

IN THE FAMILY COURT SITTING AT BRIGHTON

Case No: SD18C00984

William Street
Brighton
BN2 0RF

Thursday, 28th March 2019

Before:
HIS HONOUR JUDGE BEDFORD

B E T W E E N:

WEST SUSSEX COUNTY COUNCIL

and

B

MS TROY appeared on behalf of the Applicant instructed by Orbis Law
MS BHARI appeared on behalf of the First Respondent, M, instructed by Woolens Solicitors
MS EARLEY appeared on behalf of the Second Respondent, F, instructed by Helen Fitzsimons
Family Law
MR AMIN of Bosley & Co appeared on behalf of the children C, D, E and F through their
Children's Guardian Theresa Seale.

APPROVED JUDGMENT

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.

HHJ BEDFORD:

1. These proceedings concern C, who was born on [a date in] 2018 and therefore at the date of the final hearing in February of 2019 was aged nine months; D who was born on [a date in] 2010 and is therefore aged over eight years; E, born on [a date in] 2009 aged just short of 10 years; and F, born on [a date in] 2006 aged 12 and a half years.
2. The Local Authority issued proceedings in relation to the children on 7 September 2018 and applied for interim care orders. Since then the mother, during the proceedings, sought to persuade the court to enable her and the child C to return to the family home but that application was unsuccessful. Ultimately, the Local Authority sought permission to withdraw the proceedings in the circumstances which I shall go on to set out.
3. These proceedings have been allocated to myself throughout. There have been the following hearings to date. On 7 September 2018, there was a contested application for interim care orders. I made an interim care order in respect of C on the basis that the child and his mother be placed in a mother and child foster placement. The Local Authority sought the removal of the three older children and placement in foster care and I adjourned that application until 12 September.
4. On 12 September, I heard a contested interim care application in respect of the older children. The Local Authority's plan was removal but I refused that application with the result that the three older children remained at home with the father under supervision by approved family members.
5. On 9 October at a case management hearing I approved the instruction of Mr Richards, consultant paediatric neurosurgeon, Dr Carlidge, consultant paediatrician, and Dr Keenan, consultant paediatric haematologist. Unfortunately, they were unable to report swiftly and I had no option but to list the fact find hearing several months thereafter and I listed it to commence on 25 March with a time estimate of five days.
6. On 19 November 2018, the mother at a further case management hearing, sought to persuade the court to allow her to return home with C or to review the contact arrangements which were in place. I refused her application and I also refused an application made by the Local Authority which was to instruct an independent social worker whom they considered to be more culturally appropriate than the allocated social worker. I did so in the context of the family being of the view that the proposed independent social worker was no more culturally appropriate than the allocated social worker. At that hearing, I also made directions regarding viability assessments of family members and a parenting assessment.
7. As I have already indicated although this judgment is being handed down on 28 March being one of the dates allocated to the fact find hearing. I did in fact order on 6 February that the Local Authority had permission to withdraw the proceedings. It was agreed by all parties that due to the lack of judicial availability between that hearing and today my judgment would not be handed down until sometime during this week.

Background

8. There has been involvement between the Local Authority and the family at various points since 2008. Social Services were involved at that point due to reports of domestic violence made by the mother and F. The mother left the family home on two occasions according to the Local Authority chronology and in 2011 the family moved to Scotland, unexpectedly so far as Social Services were concerned, before returning to West Sussex in 2013. The most recent involvement prior to these proceedings was a period of intervention which ended in June 2016.
9. In November 2017, the children were taken into police protection due to concerns that the mother was taking them abroad for the purposes of FGM but it has transpired that that

