

Case No: ZW18C00383

IN THE FAMILY COURT AT WEST LONDON

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

Date: 24/01/2019

Before :

HIS HONOUR JUDGE WILLANS

Between :

THE LONDON BOROUGH OF HILLINGDON

Applicant

- and -

(1) Mother (“the Mother”)

Respondents

(2) Father to A and B

(3) Father to C (“the Father”)

(4) Maternal Grandmother

(5) Maternal Grandfather

(6 - 8) A, B and C

**(the children through their Guardian Claudia
Poienar)**

Nylah Abbasi (instructed by **Legal Department London Borough of Hillingdon**) for the
Applicant

Judith Pepper (instructed by **IBB Solicitors**) for the **First Respondent**

The Second Respondent was neither present nor represented at the hearing

Christopher Poole (instructed by **Nicholls Christie & Crocker**) for the **Third Respondent**

Jitender Birah (instructed by **Duncan Lewis & Co**) for the **Fourth and Fifth Respondents**

Gill Honeyman (instructed by **Lovell Chohan Solicitors**) for the **sixth to Eighth Respondents**

Hearing dates: 16 (Reading Day), 18, 21, 22-24 January 2019

JUDGMENT

HIS HONOUR JUDGE WILLANS :

A. Introduction

1. This hearing arises within care proceedings brought by the London Borough of Hillingdon begun on 26 July 2018 in which they seek findings of fact against

the parents of C. C's half-siblings' A and B are also subject to the proceedings but no specific findings are sought in their regard. Their father has played no part in the proceedings and no allegations are raised against him. Further to earlier order of the Court the three children are currently in the care of the maternal grandparents who are also party to the proceedings.

2. The central allegation relates to C suffering a significant brain injury on 24 July 2018 with resulting sight damage and consequential disability. At this time his future is uncertain. In addition, I am asked to investigate 3 marks identified on C's body at a time shortly prior to 26 June 2018. These marks have had no lasting effect on C.
3. I heard live evidence from Dr Cartlidge (Consultant Paediatrician: Single Joint Expert); Dr Govinden (treating consultant paediatrician in respect of the marks); C's mother and C's father. I also considered the papers in the extensive hearing bundle and I note the written evidence from: Dr Stoodley (Consultant Neuro-Radiologist); Mr Newman (Consultant Paediatric Ophthalmologist); Mr Jayamohan (Paediatric Neurosurgeon) ~ all single joint experts. Further to the above I also considered the written and oral submissions from counsel for each party. I have taken all this information into account in reaching my decision.
4. The local authority allege that *(1) On 24 July 2018 C was admitted to hospital with seizures and apnoeic episodes; (2) a CT scan revealed a bilateral subdural haemorrhage; (3) after examination C was found to have retinal haemorrhages to the right eye and intra retinal haemorrhages to the left eye; (4) the retinal haemorrhages are consistent with having occurred at or around the time C became unwell resulting in his admission to hospital; (5) the retinal haemorrhages are consistent with a shaking type injury (NAI); (6) the subdural haemorrhage is consistent with a shaking injury (NAI); (7) either C's mother or father caused C to suffer the haemorrhages at (5) and (6) above and the extensive hypoxic-ischaemic brain injury at (9) below by shaking him on or before 24 July 2018; (8) Before 26 June 2018 C was handled inappropriately/roughly by either his mother or father causing him to sustain the following bruises: (a) 20mm by 5mm horizontal purple mark on front left shoulder; (b) 30mm horizontal purple mark just below the umbilicus; (c) linear mark to posterior aspect of right upper arm; (9) C has suffered an extensive hypoxic-ischaemic brain injury¹.*
5. It is conceded by the parents that the brain injury and haemorrhages result from a shaking injury. The key issue before me has been as to the circumstances surrounding the incident and the likely mechanism in respect of the shaking. The question of whether the marks are bruises and arise from poor or neglectful parenting is in dispute.

B. Legal Principles

¹ Note this extrapolation of the threshold is based on the local authority's position at start of hearing. I have for reasons which I explained in Court joined the causative allegation (re haemorrhages and brain injury) under one allegation

6. This hearing is a fact-finding hearing in which I am asked to determine the truth or otherwise of the allegations set out at paragraph 4 above. The following points are therefore of relevance:
- i) The burden of proof lies at all times with the local authority. The standard of proof being the ordinary balance of probabilities (“more likely than not”). Neither the father nor mother bear an evidential burden to disprove the allegations.
 - ii) Findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence but not on suspicion or speculation. I must take into account all the evidence and consider each piece of evidence in the context of all the evidence. In doing so I survey a wide canvas and carry out an overview of the totality of the evidence in order to conclude whether the case put forward by the local authority has been made to the appropriate standard of proof. In carrying out this assessment the evidence of the parents and other carers is of the utmost importance and it is essential for me to form a clear assessment of their credibility and reliability. In assessing such credibility and reliability I will have regard to their demeanour in Court but will caution myself as to the probative value of the same²
 - iii) I have regard to the fact that it is common for witnesses to tell lies in the course of any investigation and during the hearing. I must be careful in the approach I take to any finding as to lies. I must bear in mind that a witness may lie for a multitude of reasons and it is important to consider such lies in the context of the prevailing circumstances. I should not

² Sri Lanka v The Secretary of State for the Home Department [2018] EWCA Civ 1391 per Leggatt LJ at 41:

No doubt it is impossible, and perhaps undesirable, to ignore altogether the impression created by the demeanour of a witness giving evidence. But to attach any significant weight to such impressions in assessing credibility risks making judgments which at best have no rational basis and at worst reflect conscious or unconscious biases and prejudices. One of the most important qualities expected of a judge is that they will strive to avoid being influenced by personal biases and prejudices in their decision-making. That requires eschewing judgments based on the appearance of a witness or on their tone, manner or other aspects of their behaviour in answering questions. Rather than attempting to assess whether testimony is truthful from the manner in which it is given, the only objective and reliable approach is to focus on the content of the testimony and to consider whether it is consistent with other evidence (including evidence of what the witness has said on other occasions) and with known or probable facts.

reach the conclusion that just because that witness has lied about one matter then they should be viewed as being incredible more generally.

