient advices of the 999 operator. She replied that did not have time or panicked and she thought in any event that the floor would hurt A, but in truth sadly in my judgment it was because the mother knew that it was too late.

50. Overall, the mother's evidence seemed to me a show, little relation as bearing to reality, but more an idealised picture, a fairytale, of what she thought life should have been like with the twins. The reality was rather different.

Review

51. In the early hours of 15 August 2017 A suffered a catastrophic collapse and was almost certainly dead by the time the paramedics arrived.

52. The mother gives a description of A being normal (although having a cold and a slight temperature), and of feeding normally at 11.30pm. After going back to sleep for about 10 minutes A woke up the mother coughing; she was soothed and everyone went back to sleep. Sometime later A again woke her mother, apparently similar to previous episode(s) in July. The mother called 999.

53. Post mortem it became clear that A had multiple injuries: to the head, a fracture on each side of the skull; traumatic brain injury; subdural bruising, subarachnoid bruising and a focal axonal injury, multiple retinal haemorrhages in all regions and all locations; as well as bleeding on the optic nerve scleral junction nerve sheath and orbital bleeding. There was evidence of retinal bleeds in both eyes. She had bruising at the external skull periosteal and 2 rows of 3 faint bruises on the left side of the forehead:

    To the body A had 3 anterior and 3 posterior rib fractures.

    To the left leg a metaphyseal fracture between 3 and 7 days old.

    To the left leg a tibial and fibular fracture at least 4 weeks old.

54. The Court has heard evidence from treating doctors, specialist consultants and pathologists. Each, according to 1) their specific discipline, and 2) generally in relation to the overall picture, advises the Court that those injuries were most likely to be inflicted. Notwithstanding the suggestions raised by Mr Larizadeh QC, each expert witness remained firm. Inflicted injuries occasioned on different dates. There

is an unusual unanimity of opinion. The expert witnesses were each, and together, impressive. Impressive especially for their care and moderation. Of course standing back I take into account all the evidence from the mother and father and in particular the other professionals and lay witnesses who comment on the care apparently provided. If inflicted only the one fracture to the tibia and fibula could have been caused by either parent, since the children were in the sole care of the mother from 5 August 2017 when the father left the family home (the last time the father saw A).

55. Summarising each expert by discipline (as opposed to the specific injury), Professor Mangham dated the skull fractures and the haemorrhage in the spinal cord between 2 and 12 hours before death, the rib fractures 24-48 hours before death, the metaphyseal lesion (and external skull periosteal haemorrhage) 3-7 days before death, and the tibial and fibular fracture at least 4, and more likely 6, weeks before death.

56. The skull fractures would have been caused by a significant blunt force or impact, the rib fractures by compression, the metaphyseal lesion by pulling and possibly twisting, the older "pretty severe" fracture by a blow.

57. Professor Mangham concluded that taking all the findings together, whist there is some evidence of underlying bone disease (focal dysplasia affecting the ribs and a delayed anterior fontanelle closure), there was no histological evidence of an underlying disease that would have made the bones more susceptible to fracture. The fractures present, by virtue of their number, type or occurrence at different points, indicate that they were caused by significant trauma, and that in the absence of plausible multiple event explanations (or any event explanation), they are indicative of non-accidental injury.

58. Mr Larizadeh submits that there is a pressing need to obtain an overview by a geneticist given the multiple congenital abnormalities in life and post mortem, in particular but not exclusively in relation to skeletal and cardiac malformations. This is in part derived from the experience of this Court and of other Judges of the Division, frequently but not necessarily in relation to twins, that a previously unidentified rare genetic condition was or might be responsible for the constellation of injuries exhibited by this child. I have some natural sympathy with this approach in endeavouring not just to produce the gold standard of opinion, but also especially since in rare cases medical science is on the cusp of what is understood and explained, and whilst a diagnosis of inflicted injury may still remain one of a number of differential diagnoses, it may not necessarily be the primary one.

59. It should not be thought that if in the interests of fairness and justice I considered it a reasonable and justified course, that it was necessary to commission further evidence, that I would not hesitate but halt these proceedings as argued. All the experts are clear and unanimous that there is, here no realistic alternative explanation. At best such an enquiry might be informative, but of what? It is an aspect each witness, including Dr Ward (who is relied upon) commented – there is no evidence of any disorder (genetic or metabolic), the "gold standard" is in truth the post mortem overview of A's condition and pathology. Even if A hypothetically did have a genetic disorder, it did not express itself in her bones (or blood vessels). There must, I agree with the experts, be a solid basis of enquiry, rather than casting around (as Dr Al-Sarraj said in the related application), "there is a need to focus", otherwise testing would be endless, this is the wrong approach, there has to be a real basis for further

enquiry). Histologically Professor Mangham was clear that there was no bone weakness affecting the bones.