- action appears to have been based on out of date information when in fact there were no current concerns.
10. Thus one has a situation where despite the Local Authority being aware of this family, there has been no suggestion of there being a need for the children to be cared for elsewhere until the current application was issued.
 11. On 21 August 2018, C who was then aged three months was admitted to East Surrey Hospital with head injuries. The mother reported that he had been taken out of his baby bouncer by his sister F. The mother said that she heard a bang after they had left the room and the baby was in his sister's arms. F immediately informed the mother that he had fallen from her arms. When C was picked up he was floppy at first and seemed to suffer a seizure of his upper and lower limbs for two to three minutes.
 12. Paramedics were called and were on the scene 14 minutes later. An urgent CT scan was undertaken which showed an acute subdural haemorrhage and C was admitted to the Outwood ward. Following that he underwent full safeguarding medical examinations. There was an ophthalmology examination which did not show any evidence of retinal haemorrhages and there was also a skeletal survey which did not show evidence of any fractures.
 13. The CT scan was considered by Dr Vive, a paediatric radiologist whose view was that there may have been a chronic bleed in addition to the acute subdural haemorrhage. He recommended an urgent MRI scan. Meantime, on 24 August there was a strategy meeting and it was confirmed that F had been questioned by the police and she said that she had been sitting on the second step of the stairs. She had got up and C slipped from her arms and fell down. She picked him up immediately.
 14. On the same day 24 August the MRI scan was undertaken and a specialist neuroradiological opinion was sought from Dr Rich, consultant paediatric neuroradiologist. He reported that the right parietal subdural haemorrhage seen on the CT scan of 21 August was acute and that it had arisen within approximately one week of the scan date. He also reported that the CT scan showed a subdural collection over the right cerebral hemisphere with a different appearance. The MRI scan showed subdural fluid collections over both cerebral hemispheres and in the child's spine.
 15. Dr Rich was of the view that the evidence was indicative of non-accidental injury and a second opinion in respect of the brain and spine MRI was subsequently requested from Alder Hey Children's Hospital. The Alder Hey documents are to be found in section R of the bundle. The report comes from Dr Landes and is dated 7 September 2018. It confirms that Dr Landes has carried out a review of the skeletal survey and confirms that the neuroimaging had already been reported on by Dr Rich.
 16. Dr Landes goes on to comment that, 'The long bone metaphyses appear rather splayed and a little irregular suggestive of rickets. No other skeletal abnormality has been identified. No acute or healing fractures have been identified in particular there is no evidence of healing rib fractures'. I mention that report at this stage because it raises the suggestion of rickets. As I will comment in due course, there appears to be an absence of a reaction by the treating doctors to the mention of rickets. This report was dated 7 September 2018 yet only became available or was made available to the parties following a specific order for disclosure. In my judgment in the interests of transparency and in the interests of seeking to identify the true cause of this child's presentation the question of rickets should have received more attention and been given more publicity at the time that report was received.
 17. There was a further strategy meeting on 30 August when Dr Katta, who is the consultant paediatrician who carried out the child protection medical report which appears at G1 and is dated 31 August 2018, advised that the MRI scan showed evidence of older bleeding on C's