- iv) I bear in mind that with repeated accounts of an event discrepancies and contradictions may arise. This may be due to an inherent falsehood in the account but I must also have regard to the potential for inaccuracy to flow from faulty recollection or contamination from other sources. I am mindful of the observations that with time and repeated telling a witness may naturally seek to iron out wrinkles in an account³.
- v) Expert evidence must be viewed against the broad canvas of all the relevant evidence before the Court. It *“has to be carefully analysed, fitted into the factual matrix and measured against assessments of witness credibility”*⁴. Ultimately, I must bear in mind the expert advises, the Court decides.
- vi) It is acceptable for a Court to reach a conclusion that a medical condition or presentation has an unknown cause. I bear in mind that scientific understanding changes and today’s medical certainty may be discarded later as research shines light into current areas of darkness⁵. It is open to me having assessed the totality of evidence to reach a conclusion which does not accord with the conclusion reached by the medical experts. However, if I am to reject medical evidence I must have a sound basis upon which to do so and I must explain why the medical advice is being rejected⁶.
- vii) In approaching the balance of probabilities, I must apply common sense. I am entitled to have regard to the inherent probabilities of an event or incident but this does not change the standard of proof. The standard is fixed and does not move having regard to the seriousness of the allegation.
- viii) It is in the public interest that those who cause non-accidental injuries to children are identified but I should strain the evidence to identify on the balance of probabilities the individual who inflicted the injuries. If identification is not possible the court should reach that conclusion and the consequence may be of a finding that more than one individual falls within a pool of perpetrators on the basis that the Court can be satisfied that one of the individuals likely caused the harm but none of the group can be excluded as the likely perpetrator.
- ix) I further take into account the additional legal principles and authorities referred to by counsel for the father and guardian within their written submissions.

C. Background

³ Lancashire County Council v The Children [2014] EWHC 3 Fam per Peter Jackson J (at 9)

⁴ Wall LJ in *Webster v Norfolk County Council* [2009] 1 FLR 1378

⁵ Re U (A Child) (Serious Injury: Standard of Proof); Re B (A Child) [2004] EWCA Civ 567

⁶ Re M-W (Care proceedings: Expert Evidence) [2010] EWCA Civ 12

7. C has two older half-siblings. Their father plays no role in these proceedings and his current whereabouts are unknown. He forms no part of my fact-finding investigation. Within this judgment I refer to C's parents as 'the mother' and 'the father'. No discourtesy is intended.
8. The parent's pre-relationship history is referred to within the statement evidence. There is nothing of concerning relevance to note. They met in early 2016 and whilst they have maintained separate homes the evidence suggests a positive relationship in which the father has a valuable role in the lives of all the children. There is no suggestion of issues with drink or drugs and no report of domestic violence or problematic mental health.
9. Evidence suggests the children were receiving a good level of care. The older siblings are reported to be polite, eating a healthy diet and engaged in creative activities rather than interested in television. Prior to June 2016 neither the parents nor the children had come to the attention of the local authority. Indeed, the local authority chronology commences in June 2018.
10. On 24 July 2018 C was aged 8 weeks. In the preceding weeks the parents had sought and received support for medical issues unrelated to this hearing. Health visitor engagement indicated a warm and affectionate developing bond between the parents and the child.
11. On 26 June 2018 C was admitted to A&E in relation to a range of marks on his body. These marks comprise allegation 8 (paragraph 4 above). I intend to detail the evidence relating to these issues at section D below. On 28 June 2018 C was discharged into the care of his parents and no further action was deemed necessary.
12. On 23 July 2018 C received his 8-week vaccinations⁷.
13. On 24 July 2018 at 0510 hours the London Ambulance Service was called by the father as a result of concerns around C's presentation. He was subsequently transferred to A&E. The circumstances of this date comprise allegations 1-7 and 9 (paragraph 4). I intend to detail the evidence relating to these issues at section E below.
14. On 24 July 2018 the half-siblings were taken into emergency police protection. On 26 July 2018 the local authority issued its application in the light of the matters set out above. The mother agreed to the sibling's section 20 accommodation and both parents agreed to contact restrictions in respect of C. An interim care order was not sought. Her Honour Judge Rowe QC provided case management directions towards CMH including a requirement for the parents to file statement evidence relating to the period prior to hospital admission. I also note a direction relating to a case note associated with an allegation made against the father by one of the other children⁸.

⁷ Diphtheria, hepatitis B, Hib, Polio, Tetanus, Whooping Cough, PCV, RV, and Men B: G1752

⁸ This point has not been developed within the proceedings. Having read the social work evidence and the note it appears to have no relevance to the issues before me.

15. The case came before me for case management on 17 August 2018 since which time there has been judicial continuity. At CMH I gave extensive directions including the expert instruction in the case⁹. I determined the half-siblings should be placed with the maternal grandparents under a child arrangements order with a supporting interim supervision order. On 18 September 2018 I held a directions appointment at the conclusion of which I endorsed the placement of C into the care of his maternal grandparents. All the children continue to reside with their grandparents at the date of this hearing. I have received no reports suggesting this has been anything other than a positive placement. On 10 January 2019 I held a pre-trial review which confirmed this hearing.

D. June 2018: ‘Bruises’

16. The mother reports¹⁰ noticing a mark at the back of C’s arm on 19 or 20 June 2018. She appears to have put it down to his arm being trapped between slats to the side of his cot. Whilst this mark was photographed it was not present on admission to hospital and so the only evidence relating to it is that of the parents and the photograph. She tells me about a week later her own mother noticed a mark on C’s tummy when changing him and so they decided to check him over. In the course of doing so they noted a mark by his armpit and a faint mark on his back. As a result, the mother called her GP and was advised to go to hospital. She took photographs of the marks and these are attached to her statement.
17. On admission to hospital the mother spoke to the paediatric registrar and is reported as commenting that she thought the marks might be associated with the way the child had been held¹¹. In a separate meeting the father suggested marking might relate to winding or the child being held too firmly. Thereafter the case was handled by Dr Govinden who took part in a multi-agency strategy meeting. The documents report the following: It was felt the marks were *‘pressure marks rather than bruising per se’* – due to the marks fading quickly; the meeting entertained the cot explanation and also considered the suggestion (made by the mother) that as C was a wriggly baby and that is how *‘she’* may have caused the marks to his arm; the nappy area mark *‘could feasibly been (sic) caused by an overly tight nappy’*; it was considered possible the marks to the chest and back may have related to the manner in which C was held; there was consideration as to whether one of the older siblings may have mishandled the child¹². In conclusion it was felt there was not enough evidence to suggest the marks were caused by a non-accidental injury¹³.
18. Dr Govinden has provided a letter report¹⁴ in which he refers to the marks as bruise-like lesions and to his impression that they were not consistent with bruises and that C was discharged into the care of his parents in the light of the surrounding circumstances even though there was *‘no clear explanation for the marks’*. Dr Govinden reports reviewing the situation on 19 July 2018 when C

⁹ B87

¹⁰ C28 ~ the hearing proceeded on the basis of a colour photograph attached to an email including Dr Cartledge’s addendum report

¹¹ F2

¹² F7-12;

¹³ F30

¹⁴ G10: 3 August 2018

was admitted for an unrelated ear infection. He records the mother reporting marking on C as a result of the wrist band applied on the previous occasion and a bruise like mark following his having been held by staff for a procedure on admission. In a letter dated 25 July 2018¹⁵ he refers to the marks as ‘*unexplained bruises*’ and he wondered whether C had ‘*very sensitive skin*’. He signed off by reporting he was not concerned about the bruises.