60. Dr Ward, commenting on the leg fractures, said that they would be memorable and obviously painful events. In relation to bone density, she was clear that the child, family history and other evidence needed evaluating first (osteogenesis imperfacta being demonstrated – a skull being unusual). The site of the older fracture was unusual, she agreed with Dr Halliday and others, that it was not caused by earlier medical intervention (any more than the skull fractures had, which could not have been caused accidentally either by holding the head for feeding or medical procedures). Dr Ward, a powerful, persuasive and considered witness in evidence, did not consider that there was any "missing" evidence justifying further enquiry. I was especially impressed by the depth of knowledge of Dr Ward when discussing but more importantly distinguishing the very many research papers put to her in cross-examination.

61. Turning to the other main area of injury – the head. Professor Al-Sarraj identified at least 2 areas of subdural and subarachnoid injury of differing ages. A would have become immediately unwell. The local authority suggest the earlier injury may be consistent with A's reported collapse in July. Professor Al-Sarraj was clear and concise, describing the 2 different injuries supporting his conclusion that together they were powerful indicators of traumatic brain injury.

62. Mr Larizadeh QC argues that it is necessary to have a Report from a Paediatric Neuro Radiologist. As long ago as December 2017 Dr Halliday stated if there is any question of brain injury or abnormality you will need a neuro radiologist. Professor Al-Sarraj is of course a neuro pathologist. Dr Halliday did not consider such a report from such a discipline was necessary (since no neuro imaging was taken at or around the time of A's death). The mother's legal team approached Professor Stivaros, an expert well known to the Court. He was not able to offer assistance in relation to any pre-existing conditions at birth, but could review the imaging for possible birth related abnormality. The usefulness of that enquiry in the context of this case on analysis is however rather limited. Dr Halliday thought such an enquiry would be of little use. Professor Al-Sarraj considered it would be "necessary - every aspect should be explored", but I noted in particular the manner in which he gave that reply and in any event it sat in rather stark contradistinction to what he had to say in relation to genetic testing and EDS. Having reviewed his other evidence, in particular the unwavering conclusive diagnoses to the Court and in particular his underlying thesis that medical diagnosis is about connecting factors, and focusing on all the evidence together, whilst alternative causation might individually explain some, it could not explain all the injuries, either individually or collectively.

63. Of course, I am ever anxious and wary that a whole series of misdiagnoses each apparently supporting the other, could lead to the most catastrophic misdiagnosis and the wrong conclusion. But here there are so many different areas, types of injury and of different ages that I do not conclude that further investigation is justified or necessary. The unifying, underlying differential diagnosis or explanation being inflicted injury.

64. I am exhorted nonetheless in this context to review supporting evidence, the parents' and the mother's evidence in particular.

The other supporting evidence

65. I heard additionally from a number of witnesses who spoke about the mother's abilities as a mother and more generally about A. Carly Cottrell in particular (the community nurse), describing how fretful A could be, irritable, upset, not tolerating the nasogastric tube well. Lynn Dowrick, a close friend and a great support to the mother, however, described A quite differently, but importantly describing how the mother coped well with the demands upon her. She did note that the mother downplayed concerns about A and her condition to her family.

66. One of the paramedics commented on the mother's reactions when they first arrived, but I read nothing into that, people react in all manner of ways in distressing situations.

67. Whatever my view of the mother's evidence, the real question is whether it is necessary to seek further medical enquiry of the types sought by Mr Larizadeh QC. Here the expert witnesses speak unanimously from their discipline, and cumulatively, their diagnosis is 1) inflicted injury and 2) that there is no realistic alternative explanation for the constellation of injury, that further expert evidence was not necessary. The ultimate enquiry is post mortem. Professor Al-Sarraj and Professor Mangham concluded that there was no evidence of genetic or metabolic disease that would require further explanation. Within their discipline they resisted further testing. If A had a genetic disorder it had not expressed itself either in her bones or in her blood vessels.

68. Accordingly, relying on their evidence and placing it side by side with all the evidence, such further enquiry is unnecessary. I refuse both applications.

Discussion and Conclusions

69. It is appropriate to place the mother's evidence alongside that of all the medical professionals, and those who speak highly of her (for example the health professionals and Lynn Dowrick). I have already recorded the unsatisfactory nature of the mother's evidence. Self evidently the fact that the mother has no explanation for any of the injuries, let alone all of them, can hardly be evidence that it was she who caused them. Nonetheless as Mr Larizadeh QC submits (but in a different context), so much of the diagnosis is the account, the explanation; here there is none. More than that, the mother has not described a single occasion when A demonstrated pain, as the evidence suggests she would on each occasion of injury have suffered in different degrees.

70. I am deeply troubled by the picture which the mother seeks to portray of "perfect family life"; candidly, I do not believe her. I think it more likely than not that she relied upon the father, and that after 5/8/17 he simply was not there. Ultimately, I am driven to the conclusion that the mother has painted an inaccurate imaginary image of this little girl and her relationship with her.

71. In my view she has done so to quite a comprehensive degree. I weigh the evidence of those who spoke well of the mother's parenting but with a cautious perspective. In interview she told the police that A was tiny, that she was afraid to touch her, yet Ms Dowrick said something different (holding her up and throwing her in the air); the

mother ultimately endeavouring to portray A as fragile, when in truth she was not. I cannot say whether that false picture is dishonest or honestly but erroneously held through some trick of the mind.