- brain and spine which was suspicious for non-accidental injury. It was noted at that time that no concerns were observed in respect of the parents' interactions and C on the ward.
18. In passing, I comment at this point that this document was significant in directing the court's attention to the possibility of an older bleed on the brain and on the spine as well as the acute bleed. This meant that at that stage in the proceedings the Local Authority and the court were working in the context of evidence which suggested that even if the account given by the family for the injury which had led to C's admission to hospital were genuine and accurate as to causation there was an earlier incident or incidents which had led to older bleeding in the brain and the spine.
 19. On 31 August, a written safety plan was agreed. It was that the mother and C would remain in hospital with 24/7 supervision whilst the older children remained in the care of their father but also under the supervision of the father's adult son. In the meantime, specialist opinion was sought in respect of C's blood tests. Dr Thomas a paediatric haematologist considered additional clotting tests carried out and found them to be within acceptable limits and not indicative of a bleeding disorder.
 20. C was found to have low calcium and vitamin D levels. I have already indicated that ultimately the haematology aspect of this case has been looked at by an independent expert. There was a repeat skeletal survey undertaken on 5 September which did not reveal any evidence of fractures. Child protection medicals were undertaken in respect of the other children on 31 August and no concerns were raised.
 21. On 6 September, it is said by the Local Authority, the father brought the children to the hospital with the stated intention of abandoning them there. It is said by the Local Authority that the supervisor who should have been present with the father was not present and that the children were exposed to the father's anger and conversations in respect of abandoning them. Further, they were heard by the social worker to be distressed. The father has a different view of the events of that day and I am not asked to make any findings and I certainly do not do so.
 22. It is relevant to note that the school attended by E and D have no concerns and that the children were working at an age-related attainment with the parents reported to have a good relationship with the school.
 23. I also note that throughout the proceedings the older children have expressed their wish to remain in the care of their parents.
 24. Pausing at this stage, I have already mentioned that I refused the Local Authority's application for the older children to be removed from the care of the father. As is obvious from my decision, I was of the view that such a change was not proportionate and was not in the welfare of each of those children. In my view, the Local Authority had not taken the opportunity to have a sufficiently in-depth look at the arrangements which the wider family could offer. Those arrangements which ultimately held good and enabled these children to have the trauma experienced by them limited to having their mother and younger sibling living away from them whilst at the same time not being removed into foster care.
 25. Turning to the position of the medical evidence at September 2018 the clinical opinions were set out in two reports of Dr Katta the consultant paediatrician dated 31 August and 7 September. In the report of 7 September, Dr Katta stated that, 'At this stage, the chronic subdural bleed noted in C's brain and spine remains unexplained. Non-accidental injury should be considered highly likely as per the MRI report'. The results of the testing for the glutaric aciduria type 1 were received in September and confirmed that there was no evidence to support a diagnosis of the same.
 26. The Local Authority arranged for the mother and child to remain together and so it has been that during the proceedings the mother and child spent their time in a mother and baby

placement with contact with the other children being supervised. As I have already indicated, the court commissioned expert reports which were duly filed during January 2019.

27. Mr Peter Richards, consultant paediatric neurosurgeon, filed his report on 19 January 2019. His opinion is found at page E55 in the bundle and paragraph 2 of his report. I shall set out his conclusion first before returning to the body of his opinion. His conclusion is as follows:

‘In summary, therefore, I consider this to be a difficult case. It involves a very transient encephalopathy following a fall that was not witnessed by an adult, the details of which are not clear in the documentation.

No neurological sequelae resulted from this event but investigation identified some features that are associated with non-accidental, inflicted shaking injuries but also a number of vulnerabilities in terms of a deficient blood clotting factor and a mild change in the subarachnoid spaces.

It would therefore be a case that would be worthy of multidisciplinary discussion involving paediatricians, paediatric haematologists and paediatric neuroradiologists’.

28. In order to understand how Mr Richards comes to that conclusion it is important to have in mind in its entirety his opinion which starts at paragraph 2.1 and which I shall therefore set out verbatim. In my judgment, it is necessary to do so in order to understand how one comes to the conclusion that the Local Authority is right to apply to withdraw these proceedings and the court is right to grant that application.

29. Mr Richards says as follows, paragraph 2.1:

‘Against the background of apparent good health, C was involved in an event which was not witnessed by an adult that as speculated involved him being dropped a short distance, following which he had an acute short-lived change in his neurological behaviour which had resolved by the time the emergency services attended. In hospital he remained clinically well, the only abnormality being a head circumference at the upper limit of normal which had increased from the 75th centile to the 99th centile since birth. Specialist neuroradiological investigation found fresh blood over both cerebral hemispheres along with fluid which may represent either a chronic subdural haematoma or acute traumatic effusion and some spinal subdural blood. A mild deficiency of clotting factor VII has been identified along with low vitamin D levels’.