19. I find a body map of the marks at G123-4.
20. Prior to his placement with the maternal grandparents C was seen at hospital. On that occasion the mother expressed concern as to a red linear mark to the front of C’s lower leg. She felt this mark bore similarity to those seen in June 2018. A photograph was taken¹⁶.
21. The expert evidence in this case on this subject is provided by Dr Cartlidge¹⁷. Summarising his views, he advises: ‘*I think that the...purple marks were bruises and they were caused by excessively rough handling*’. In the body of his report Dr Cartlidge comments that he has seen the mark identified in September 2018 but does not think it looks like a bruise. At paragraph 4.3. the expert sets out his reasoning in respect of the marks. He notes the initial ambiguity as to whether the marks were viewed as being bruises or not. He expresses his position as being hampered by not having access to coloured photographs. He points to the fact of investigations as probative of bruising. He discounts ink marking as an alternative explanation and concludes that Dr Govinden was not certain the lesions were bruises but in his judgment, they were very likely bruises. He then considers timing and concludes that whilst there is a basis for concluding some of the marks have signs consistent with being less than 48 hours old it cannot be excluded that all are older in age. He then turns to causation and concludes the likely cause to be excessive rough handling.
22. On 14 January 2019 Dr Cartlidge reviewed his position in the light of colour photographs, in particular relating to the mark below the umbilicus (picture 1 / allegation 8(b) above: C33); mark to the posterior of right arm (picture 2 / allegation 8(c): C34); mark to anterior aspect of the right shoulder (picture 3 / allegation 8(a): C35). He also confirmed he had seen the colour photographs relating to the September report. He observed picture 1 and 3 was consistent with a bruise and 2 typical of a bruise. His opinion was that picture 1 had possible explanations but on balance was likely a bruise. He felt picture 2 was a bruise and picture 3 was almost certainly a bruise. His conclusions remained unchanged.
23. I would conclude this part of the history by noting precautionary skeletal surveys were undertaken and showed nothing of concern. A retinal survey was also undertaken and showed no concerns.

E. 24 July 2018: ‘Brain Injury’

¹⁵ G884

¹⁶ C42

¹⁷ E122

24. The pre-admission evidence comes from the mother and father who provide an internally consistent account of the short period prior to the calling of the London Ambulance service.
25. The mother reports¹⁸ C responding poorly to his immunisations, he had a temperature, would not settle and was distressed. As a result, she asked the father to stay the night to help. That evening she remained awake with C until about 0200 hours as he wouldn't settle and appeared to be in pain. However, after a bottle he settled and fell asleep (around 0130 hours) following which the mother placed him in his cot and went to sleep. Her next recollection is being woken by the father in a panic. The mother's account is supplemented in her police interview¹⁹ which gives a substantially consistent account of the events of the evening. I note some further details such as the mother being woken by the father taking C downstairs. I also note she comments on being woken by the sound of the father running up the stairs.
26. The father reports²⁰ it was his turn to get up and deal with night feeds and he was attuned to C's movements. He awoke at about 0400hours finding C '*fidgeting*'. He picked him up in the normal way under his shoulders and took him downstairs cradling him on the way. C was not crying and the father took steps to prepare a bottle whilst holding C. Shortly after he attempted to feed C who would not take the bottle. The father sought to comfort him but he began coughing and then went limp showing no signs of life. The father reports running upstairs with C in a panic. He woke the mother and an ambulance was called. He thinks this was about 0445hours. In his statement the father reports C only took two drops of Infacol (a medicine used for wind/colic) prior to the crisis. In his police interview²¹ the father describes C fidgeting as a sign he wants to be fed. He then gave an account in line with that set out above before continuing: '*then he started coughing or choking and then he just went – he went limp. I wasn't sure why, so I left him for about 5 or 10 seconds and then I realised something was seriously wrong and then I went upstairs and woke [the mother]*'. Later in the interview he describes panicking and running upstairs.
27. The father has produced a recent (second) statement in which he details his reaction to the child going limp. He comments that '*he probably went up the stairs two or three at a time but I cannot now say how I was holding him then. I would have hoped I would have had him with his head supported...but I cannot honestly remember...I do not think I would have run up the stairs holding him under the arms...but I cannot say for sure*'.
28. The parents do not seek to challenge the essential medical evidence in this case as to what physical harm has been suffered by C and so I will not burden this judgment with a detailed exposition in such regard. Instead I will highlight the agreed expert evidence.

¹⁸ C25

¹⁹ H98

²⁰ C38

²¹ H54

29. Mr Newman²² notes the history of no retinal haemorrhage when assessed in late June 2018. On 26 July 2018 extensive haemorrhagic retinopathy was found on the right eye and a few intra retinal haemorrhages on the left eye. Having carried out an extensive consideration of a range of possible explanations he concluded the haemorrhages were most consistent with having occurred at or around the time C became unwell resulting in his admission to hospital and that the eye findings remain unexplained and are most consistent with a shaking type injury. The required shaking action would be considered as obviously dangerous and inappropriate by an independent observer although the actual cause and the minimal forces required to generate retinal haemorrhages is not known. Dealing with likely forces the expert observes that *'once the threshold for injury has been reached, and this value is unknown, it is not possible to then say that increasing amounts of retinal haemorrhage is associated with more severe trauma or that fewer retinal haemorrhages means that there has been less'* before commenting that the extent of injury here suggests the force was at the upper end of the spectrum.
30. Subsequently the expert has been asked to comment as to whether the explanation of running up the stairs may have caused the retinal damage. He felt this was very unlikely. Although holding upright whilst running up the stairs may cause a repetitive movement of the unsupported head through the midline this is unlikely as the head is likely to flop either forwards or backwards due to its weight thus preventing additional backwards and forwards motion. He recommended Dr Cartlidge be asked about this as the paediatric expert and noted that he was not himself an expert in biomechanics.
31. Dr Stoodley²³ agrees that the absolute degree of force required to produce any or all of the features attributed to an abusive head trauma is not known but it is safe to conclude that the minimum degree of force required is likely to be such that an independent witness would regard it as obviously inappropriate. Further the causative event is likely to have occurred after the last time that the Court can find the child was behaving within the bounds of normality. The 'perpetrator' would be likely to realise that the change in behaviour arose out of their actions but a non-present carer who had not witnessed the causative event would not necessarily ascribe the change to a traumatic event. The radiological evidence was all explicable on the basis of being due to an episode of abusive head trauma. The mechanism was likely to be shaking (with a repetitive backwards and forwards motion alternating rapidly between full extension and flexion).
32. When asked to comment on the stairs 'explanation' Dr Stoodley did not accept that such injuries could be caused by being held whilst an adult run up the stairs. If this were the case then such injuries would be *'even more common than they are!'*. The expert also pointed to evidence of the neurological changes in behaviour occurring in advance of the child being taken upstairs and thus a trigger for this action rather than the cause of the behaviour.