72. The mother's idealised relationship with A was no doubt not what she anticipated; A had a close bond with the father, the mother thought that the father spoilt A.

73. Additionally, there is clear evidence that the mother struggled to accept A's health needs, she was desperate for A to "get better". Essentially I accept the father's evidence that in truth she had no patience with A, nor any real understanding of her health needs. Additionally, the mother struggled with her own mental health needs and perspectives. I remain troubled about those aspects, the mother's outlook, mental health and perspectives, which I have already recorded, none more so than on 14/15 August.

74. It is not for the Court to speculate as to why this mother would so seriously and repeatedly injured her small baby; frustration, disappointment, inability to cope, shame, tiredness, mental health problems. Each might have played a part. Nor is it appropriate to speculate as to previous occurrence; upset on July 3 might have led to the fracture, the painful leg immediately identified by the father. The stress of the father returning to work could have caused her to shake A, I do not speculate whether it was this that led to the ambulance calls on 21 and 22 July.

75. Taking the medical evidence and the mother's evidence separately and together, I am completely satisfied that the injuries which led to A's death resulted from a trajectory consequent upon the mother's actions; I find that it was she who was responsible. The mother subjected A on several occasions to emotionally and physically abusive behaviour, giving rise to pain, injury and tragically, ultimately death. I doubt that the mother intended to kill A, it being much more likely that she vented her frustration upon her. I remain troubled about an aspect which I have wrestled with, even though the evidence is clear: the mother's failure to properly intervene at all, under the patient instruction of the telephone operator. Only the mother knows what happened to A, but she knew that she was responsible; she knew that she had injured her. The mother told me that she did not think that A would die, suggesting a) a responsibility and b) that it had happened before (e.g. 21 July), but importantly she had recovered. The mother maintained that she had continued the CPR as instructed, but in evidence admitted that she had not. It is unhelpful now to speculate whether if she had, A might even so have survived.

76. Conspicuous by its absence in my review so far has been the absence of the father as potentially responsible for the early tibial fracture and the old haemorrhage in the left eye. I do not believe the local authority pursue the latter, but if they do similar considerations apply, as to the leg. There is overwhelming evidence having regard to my findings in relation to the mother being responsible for both; it seems inherently unlikely that A would have sustained two leg injuries on separate occasions, one from each parent (the father clearly could not be responsible for the later fracture, or all the other later injuries, or to the eyes). Whilst such a situation is not impossible, it is highly unlikely. I do not consider here that there is, or could be, active collusion between the parents, or two perpetrators of abusive conduct.

77. The mother was usually alone with the children, the father not. The earlier fracture was identified by the father, he sought with a degree of determination to seek medical assistance. It is unlikely (though not impossible) that he would have done so had he been responsible. (I note here the mother's responses at the time which are much more likely to denote responsibility).

78. Similar points can be made in relation to the bleeding and multiple retinal haemorrhages, themselves similar to the older injuries – there is here a pattern which save for the first, demonstrably have nothing to do with the father.

79. Whilst the local authority do not vigorously maintain that the father could be responsible, they do assert that the father displayed a serious failure to protect A from serious emotional harm and physical neglect. He was taken at length through the contended aspects, the mother being "detached", a lack of patience when feeding, gritting her teeth when caring for her, shouting at her and physical remonstrations – tapping her bottom, seizing her face and cheek, or forcing her head backwards. The father described or tried to put into context these behaviours. In black and white, and with the benefit of hindsight, they portray a worrying picture. It is said that he failed to take reasonable steps to protect the children.

80. A was only cared for at home for just over 3 months. The worrying behaviours came to the father's attention during the last weeks. The mother had a lot on her plate. She was obviously mostly affectionate and behaved appropriately as well as on occasion being frustrated. There was a raft of professional involvement and support. The father (I accept his evidence on this point) did try to get the mother to be more patient and understanding.

81. Families go through difficult times. The parents are traditional in outlook and understanding, and were unlikely to lay themselves and their relationship bare, until it became obvious that the relationship was in crisis, even so the father in my view was entitled to hope and believe that the very great raft of professional support would help the mother and her relationship with A. I accept the father's evidence. I do not think that his failure to report his concerns begins to meet the s31 threshold triggers, nor do I think that there was an element of failure to protect the children. In the real world, intelligent adults are entitled to think that they will be able to sort out what they believe at that time to be short term problems and difficulties, without "reporting" their anxieties to others. How could the father possibly have known that the mother's covert behaviours would have led to the death of A? I do not consider either that the father's suggested passivity requires addressing. Knowing that the mother was responsible for the death of A, the father is hardly likely to put B's welfare, let alone, life, at risk.

82. Unusually, having regard to my clear perspectives of the parents' evidence, I have already ordered that B should return to the care of his father, a decision which I remain convinced was, and is, the right one.