30. Paragraph 2.2:

‘This is a slightly complex case. There is documentation of an injury, although not witnessed by an adult, in which it is speculated that there was a low level fall with C possibly being grabbed during it by a 12-year-old. There is no clinical or radiological evidence of impact from this event. Following this event, there was, as described by Mother, a very short episode where he was described as unconscious, which had recovered almost completely by the time the emergency services attended and was recovered completely on arrival in hospital and remained that way. This could be a short-lived episode of encephalopathy, encephalopathy being the general term describing impaired neurological function. Whether this was a seizure or not cannot be determined on the basis of the documentation but

whatever it is, it was short-term with rapid recovery’.

31. Paragraph 2.3:

‘On the basis of the neuroradiological investigations, the possibility of non-accidental inflicted injury has been considered. There was fresh subdural blood radiologically, fluid which may represent chronic subdural haematoma or acute traumatic effusion and spinal subdural blood. These are all radiological features associated with non-accidental inflicted head injury, particularly of this shape and variety, and they are generally thought not to occur as a result of low level falls, which is current radiological mainstream opinion. I have no disagreement with this view and would agree that in those infants whom are imaged following low level falls the presence of fresh subdural blood, fluid which may represent chronic subdural haematoma or acute traumatic effusion and spinal subdural blood is rare, whereas it is more common in infants who have been subject to non-accidental inflicted head injuries of this shape and type. However, it has to be appreciated that the majority of infants who suffer low level falls never get imaged because they were clinically well. From a neurosurgical perspective, in those infants who are imaged the findings in this case are unusual for a low level fall, we don’t know whether these findings are more common in infants who appear well following a low level fall. It used to be said that birth never caused subdural bleeding except in rare catastrophic cases, but research projects which imaged well infants after birth identified that subdural bleeding was much more common than believed. I have no idea whether this would apply to low level falls if similar research projects were carried out. On current technology, because of the need for sedation or general anaesthetic, such research project is unlikely to be carried out. I as a neurosurgeon therefore I’m not sure whether low level falls cannot cause the changes identified in C for I have no data that allows me to say that these changes can be caused by a low level fall’.

32. Paragraph 2.4:

‘Ophthalmic investigations and skeletal survey have identified no other features associated with non-accidental inflicted head injuries’.

33. Paragraph 2.5:

‘The question of whether there is a pre-existing chronic subdural haematoma or not is unclear. The head circumference did grow from the 75th to 99th centile a feature which is associated with chronic subdural haematomas but he also has prominent subarachnoid spaces frontally which is also feature associated with a degree of excess head growth. The sutures which normally separate excessively if there is abnormal enlargement of the head for whatever reason (e.g. tumour, hydrocephalus, benign enlargement of the subarachnoid space, chronic subdural haematoma) are not separated. There is therefore no clear reason apparent for the head circumference change which still remains within normal limits and it should be monitored to see how it progresses.

34. Paragraph 2.6:

‘If the fluid that was in the subdural space that was not fresh blood was chronic subdural haematoma rather than acute traumatic effusion then it is known to be associated with fresh subdural bleeding following minor trauma or even spontaneously. Therefore the speculative fall might explain the fresh subdural bleeding identified. However, it would not explain the subdural blood seen in the spinal canal and, given that there was no blood seen within the third intracranial compartment, which any blood moving from the cerebral hemispheres through to the spinal canal will have to pass through, it would suggest that the subdural blood identified originated in the spinal canal rather than migrated there’.

35. Paragraph 2.7:

‘If the fluid in the subdural space that is not fresh blood is chronic subdural haematoma the question has to be considered as to why it was there. To have a chronic subdural bleed it has to start with fresh subdural blood. There are a number of medical causes for fresh subdural bleeding but if they are eliminated then a traumatic cause is what remains. Traumatic causes are known to include birth although as yet no birth fresh subdural bleeds have been identified as progressing to chronic subdural bleeds, accidental trauma and non-accidental shaken trauma. Community-based studies will indicate that non-accidental inflicted shaking injuries are the commonest cause of chronic subdural haematomas but the same community-based studies have identified a cohort of between 9-15% depending on how the statistics are viewed as unknown’.