²² 26 October 2018 [E65]

²³ 2 November 2018 [E69]

33. Mr Jayamohan²⁴ concludes *‘that the entire combination of findings in this case of bilateral acute subdural and acute subarachnoid blood and acute subdural effusion, severe hypoxic ischaemic injury to the brain, clear evidence of abnormal neurological function or encephalopathy would really only be explainable by a traumatic event’* and is likely to have been caused by a shaking injury. An impact would not be required, however whilst the level of force required cannot be stated with precision it would be outside the range of normal handling and of a level where an objective bystander would step in. As to timing matters the symptoms are consistent with an acute collapse with there not being a period of normality post-injury and prior to collapse.
34. The expert did not change his opinion in light of the explanation given as to mounting the stairs.
35. Dr Cartlidge²⁵ concluded C would have been unwell immediately after the causal event. He noted the level of force required to cause such injury is not known but given such injuries are not sustained during normal handling it is appropriate to conclude that the forces would be obviously excessive to a normally competent and responsible person. As to causation he considered the most likely cause was shaking with or without impact. As with other expert evidence in the case he carried out an extensive consideration of other options prior to reaching this conclusion.
36. Importantly²⁶ in considering the possibility of ‘accident’ Dr Cartlidge considered the history given by the father of running up the stairs in a panic when holding C. He felt consideration needed to be given to a scenario under which C had experienced an ‘Apparent Life-Threatening Event’ (ALTE) consequent upon which the father panicked and inadvertently caused C’s head to move around to an alarming degree whilst mounting the stairs. This led the expert to seek further information from the father as to how he carried C when mounting the stairs. In turn this has led each of the experts to comment on the explanation given ~ as noted above.
37. Having received the father’s response (see paragraph 27 above) he confirmed his conclusions remained unchanged.

F. Assessment of witnesses

38. I remind myself as to footnote [2] above.
39. Bearing this in mind I reached the following conclusions with respect to the witnesses:
- i) I found Dr Cartlidge an impressive witness. There can be no doubt he has a high level of expertise and experience in his field and as such his evidence deserves real respect. I found him to be a balanced and fair witness who was able and willing to consider all options without any sense of dogma. In the course of his evidence he demonstrated the ability

²⁴ 21 May 2018 [E88]

²⁵ 2 December 2018 [E122]

²⁶ E143

to reconsider provisional conclusions and adapted his views in the light of further argument. He dealt with all points in a measured and appropriate manner. There were no issues which he left unanswered. He appropriately identified the constraints of his expertise. I will develop his live evidence below. He was a very helpful witness and I am grateful for his assistance.

- ii) Dr Govinden ultimately came close to full agreement with Dr Cartlidge and as such there is little for me to say. Importantly he conceded his initial views required reconsideration and he explained how he had developed his understanding in the light of the case. As with Dr Cartlidge this suggested to me he was a sensible witness who was willing to follow the evidence to a natural conclusion rather than allowing personal pride or position to obscure the truth. It is important for me to note the fact that Dr Govinden was operating at a time of developing understanding of the facts. The landscape of understanding was in flux. This stands in stark contrast to the opportunity given to Dr Cartlidge to reflect on the settled evidence. To an extent this is a luxury available to a Court appointed expert, although the Court expert is consequently limited to the information gathered at the time of investigation. Furthermore, it is important to note the fact that whereas there was the appearance of disagreement between the experts as to whether marks were bruises or not, ultimately Dr Cartlidge did not suggest the ultimate outcome ~ C being released into the care of his parents ~ was inappropriate.
- iii) By the time of giving evidence the mother was no longer in the full headlight insofar as potential perpetration was concerned. My sense was of a parent who remained devastated by what had happened and who wanted to know the truth for her own sake of mind. My assessment was of a wholly genuine individual who was searching for the truth. She was appropriately and understandably emotional in the course of her evidence. I considered her approach to the father with care to seek to ascertain whether she was in any way crafting her evidence with an ulterior purpose. I found no evidence of the same or of collusion. Her evidence by reference to both the statement and police evidence was consistent and I perceived no areas in which she appeared to modify her evidence such as to call into question her credibility. I formed the clear impression that this was a parent who was not seeking to shield her former partner, to the contrary I formed the view that she would have likely informed the Court of all she knew whether or not this improved the father's case.
- iv) The father was the last witness. During the process of these proceedings I had developed a sense that he was somewhat lacking in emotion. The police made the same point in interview. However, having seen him give evidence I have modified my view. My sense is that he is naturally a person who does not wear his emotions on his sleeve and this process, including the logic of the allegations, has added to this. In the witness box it was clear he is emotionally scarred by the events and the fallout

from the events of July 2018. Counsel described him as being ‘*haunted*’ by these events ~ I would not disagree. As regards his evidence he was consistent ~ with some modest and wholly unsurprising differences ~ in his account. He was unwilling to speculate or adapt his evidence to make his case comparatively easier. I will ultimately have to consider what I make of this. But, he was not a witness who left me with an abiding lack of confidence as to his evidence.

G. Summary of live evidence

40. I will pick out the key evidence.
41. Dr Cartlidge agreed the person best able to comment on a mark would be the hands on clinician who can take account of all the clinical features. Having initially concluded the three marks were all bruises he developed his thinking. In relation to the mark near the umbilicus he was balancing the absence of a history suggesting accidental abrasion (caused by a nappy adhesive) against the appearance of the mark with an oblique shaping to the left side and a sharp division at the nappy line which supported the nappy explanation. On further reflexion he considered the absence of underlying bony tissue as being less supportive of a bruise as he would have expected the skin to flex. In his evidence he indicated he was moving in the direction of the nappy explanation rather than bruise. In respect of the shoulder mark he was confident this was a bruise but when questioned as to the possibility of this having been caused when the child was winded he accepted this was a possible explanation taking account of the proximity of the clavicle and the possibility the winding motion (perhaps with a little too much force) may have had the impact of pressing the tissue on the bone in a manner akin to material on an anvil. He also considered it was possible this may have occurred when a wriggly child was too forcibly gripped to prevent a loss of control. As to the mark on the rear of the arm again he felt this was bruising but again modified his view as to the likely level of force required. His conclusion was this may have been caused by somewhat heavy-handed handling in circumstances where the seam or part of the fabric of the child’s clothing had caused a crease upon which the heavy handedness was applied. He noted the linear character of the mark which did not remind him of anything in particular. He struggled with the explanation of the slat in the cot causing the injury given the force/weight the child would apply whilst lying – such an explanation would likely lead to a pressure mark which did not appear to be the case in the photograph. Ultimately, he moved from considering that the bruises would have been caused by excess rough handling which would have been obvious to any bystander to a position in which the bruises were likely caused by non-abusive heavy handling which may have been un-noteworthy to a third-party present at the time. The fact the back of the arm mark disappeared without a cycle of colour change was not relevant given his opinion as to the appearance of tiny petechiae.
42. As to the head injuries he considered there were two scenarios. Under the first there had been an inappropriate shake following which the father panicked and run up the stairs with an **already injured** child, Under the second there was a ALTE such as reflux which may have caused stiffness or floppiness with the head going back and the child going pale. This may have induced panic in the

parent and may have led to the father mounting the stairs in a manner which **caused** the injury.

43. He was clear the injury could have resulted from anything done to cause the head to move around in an alarming manner sufficient for the intra cranial injuries. He had experiences of both resuscitative shakes and parents running in a panic inducing such an injury. A state of floppiness would itself create a starting position of enhanced vulnerability given reduced muscle tone. The movement need not be simply backwards/forwards but could include sideward motion. He observed bleeding in three compartments which suggests some sideward movement but that does not rule out an inappropriate shake.
44. He felt one had to be cautious as to the quantum of movement required but it would need to be a very sharp movement of an alarming degree which would appear frightening to an observer but did not need to be significantly repeated or intentional in character. As to forces this could not be stated with confidence but would need to cross a threshold.
45. Whether running up the stairs supplied the explanation depended on the evidence as to the level of support offered to C's head. Without support, running up the stairs at 2-3 steps a time would be a dangerous situation. He made clear he was unable to comment on the biomechanics of the motion in question.
46. As to the father's explanation he commented the account of coughing might fit the colloquial description of a 'funny turn' and was consistent with reflux. It was not necessary for the child to have taken milk from the father to have had a reflux incident. This is why he felt the explanation was worthy of investigation. He was willing to accept a panicked response might lead to the head not being supported which could have caused the injuries. Absent action the situation (reflux) would likely have resolved itself but he accepted such a situation can be frightening for parents. The suggestion of coughing was not consistent with a post shake noise as such a reflexive response would be diminished by the nature of the brain injury.
47. He did not agree with Mr Stoodley's addendum observations as to likelihood. His job is to examine relatively unusual scenarios and he considered the Court should not close its mind to the unusual. In any event he was differently placed to the radiologist given his role in taking (and assessing) histories.
48. Dr Govinden explained his initial reports in the context of a developing picture. He now considered the shoulder mark to be a bruise. He would normally have conducted a glass (blanch) test but he could not remember whether he did. He did not see the mark to the back of the arm but was shown a photograph. He was concerned it was a long mark but he only had a picture. After the full strategy meeting he was less concerned it was a bruise but this is why he provided for a follow up meeting. He did wonder whether the umbilicus mark was nappy related. He did think the cot explanation was plausible. Ultimately, he agreed that whilst he did not have a clear explanation the terminology should have been bruises.

49. The mother told me she could add nothing with respect to the bruises. She had winded C in the same way as the father until he became too big for her. But that technique had worked successfully for both parents. She is an experienced parent and could add little more to the understanding with respect to the bruises.
50. She agreed the feeding circumstances were slightly unusual on 24 July as C had received a feed around 0130 hours which the father would not have expected. When she saw C, he was being cradled by his father and his limbs were completely limp. She had spoken to the father subsequently as to what happened but he had not been able to provide further details beyond that otherwise known. They are no longer in a relationship.
51. She described the father as being a 'hand's on' parent. He had been involved with the older children from when the middle child was 4-months of age. They worked as a team including night feeds. The father took responsibility that night as C was unsettled and the mother needed to get the other children up for school. The father was quite good at holding C but on occasion was slightly heavy handed but would adjust his action when told or reminded. She felt the back of the arm mark was linked to the cot as she recalls him waking up screaming with his arm trapped prior to the mark being noted.
52. On 24 July there was nothing unusual until she was woken. She could not describe exactly how C was being held when she saw him although he was in his father's arms and was floppy/lifeless. There are around 12 steps at the home. C has not previously suffered with reflux but he has a strong gag reflex. She had never seen the father act roughly or in a frustrated manner and he had never lost his temper with the other children. She did recall the sound of him running up the stairs but was pulled out of sleep. She thought C had suffered a febrile convulsion.
53. The father told me his recollection was clear about taking C downstairs and attempting to feed him. He explained the routine he followed which was wholly unexceptional. He explained an attempt to feed before C went limp. He was scared as he had never experienced anything like this. His immediate thought was to get him to the mother and he run out of the room and up the stairs. He couldn't remember how he held him and did not want to speculate. He denied doing anything to harm C and denied a deliberate unjustified shake.
54. He felt the bruises were from winding; from the cot and from the nappy. Of him and the mother he thought it likely he would have caused the bruise on the shoulder.
55. He had not been frustrated to get up that morning. This was a chance to spend time with C who he had not seen for a period due to work. He had tried to calm C as he felt he was going to start crying. It was when he attempted the dummy that C started coughing and choking. It was a sound he never wanted to hear again. At this point he was standing. C was lifeless with he thought C's head in the crease of his arm. He could not be 100% sure as to how he was holding C when mounting the stairs although he would like to think he did not move him from being protected in the cradle of his arm. He was panicked and scared and this took only a few seconds (6-8). He told me he didn't shake him when he

couldn't breathe. If he had of then he would have said this at the start '*to avoid our kids going into foster care*'. He thought something had happened when he was going up the stairs as this was the only part he could not remember. As to timing he indicated he go out of bed around '4ish'. He could not explain the timeline of a call to the ambulance at 0510 hours as it had not been this long. The father put together the various stages in seconds rather than minutes. The noise was a cough/gasp/choke sound. He didn't hit him on the back.

H. Analysis & Conclusions

56. The evidence points to the following clear findings:
- i) On 24 July 2018 C was admitted to hospital with seizures and apnoeic episodes
 - ii) On 24 July 2018 a CT scan of C revealed a bilateral subdural haemorrhage
 - iii) On 26 July 2018 after examination at the hospital C was found to have retinal haemorrhages to the right eye and intra retinal haemorrhages to the left eye
 - iv) The retinal haemorrhages are consistent with having occurred at or around the time C became unwell resulting in his admission to hospital on 24 July 2018
 - v) The retinal haemorrhages are consistent with a shaking injury
 - vi) The subdural haemorrhage is consistent with a shaking injury
 - vii) C suffered an extensive hypoxic ischaemic brain injury as a result of the events on 24 July 2018
57. I make these findings of fact as the unchallenged medical evidence provides a compelling basis in support of the same. The expert evidence in this regard is internally consistent and mutually supportive, all other plausible explanations have been ruled out with a sufficient level of confidence. Whilst one must bear in mind medical science remains surrounded by uncertainty I find it more likely than not that each of these statements are correct statements of medical fact. The parents accept the same without challenge.
58. I consider it more likely than not (indeed at a high level of probability) that these witnessed injuries were caused whilst in the care of the father. The local authority did not seek a finding against the mother and the father accepts the injuries occurred in his care. I rule out any complicit planning between the parents (either pre- or post-event). The evidence and presentation of the parents is strongly suggestive as to no complicity. The medical evidence is clear as to the likely absence of any period of normality post-injury. I accept the evidence of the father that C was acting normally in the minutes prior to his ultimate collapse. I find the injuries were occasioned after C was brought downstairs to be fed.