36. Paragraph 2.8:

‘The above comments relate to children where there are no potential vulnerabilities leading to fresh subdural bleeding from events where fresh subdural bleeding would not be expected. In this case, it has been identified that there is a mild factor VII deficiency. I would defer to a general paediatrician or paediatric haematologist on the significance of this both as a primary cause of chronic subdural haematoma or re bleeding from trauma that would not normally cause subdural bleeding. I also note that the subarachnoid spaces frontally are prominent, although not excessively so, and given that the head circumference remained within the normal limits, this would not qualify from a neurosurgical perspective as a condition known as benign enlargement of the subarachnoid space (BES), which is a larger than normal head in a well child where the subarachnoid spaces are larger than normal on imaging. This condition, usually resolves spontaneously without long-term effect by the age of two. BES is believed, although not proven, to allow subdural bleeding to occur in circumstances where subdural may not be expected if there was no BES. However it has to be accepted that there will be a close line between what is considered to be upper limit of normality in terms of the size of the subarachnoid space and lower level BES and it is unknown what influence such a situation may have on the force required to cause subdural bleeding. This may, or may not be such a situation. I do not know’.

37. Thus it is that the summary of Mr Richard which I referred to at the outset of his evidence is

- reached.
38. For my part, following receipt of the medical reports I asked the question, ‘Is it the view of the medics that the increased vulnerability identified in respect of the later injury also sets the context of the older bleeds?’ The response of Mr Richards by email was, ‘If there is an increased vulnerability to subdural bleeding it would be expected to apply from birth, so the vulnerability would apply to the question of the origin of any earlier subdural bleeds’.
39. Dr Cartlidge reported on 23 January 2019. His report is at E63 and his summary appears at E65 as follows:
- ‘This report will show that in my professional opinion C was at increased risk of subdural bleeding because of enlargement of the subarachnoid space, which was probably more pronounced prior to the head trauma than found on newer imaging after the event. I think that the subdural bleeding and the acute traumatic effusions were most likely caused by the fall as described. I think that C also probably had rickets but this did not increase the risk of the intracranial and spinal bleeding’.
40. Dr Cartlidge concludes at paragraph 4.3.2 at page E87 that, ‘In my opinion there was no chronic subdural fluid collection (see above). Without a chronic subdural collection, I cannot logically link the recent subdural bleeding with birth’.
41. The view that there was no chronic subdural fluid collection is also reflected in his answer to the question which I put to the medics. By way of a reminder the question was, ‘Is it the view of the medics that increased vulnerability identified in respect of the later injury also sets the context of the older bleeds?’ He replied as follows:
- ‘1) The factors increasing the vulnerability to the intracranial bleeding would have been present earlier and so rendered C at increased risk if earlier subdural bleeding.
2) I think it most likely that C sustained the injuries during a single event. In other words, I think it unlikely that there was an earlier (older) intracranial bleed’.
42. At paragraph 4.3.5 of his report Dr Cartlidge answered the question, ‘What is the relevance of the spinal subdural haemorrhages?’ His reply is as follows:
- ‘The spinal subdural blood was found on the MR scan done on 24 August 2018. There were no other features of spinal injury. It is quite common to find spinal subdural blood after effusive head trauma, yet my experience of the three cases detailed above causes me to think it is not diagnostic of abuse. I am aware that some neuropathologists hypothesise (other potential mechanisms are also hypotheses) that subdural bleeding in such cases is the result of hyperflexion /hyperextension of the neck putting a traction force along the spinal course but then I defer to Mr Richards as to whether he feels this is plausible’.
43. Dr Cartlidge repeated his summary as his conclusion at E89, the crucial sentence being, ‘I think that the subdural bleeding and the acute traumatic effusions were most likely caused by the fall as described’.
44. Dr Keenan, consultant paediatric haematologist, reported on 27 January and his conclusion is that C does not have any bleeding or clotting disorder as evidenced by the tests which Dr Keenan has reviewed. At the time of his report, the tests of the Von Willebrand factor were outstanding but he did not consider himself unable to provide an opinion in the