59. I am not satisfied in respect of the allegation relating to bruising for the following reasons:

- i) I am not satisfied the mark proximate to the umbilicus is a bruise. I accept the ultimate evidence of Dr Cartlidge in this regard. His rationale was in my judgment clear and sensible. I find the mark was likely caused by the nappy adhesive lightly abrading the skin in a similar manner to a sticking plaster might. I take into account the soft nature of the underlying tissue and the presentation of the mark which fits very comfortably with the notion of an adhesive section riding up about the nappy proper and affixing to the skin. This fits with the impression formed by Dr Govinden albeit in slightly different terms. The absence of an explanation is noted but is in my judgement of limited probative value. At worst this signifies momentary careless and no more. I cannot attribute to who this carelessness applies (mother, father or another) but that does not really matter given my finding.
- ii) I am satisfied the mark on the shoulder is a bruise. On balance I consider it is likely this was caused by the father when winding C. I accept the medical explanation given by Dr Cartlidge of tissue being pressed against bony material. It is possible this was caused when C was forcibly gripped to prevent slipping. In any event I agree this was at most somewhat rough (but non-abusive) handling but no more. I found the account of the winding process perfectly logical and reasonable. It was endorsed by the mother and I accept her evidence in this regard. In the hands of the father on this occasion it caused a wholly unintentional and modest bruise. This does not call for wider condemnation and does not evidence any trajectory towards more worrying behaviour.
- iii) As to the mark on the back of the arm I have found this the most difficult of the marks but I have reached the conclusion I am not satisfied this is on balance a bruise. I reach this conclusion with some diffidence knowing that I disagree with Dr Cartlidge in this regard. However, I have to view a broad canvas and my judgment pays particular regard to (a) the timeline explanation of the mother as to the baby being upset and the mark being noted. This is strongly probative as to cause and I accept the evidence of the mother as to a scream from C being associated with the arm being trapped. It is noteworthy no evidence as to the presence of the father at this time was put before the Court; (b) the reality that no clinician actually observed the mark in situ but was wholly reliant on photographic evidence ~ the mark having disappeared; (c) the reliance Dr Cartlidge had to place on non-professional photography to determine the mark ~ this is bound to undermine the weight I can attach to his evidence in this regard; (d) the willingness of the parents to promote consideration of this mark. Perhaps the last point matters less when I also observe that I would have gone on to reach a similar conclusion to that in the case of the shoulder had I found the mark to be a bruise. On the evidence of the expert this would likely not have been conduct that would have alerted a third party and I question whether it would necessarily have been readily apparent even to the responsible parent at

the time of infliction. Nonetheless I do not find this to be a bruise. I am not required to determine what it is. I do not know and the time for clarity has long gone.

60. I am left therefore with one bruise. In my judgment this falls far short of the test for significant harm required under section 31(2). For the avoidance of doubt had I found the mark to the back of the arm to be a bruise then I would have equally characterised it as non-abusive and resulting from somewhat heavy-handed care. Taken individually or cumulatively with the identified bruise it would not have met the test for threshold.
61. Consequent upon this finding there are no remaining findings that can be made against the mother. I reject allegation 8.
62. I therefore return to the more pressing issue of the head injuries.
63. In analysing this issue, I would first wish to caution against any pejorative use of the word ‘shaking’. On the evidence this word does not of itself lead to an attribution of moral culpability. Shaking is merely a descriptor of the motion required to cause the injury. It is easy to contemplate in the classic form of the baby being held under the armpits and shaken though the midline. However, it is clear on the evidence it would be equally applicable as a descriptor to the alternative scenario of an unsupported head being shaken whilst mounting the stairs.
64. Having considered the evidence I accept the central premise of Dr Cartlidge (and prefer this to the extent there is any expert disagreement) that:
- i) The key aspect is consideration that the motion will be at an alarming rate to an observer
 - ii) This may include flexion through the midline or lateral movement to the side
 - iii) The quantum of movement cannot be stated with precision but need not require multiple movements so long as a threshold is crossed
 - iv) Once the threshold is crossed there is limited probative value that can be gained from the extent of the injury as to the level of force.

In reaching this conclusion I pay full respect to the view of Mr Newman as to forces being ‘*at the upper end of the spectrum*’ however I find it difficult to reconcile this view with the observation made earlier in the same report that once a threshold has been crossed (the value of which is unknown) it is not then possible to associate greater damage with greater force and *vis a versa*²⁷. My understanding is Dr Cartlidge shared this caution and I favour his evidence in this regard.

65. The upshot of the above is found in the evidence of Dr Cartlidge, namely that the Court cannot rule out as implausible or inherently unlikely the scenario of

²⁷ E52

inadvertent shaking when mounting the stairs. In this regard I favour the viewpoint of Dr Cartlidge over that of Dr Stoodley in respect of the inherent unlikelihood of such injuries being caused in such manner, I gain little if any probative benefit from the suggestion that we would see more of these injuries if they could be caused by parents running up the stairs whilst holding children. The reality is, as Dr Cartlidge observed, that the Court is considering an unusual explanation. By its very nature one can expect that children aged 8 weeks are not with any regularity carried by panicking parents upstairs at the rate of 2/3 steps at a time. This being the case it is difficult to understand the evidential basis upon which this can be ruled out without further consideration. This does not mean the explanation is more likely than not.

66. A further consequence is as to the extent to which the medical evidence assists the Court in its ultimate analysis. It seems to me all the experts deferred to Dr Cartlidge. Further none of the experts claim to possess any expertise in biomechanics. Indeed, Dr Cartlidge made clear he did not. It therefore seems to me that once a scenario is capable of providing an explanation it will be for the Court to assess on the ‘broad landscape’ of the evidence what is more likely than not. I will approach the case on that basis, assisted and guided by the medical learning but ultimately having to assess the respective probabilities of each explanation.
67. At outset I agree there are three possible explanations at large. Scenario 1 is the ‘**classic shake**’ in which the father out of frustration or some other motive and without any objective justification holds and shakes C. This is the local authority case. Scenario 2 is the ‘**resuscitative shake**’ in which father responds to a crisis by shaking C in an attempt to revive him. Scenario 3 is the ‘**inadvertent shake**’ in which C’s head is shaken without any conscious consideration as the father mounts the stairs. It is conceivable scenario 2 and 3 could occur in concert as could 1, 2 and 3.
68. For the purpose of this analysis I intend to consider each in separation. In doing so I have concluded I can sufficiently discount the likelihood of the ‘resuscitative shake’ to remove it from any further consideration. I feel able to do so for the following reasons:
- i) The father was clear in his evidence as to his relative clarity as to the events prior to panicking and running up the stairs. On my assessment the shake would have preceded the race up the stairs and it is very likely the father would have remembered such an action if it occurred. There is a world of distinction between being unable to remember the detail of a panicked race up the stairs and a conscious shake.
 - ii) On my understanding of the evidence the father was sufficiently clear that he did not shake C in any way. He denied shaking C when questioned by the local authority. My overall impression of his evidence was that he not only did not recall shaking C but was confident he did not shake C.
 - iii) On balance I consider his evidence would have been different if there had been such a shake. It is more likely than not he would have told the

police when questioned contemporaneously that he shook C prior to running up the stairs. The absence of a response to the same would have fed into his panic.