- absence of those tests and his opinion has been accepted by Mr Richards and Dr Cartlidge.
45. Following the experts receiving the reports of each other, there was discussion as to whether there should be an experts' meeting. In his report, Dr Cartlidge said:
 'I think an experts' meeting is required only if Mr Richards disagrees or has significant doubts about the factors I identified in my report as increasing the vulnerability of C to an injury caused by a purported accident. I will be content if there was no experts' meeting'.
46. Following that comment a further question was put to Dr Richards to ask whether he disagreed with Dr Cartlidge or had significant doubts about the factors that Dr Cartlidge had identified as increasing the vulnerability of C to an injury caused by a purported accident and Mr Richards responded by email on 4 February at 9.45 as follows:
 'I commented that in clinical practice this would be a case worthy of discussion to form a consensus as to what happened. If the court is happy that the consensus has emerged from the individual reports that is sufficient to assist the decision-making process then a meeting would not be required'.
47. Thus it was the matter came before me on 6 February with the Local Authority asking for permission to withdraw the proceedings. The Local Authority set out in its case summary that it had carefully considered and analysed the totality of the evidence before the court in order to review whether there was sufficient evidence to satisfy the court on the balance of probabilities that C had suffered a non-accidental injury and if so who the perpetrator of that injury was or who would be in the pool of potential perpetrators.
48. The Local Authority argued that the expert medical evidence before the court and in particular that of Dr Cartlidge concluded that C's presentation could most likely be explained by one event and that is the accidental fall from his sister's arms which the family have been consistent in reporting. The Local Authority had considered whether it should ask the court to carry out a fact finding exercise with a view to concluding as to whether the threshold criteria for the making of an order could be met. However, the Local Authority having reviewed the evidence now accepted and indeed argued that it would be unlikely to be able to successfully argue that the section 31 threshold criteria test is met and that the forensic process would be unlikely to clarify matters or damage accounts so as to enable the court to conclude that C had suffered an earlier injury that was inflicted and/or non-accidental.
49. The Local Authority's view was that it would be disproportionate to conduct such a fact find hearing given that this case has always been a single issue case and given that the burden of proof is on the Local Authority. The Local Authority would be unlikely to persuade the court that the threshold criteria are met. In those circumstances the Local Authority referred me to the case of *A Local Authority v X, Y and Z (permission to withdraw)* 2017 EWHC 3741 which contained a full discussion on the factors to be taken into account when considering whether to grant permission to withdraw and also to the case of *J, A, M and X (children)* 2014 EWHC 4648.
50. The position taken by the mother at the hearing on 6 February was that the Local Authority's application to withdraw should be granted. The father's application was the same and all parties were supported at the hearing by the view of the children's guardian. I have considered carefully whether there should be a fact find exercise and I am satisfied that the totality of the evidence would not take me beyond the view of Dr Cartlidge that the account given consistently by the family of a single incident as described would be