- iv) Whilst I accept there is empirical evidence of parents responding to a ALTE with a resuscitative shake such evidence must give way to the actual evidence in the case.

69. In assessing the relative probability of the remaining scenarios, I have carried out a broad assessment and I note the following matters²⁸:

Supportive of the inadvertent shake / contrary to the classic shake

- a) I am urged to take into account the father's propensity for good quality care prior to the incident. It is right to say a history of violence and unregulated emotions might be said to be probative of poor care on this occasion. Of equivalent relevance is the fact that the father is described in entirely positive terms in respect of his prior care of C and the other children. Both the mother and wider family have commented on the father's calm and appropriate mood around the children. The mother said, '*he never lost his temper with the children*'. Prior to July 2018 other agencies engaged with the family spoke in a positive manner as to his warmth and attachment to the children. Of course, I have to bear in mind that even the best parent can momentarily lose their self-control. Nonetheless this is a matter of relevance.
- b) I bear in mind the manner in which the inadvertent shake explanation has developed. Counsel for the father is right to point to the absence on the part of the father of any perceived embellishment of his case as the account has gained traction. In fact, on my reading the father did not lead this scenario as his explanation for what caused the injuries. Rather it was merely part of his explanation of the events. It was Dr Cartlidge who recognised its potential relevance. However, thereafter and even when given the chance the father did not seek to develop his story to fit this scenario. He continues to say he cannot be 100% but would like to think he held C properly (and thus removing this scenario). As was said on his behalf this fits poorly with an individual who is consciously aware of what has happened and is seeking to shield himself from the truth.
- c) A related feature is the added detail given by the father as to the suggested crisis (coughing and choking). Once again this was not something by which the father sought to explain the injuries suffered. Again, it was simply his account. Yet again this had traction in the mind of the expert as to medical experience with respect to ALTE. Furthermore, details such as the coughing fitted

²⁸ I am grateful to counsel for following my request and identifying features of relevance within final written submissions

an ALTE rather than a status post shaking. My sense is the father did not detail this account with any understanding as to how this piece of the puzzle would fit the entire picture. This lends credibility to the account. A measure of this is consideration of the addendum of Dr Stoodley in which that expert points to the illogicity of the limpness proceeding the father running up the stairs. Despite this the father maintained the account only to find its inherent plausibility accepted by Dr Cartlidge.

- d) I of course bear in mind the fact that Dr Cartlidge did not reject this explanation and indeed identified his own experience of a circumstance in which comparable action caused similar damage.
- e) I have sought to apply my own understanding and common sense (without inappropriately speculating) as to the likely mechanics of running up the stairs. I do not consider it a particular aspect requiring expertise to conclude that a person running upstairs 2 to 3 steps at a time will produce substantial motion through their body which will likely directly impact on anything being held by them. By way of analogy one only has to think of a person holding a cup of water. When walking up the stairs some care has to be taken to keep the cup level and the forces to a minimum to avoid spillage. If one runs then control is lost and water spilt. Next imagine holding the cup and racing up the stairs as described. The implications for the contents of the cup are obvious. They follow from the dynamic of the body as it contracts and extends as the individual moves from stair to stair. Subject to the exact positioning of the child's head it is relatively easy to see how this poses a potential danger of shaking to a baby such as C (as explained by Dr Cartlidge). I consider this is relevant as the father gave this explanation without embellishment from the earliest opportunity. Without the opportunity to reflect it does not appear to suggest an explanation. Indeed, it seems not to have suggested an explanation to experienced experts in this case. But with time to reflect and time to balance out the options it has gained a plausibility factor. This makes it less likely a wholly constructed account. Of course, it is possible the father shook C and then panicked and run up the stairs (see evidence of Dr Cartlidge) and in giving a partial explanation (as to detail and truth) he has happened upon a possible explanation ~ albeit not the actual explanation.
- f) Assuming the father is telling the truth, there is some inherent plausibility in his account. It is plausible that a somewhat inexperienced father would panic when confronted by a lifeless child (see evidence of Dr Cartlidge) and would race upstairs to seek help from his more experienced partner.
- g) He has retained a consistent account throughout.

- h) There are no identified issues within the family such as drink, drugs or the like.
- i) There is no evidence of him being frustrated in having to get up to feed C. The evidence I have is to the contrary.
- j) There is no explanation as to why an otherwise model father would have acted in this way on this occasion.

Contrary to inadvertent shake / in support of classic shake

- k) I note counsel for the guardian identified the unanimity of expert evidence as to a shake. However, for reasons given above I consider this has little value in considering the likely scenario given all in fact involve a shaking mechanism.
- l) It is said the manner of holding C goes against the father. His case is that he was holding C in a cradled manner when downstairs prior to the crisis. It is suggested the evidence of the parents is that he was similarly holding C when he arrived in the bedroom. The father agreed he would not have sought to change C's positioning. It is therefore suggested that C's head could not have been unsupported whilst mounting the stairs and thus he could not have suffered the alarming movements in his head required to cause the injury. This point deserves consideration but I have approached it with some caution. I accept C would not have suffered his injury on the stairs if the father continued to properly cradle him throughout. But does the evidence really support this proposition? At most the submission seems based on a tenuous inference that nothing would have changed. But is this likely? If (and I say if) the father did race up the stairs it is highly unlikely he would have done so whilst cradling C with both arms. Instinctive need to balance using one of his arms would have likely kicked in to some extent. Further the simple motion of effectively jumping from stair to stair is likely to have modified the manner in which C was held. My sense is the process was either a panic in which case there is a relatively low likelihood of controlled and considered movement or it was not a panic at all. But to say he panicked whilst maintaining careful control seems a logical non-sequitur. I am frankly not assisted by the perception of the parents as to C's presentation in the arms of the father in the bedroom. Neither recalls it with clarity; the moment would have been surrounded by anxiety which would likely impact on recollection; the mother had just awoken, and; as Dr Cartlidge observed what is there to say the father did not unconsciously rearrange C in his arms on arrival upstairs?
- m) I am asked to reflect on perceived inconsistencies in timing. Put simply it is said the father times getting up to 0400 hours whereas the ambulance was called at 0510 hours and the account given by the father of the various steps comes nowhere close to filling this

period. What, it is wondered, really went on during this unfilled period? I am once again left somewhat concerned as to building a substantive case upon a tenuous foundation. The only evidence as to timing comes from the father who recalls it being about 4am when he got out of bed. He says this because he looked at his phone when he got up. He didn't keep his phone on him thereafter and at no point noted the time on the kitchen clock or microwave (assuming it had a clock telling the right time). When questioned by me he told me that he could not be confident of the exact time by reference to the minutes. In my assessment I would be very concerned to substantially build a case on such a feature. How confident can I be as to the exact timing beyond the hour based on what was a likely glimpse at a digital readout upon waking? I bear it in mind but it is plainly a piece of evidence which might support but not make a positive case.