- capable of accounting for the presentation of C.
51. I am satisfied that the evidence would not permit me to make a finding of any further incident and that to embark upon such a hearing would be disproportionate. I am satisfied that this is a case where the Local Authority is unable to persuade the court that the threshold criteria for the making of a public law order are made out. I am satisfied that the Local Authority is right to apply to withdraw the proceedings. The other parties are right to support that application and I grant that application. I do however have further observations to make in the context of a position statement filed by the father and drafted on his behalf by Ms Earley of counsel.
52. It is a short position statement and I intend to deal with each of the points made within it. Paragraph 1 is as follows:
‘F is obviously delighted that the Local Authority seek to withdraw these proceedings and that the family can be reunited. The court is aware from the previous hearings of the distress caused to the parents and the children of the enforced separation since August of last year’.
53. I comment that whilst one has every sympathy with the distress caused to the parents by the enforced separation, in my judgment the evidence which was available to the court at the time of that enforced separation was such as to require that enforced separation in order for the safety of C to be guaranteed. I trust the parents, despite their obvious upset and sadness, will appreciate that that was the case.
54. Paragraph 2 reads:
‘The family have always maintained that C was not the victim of abusive or neglectful parenting and his injuries were caused by an unfortunate accident when he was dropped by his sister. The expert reports of Dr Cartlidge and Dr Richards indicate the parents’ position’.
55. The court has accepted the reports of Dr Cartlidge and Dr Richards and accepts that the account given by the family has been accepted by the experts.
56. Paragraph 3:
‘There are important lessons to be learnt from this case from a safeguarding, medical and medicolegal perspective and therefore the court is asked to deliver an anonymised judgment that can be published on BAILII and shared with professionals. It is crucial for this family that the parents are clearly exonerated and all medical professionals proceed on the basis that C’s injuries were the result of an accident. In addition, the father seeks the experts’ reports to be disclosed to C’s treating medics’.
57. I agree that an anonymised version of this judgment should be published and shared with professionals. I have ordered that the report and this judgment be disclosed to the treating medics and I agree that this family should be treated by all professionals on the basis that C’s injuries resulted from the accident which the experts have come to accept as an explanation for the injuries.
58. At paragraph 4 of the position statement Ms Earley sets out what she considers are ‘lessons to be learnt’ and they appear as follows: i. ‘Professionals should always keep an open mind, accepting that their first duty is to safeguard the children concerned’. In my judgment, this is a fair comment which I am sure prevails in the work of the majority of professionals involved in safeguarding.
59. ii.

‘Professionals should explore whether children can be safeguarded in their home – it was the case of the Local Authority and the guardian that all four children should be removed from the home and placed, separately in foster care. Had the court approved this plan the consequences for the children would have been emotionally traumatic and would have resulted in a wholly unwarranted six months’ separation for these children’.

60. It follows from my decision at the outset of these proceedings and the comment I made earlier in this judgment that I agree with this contention.

61. iii.

‘It is imperative that treating medical professionals understand the need to swiftly disclose all material when there are ongoing court proceedings. Dr Landes of Alder Hay Hospital wrote to Dr Katta (lead paediatrician for C at East Surrey Hospital) on 7 September 2018 providing details of a radiological analysis and there is evidence of rickets shown on C’s skeletal survey. This was flagged by Dr Carlidge as a potential issue, in light of C’s low vitamin D levels, on 9 January. Dr Landes’ analysis only came to light as a result of a court order on 7 January requiring the Alder Hay Children’s Hospital and St George’s Hospital access to records teams to provide all medical records relating to C. However, disclosure of it had been made against East Surrey Hospital on 9 October yet Dr Landes’ report was not included in their disclosure. Although the fact that C has rickets was not ultimately linked by Dr Carlidge to a subdural bleed, early knowledge of this fact would have put the parties on notice that there was cogent evidence C had an organic condition that may well explain his injuries (rickets of course being linked to low level vitamin D which can be linked to subdural bleeding *LB of Islington and Al Alas and Wray* 2012 EWHC 865 (Fam)’.

62. It is clear from comments made earlier in this judgment that my view is that the report of Dr Landes should have been made available to all involved in these proceedings and that should have happened consequent upon my order made against East Surrey Hospital on 9 October. Whilst ultimately this default has not caused an injustice or delay in these proceedings it had the potential to do so and must not be repeated.

63. iv.

‘It is imperative when treating medical professionals have made a diagnosis of non-accidental injury that they keep this under review and update this diagnosis when new medical evidence is received and give active consideration to convene a multidisciplinary meeting. Dr Katta’s letter of 31 August opined that C’s low level vitamin D and calcium were “an unrelated issue”. It seems that neither Dr Katta or his colleagues revisited his opinion on their view that non-accidental injury was ‘highly likely’.