- n) I bear in mind the absence of detail as to running up the stairs. I consider I have covered that already but as Dr Cartlidge said (and without being a psychologist) *'when you panic you don't know what you are doing'*.
- o) I bear in mind the exact noise said to have been made by C is described as a cough but may in fact not have been a cough. Also, the evidence was of C not having suffered with reflux before.
- p) The argument (supported by his own evidence) of his instinctive understanding of the need to support C's head. It can be argued that this would have kicked in with equivalent force to the instinctive manner in which the father raced up the stairs. Against this is of course the relative recent nature of this learning given C was only 8 weeks old. How instinctive would this have in fact been at this time?
- q) I bear in mind the suggested conduct of the father of separating himself from C whilst the ambulance was on the way. It is suggested this indicates perhaps a level of guilt or panic at what he had done. I have not found this of help. I don't think it actually fits with the evidence. I have read the transcript of the ambulance call²⁹ and it is plain he is in fact with the mother and C during periods of the call, i.e. when the breathing test is being administered. That he also spent time away waiting to signal the ambulance is hardly surprising.

70. My conclusions are as follows. I find the father proceeded downstairs with C as per his account. There is nothing to suggest otherwise. As to timing I consider it unwise to tie the events to shortly after 0400 hours. On balance I find it was after 0400 hours but when exactly remains unclear and for the reasons set out below does not require greater clarity.

²⁹ G1362

71. I accept the evidence of the father as to attempting to feed C unsuccessfully. In all likelihood this arose out of the fact that unbeknown to the father the mother had only shortly (0130 hours) fed C. It is likely the father misunderstood some other emotion for hunger.
72. I accept there then followed what is described by Dr Cartlidge as a ALTE. The exact nature of the event must remain uncertain but it may well have been a reflux. Having considered the evidence, I consider it most unlikely this has been invented by the father. The detail he has given together with the plausibility of the account viewed from the perspective of the expert suggests the account is on balance true.
73. I can find no basis to satisfy me that C was shaken in an angry or frustrated manner by the father. This would be inconsistent with his role as father over the last two years and is wholly out of character with his presentation throughout this period to the mother and her family. I consider I have received a fair and honest account from the mother in this regard. I consider if she had any doubts then she would have informed me of the same.
74. Whilst the medical evidence is consistent with a shake of such nature it is not consistent only with a shake of such nature. Whilst bearing in mind the potential for an out of character act I also consider this to be inherently implausible where there is an alternative plausible account consistent with historical evidence. In considering the alternative scenarios the broad canvas suggests the father's account then more plausible. I find the father panicked and responded by leaving room. I find no shake at this time. I have set out my reasoning above.
75. I find the father raced up the stairs in close to a blind panic. He had one motivation and that was to get C to his mother for help. All other considerations were secondary. I accept his account of taking multiple steps at a time. Allowing for the number of steps this was likely between 4-6 significant strides. I find with each stride there was significant movement in the father's body as he flexed and stretched leaping upwards.
76. Sadly, I find C's exact positioning was not at the forefront of the father's contemplation and his head was or quickly became unsupported. Whether this was from outset or as part of the process I cannot say. But the process of moving up the stairs produced sufficient flexion/extension and lateral movement which when applied to C caused the necessary alarming movements of his head and with sufficient force and duration to damage him as found above.
77. It seems likely the father would to some extent, and without particular thought, have modified the manner in which he held C as he was once again able to use both arms. I find he would very likely have only held C with one arm when mounting the stairs as he instinctively left one hand available to balance and guard against a fall.
78. I am therefore satisfied on balance that the father caused the injuries inadvertently rather than as a result of a deliberate or conscious shaking motion, and particularly one without any justification.

79. I do draw weight in reaching my conclusions from the manner in which understanding has developed in this case. I agree with the suggestion that the expert in fact threw the father a '*life raft*' in this case and that the father does not give the appearance of having sought to construct an alibi account from outset. It is striking in this case that the father's account is akin to planting a seed but taking no real steps to water it. This is not the conduct of an individual who is actively seeking to mislead the Court. It so happens the detail given does logically fit a plausible scenario. I consider this it neither coincidental nor the result of deliberate construction. Rather it is likely to reflect the account fitting the truth of events.
80. That leaves the question of threshold. It is clear C has suffered harm and that this harm is attributable to the care given to him by his father. The question is whether this arises out of care which the Court would not expect a reasonable parent to give C.
81. It is submitted by the local authority and endorsed by Guardian that threshold should be found to be met on the basis that a reasonable parent would not be expected to race upstairs in the manner found without giving proper regard to the need to support the child's head. The failure to so act is argued to amount to care falling below that to be expected from the reasonable parent. The parents substantially challenge the logic of this conclusion arguing that within a range of reasonable parents it cannot be said to be threshold relevant action to make such a mistake whilst in a genuine panic induced state.
82. In my judgment this is an interesting debate but one which has limited relevance given my findings below. My conclusion is that it is not appropriate to clothe the reasonable parent with perfect foresight and to remove the surrounding circumstances in which the action took place. I am asking myself how the reasonable parent would act in such circumstances. It is wholly artificial not to consider the reasonable parent as being one who is confronted by an emergency and acts in panic. To do otherwise would be to assume a wholly artificial character who did not panic at all. How would that fairly resolve the question? In my judgment there are a range of likely reasonable responses to such a scenario but amongst those is the approach taken by the father surrounded by a lack of consideration and risk management. His wholly instinctive response is in my judgment within the bands of reasonableness. Can I really conclude that no reasonable parent would have acted in an equivalent manner? The answer is no I cannot.
83. It also begs the obvious question as to what would be gained in any event by such a finding. It would open the door to the making of a public law order. However, it is plain on my findings that the same door would then be closed against a public law order given there is no finding against the mother and no grounds for intervention and there would be at most a finding of inadvertent significant harm against the father in circumstances in which I cannot conceive of any plausible continuing concern as to his capacity to have a full relationship with his son (and the children more generally subject to the views of the mother). There is no basis for believing these findings constitute grounds for continuing concern. As such a finding on threshold would have no obvious purpose or benefit.

84. This is a most sad case. I am satisfied both parents have a deep love for all the children. I have no doubt the father will continue to carry a high level of guilt as to his role in C suffering his injuries. My findings place his actions in context. My findings do not amount to criticism of him. With hindsight he made the wrong decision. Hindsight is a wonderful thing but was not available to the father that morning. This family have been torn apart by what happened but before me they have carried themselves with composure and dignity. They now need to look to the future. I can only hope this judgment permits a sense of closure and an opportunity to grasp the very real positives that remain with respect to their relationship with C. I wish both them and the children but particularly C the very best for the future.

HIS HONOUR JUDGE WILLANS