64. Clearly, it is important that treating medical professionals do keep under review their diagnoses in the light of information as it emerges.

65. v.

‘Had the Local Authority and the court been relying solely on the treating medics the outcome of this case would be vastly different and a travesty of justice. In his January “view” the President spoke of the current difficulty

locating paediatric experts to report in cases such as C. This case highlights how imperative it is that the parties and the court can have timely access to experienced experts who can provide an independent analysis’.

66. It is difficult for me to add to the words of Ms Earley. If ever there were a case which shows the danger in relying on treating medics then this is that case. From time to time there is discussion about whether there is a need for independent expert evidence or whether such is disproportionate and one should be able to rely upon those treating the child. It is clear that in cases of this nature independent expert evidence is absolutely essential.
67. It is also clear that had that independent evidence been available earlier than January of this year then this family would have been reunited earlier than February of this year. It is a great shame that we no longer have a sufficiently large body of experts as to enable the speedy and timely consideration of evidence which already exists. It is a source of great sadness that the delay which inevitably results from there being greater demand for expert evidence than there is resource means that justice is delayed and trauma for families increased.

68. vi.

‘The publication of research papers on the incidence of birth-related subdural haemorrhage fundamentally altered the understanding as the incidence of intracranial bleeding in babies. Subdural haemorrhages were considered rare in normal deliveries. Medical research and medicolegal cases have shown that in fact they are common in babies after all types of delivery. Similarly, it had long been mainstream medical opinion that low level falls do not result in extensive subdural bleeding (see paragraph 40 of *Re N (A Child: Low level falls)* 2016 EWFC B29 for Dr Richards’ summary of the debate on this issue. Dr Cartlidge sets out at page 20 of his report, three medicolegal cases where similar injuries were sustained in these circumstances; not all of these are reported. It is important for all those involved in child protection that the details of C’s case are anonymously available to be added to that list and properly inform future diagnoses made by treating medics, experts and ultimately conclusions drawn by the family court’.

69. I agree with this suggestion and I trust that Dr Cartlidge upon receipt of my judgment will note my agreement and furthermore I authorise the solicitor for the child to draw Dr Cartlidge’s attention to this specific paragraph within my judgment.

70. vii.

‘Dr Cartlidge's report is dated 23 January; he reported earlier as he was acutely aware that his expert opinion was at variance with the treating doctors. Upon receipt of his report and that of Dr Richards, those representing the parents urged the Local Authority to view the arrangements and allow C and his mother to return home under the ICO until the matter could be returned to court. It was pointed out to the Local Authority that they share PR with the parents and are able to make this decision and to maintain the enforced separation of the family in the absence of safeguarding reasons was an unjustifiable interference with their right to family life. The Local Authority refused to permit the mother and C to return home, wrongly stating that they cannot do so until the court has approved such a plan’.

71. I make no comment as to whether the Local Authority have stated that they do not have the power to return the children home until the court has approved such a plan. However, I note that the report of Dr Cartlidge was available on 23 January and this hearing has taken place on 6 February. In my view given the complexity of the matter and given the need for reflection as to whether there should be an experts' meeting and whether there should be a fact find hearing the Local Authority has not delayed unnecessarily.
72. I appreciate that for the parents the days between 23 January and 6 February will have seemed lengthy and their separation unnecessary but I assure them that the exercise which the Local Authority has had to carry out and indeed the exercise which the court has had to carry out in considering whether leave to withdraw should be granted is an exercise in my judgment which should be carried out alongside safeguarding arrangements remaining in place. It would have been premature for the Local Authority to allow C and his mother to return to the family home prior to their application for permission to withdraw being determined.

End of Judgment

Transcript from a recording by Ubiquis
291-299 Borough High Street, London SE1 1JG
Tel: 020 7269 0370
legal@ubiquis.com

This transcript has been approved by the judge.