Neutral Citation: [2022] EWFC 208
Case No: ZE21C00046

IN THE EAST LONDON FAMILY COURT

11, Westferry Circus, LONDON, E14 4HD

Date: 8th July 2022

Before :

HER HONOUR JUDGE CAROL ATKINSON

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Between :

LONDON BOROUGH OF WALTHAM FOREST

Applicant

- and –

(1) GA

(2) HB

(3) F (a Child by his Children's Guardian, Bethan Hole)

Respondents

- -

Damian Woodward-Carlton QC and Kate Lamont (instructed by London Borough of Waltham Forest) for the Applicant Local Authority
Mark Twomey QC and Rebekah Wilson instructed by (Burke Niazi Solicitors) for the First Respondent Mother
Clive Newton QC and Jean-Paul Sinclair (instructed Edwards Duthie Shamash Solicitors) for the Second Respondent Father
Sally Stone QC and Christopher Stevenson (instructed by Creighton Solicitors) for the Third Respondent Child

Hearing dates: 18-20th May; 24-25th May; 27th May, 30th-31st May; 6th – 9th June, 16th June and 8th July 2022

JUDGMENT

HER HONOUR JUDGE CAROL ATKINSON :

Introduction

1. At the centre of this case is a little boy called F. He is now 19 months old and living with his paternal great aunt under an Interim Care Order. Before I set out the circumstances in which I come to be involved in his life, his anxious parents will forgive me, I hope, if I make some short general observations.

2. First, this is a story about the importance of evidence and the testing of evidence in a court room setting. As will become apparent, the evidence upon which I have finally made my decision was not apparent on a reading of the papers. It developed. It was, as evidence often is, dynamic - flexing and bending in response to the evidence of others. We all need to ensure that we prioritise court resources appropriately and that involves actively reducing litigation issues and avoiding the unnecessary hearing. However, we also need the occasional reminder that sometimes we must hear, test, and probe the evidence. That is our role. What better use can there be of the court's expertise than the proper testing of evidence which informs a decision affecting the lives of a child and his parents?

3. Secondly, this is a story about the skill brought to these matters by experienced and committed lawyers. I have had the pleasure and the luxury of highly experienced Counsel in this case. No relevant stone has been left unturned. Advice regularly given, the evidence examined, beautifully presented, and expertly probed. Without them this task would have been considerably more arduous. I offer my personal and genuine thanks to each one.

4. Thirdly, no one should underestimate the lifelong impact on a family of care proceedings and like so many cases at the moment, this is a story that has taken far too long to come to a conclusion. F is now 19 months old. When proceedings were issued, he was little more than 6 weeks old. There is no excuse for this delay. There is unfortunately nothing unusual about it. I offer my most sincere apologies to F and his parents that it has taken so long to get to this point.

5. Let me return to the facts of the case. On 24th Jan 2021, F was taken to a London hospital by ambulance. Shortly after arrival he was treated by the resuscitation team. During his time with various health care professionals, he was documented as having marks on his face which have been referred to variously as redness, discolouration, petechiae, purpura and bruising. What they were is subject to considerable dispute, as is when they were first seen and precisely where they were seen on his face. The LA's case is that F's collapse prior to the calling of the emergency services and his later presentation is more likely than not as a result of *"..the application of a blunt force to F's face and consequent asphyxia"* in an attempt *"at intentional suffocation through smothering"*. Originally, the LA considered that there was insufficient evidence to determine whether the perpetrator of this was the mother or father but as the evidence unfolded, it has withdrawn its accusations against the father – including that he failed to protect. The single issue for me to determine has been whether I am satisfied that this mother attempted to smother her child.

Decision

6. This has been a tough case. The evidence is extensive. The stakes are very high. As Mr Twomey QC for the mother said in November 2021: *"In plain language, the main allegation facing these parents is that there was an attempt to murder or cause very significant harm to their six-week-old baby by suffocation"*. The consequences of a wrong decision for any family is always serious but never more so when, as Ms Stone QC for the Guardian puts it, the allegations are *'at the top end of seriousness'*. The pull of the expert witness and of science is always strong and identifying a unifying diagnosis is an attractive and often irresistible means by which we determine what is most likely. However, it is our duty as lawyers and as Judges to ensure that we are not blinded by this approach and crucially that we do not ignore the possible and the fact that sometimes more than one thing is going on. This has been one of those cases for me but piecing together my reasons and double checking them to ensure that I am not being led astray by the immense sympathy I feel for these enormously likeable parents has been an arduous task. At its end, however, I am quite clear. I am not satisfied that this mother tried to smother her son, or that she placed anything over his face, forcibly or otherwise, to prompt the symptoms I have determined were seen. The threshold is not met. F can return home. These parents should be given some support to come to terms with what they have been through. I am only sorry that it has taken so long.

7. I do not think that the LA can be criticised for taking the action it has and issuing the proceedings. Not least because the evidence upon which I have hung my conclusions has developed during the course of the proceedings (beginning with the instruction of Prof B) and gained considerably more traction during the hearing. Let me explain.

Background

8. The parents met in April 2016. They were married in April 2017. The mother was born and brought up in Nottingham where her family continue to live. She has 3 older brothers all married with children. The father was born in London. He is the youngest of four children. He has lived with the paternal grandparents at the current address since he was born. His eldest sibling, M, is married with children and living close by. She is the carer for the paternal grandmother. His eldest brother, K, lives in the paternal family home with his wife, L, and their three children. They live on the top floor of the house and have separate cooking facilities. The father had another brother, J. J had significant disabilities. He died on 17th January 2019.

9. The parents were keen to have children as soon as possible. They tried for over two years before the mother fell pregnant for the first time. Sadly, that first pregnancy ended in miscarriage in 2019. The mother suffers from Polycystic Ovary Syndrome which can impact upon fertility. Fortunately, her second pregnancy was successful, and F was born on 11.12.20 after a difficult delivery. Mother and son remained in hospital for a few days following F's birth due to infections. When discharged the Mother travelled to Nottingham to stay with her family because the paternal grandparents, with whom it was intended they would live, had tested positive for Covid-19 and were isolating. The father stayed with his parents in London during this brief separation. The Mother and F returned to London on 30.12.20.

10. On 24.1.21, when he was 6 weeks old, Aunt M was at the paternal GPs home cooking a family meal. She was assisted in the kitchen by L, the wife of the eldest brother. The

grandparents were in the home as were the rest of L's family. There was a family meal planned. It was on this evening that F was taken to hospital by ambulance. The precise sequence of events will be set out further below. Suffice to say that the alert was first raised by F's mother who noticed something wrong with her son. The father was in the kitchen having a snack and was called up to their room by the mother to look. He thought that there was nothing wrong. Minutes later he was called back by the mother and what he saw then caused him to call the paternal grandmother for assistance. Aunt M arrived on the scene and a call was made to the LAS. The first responders (paramedic followed by ambulance crew) suspected an allergic reaction as the presenting symptoms appeared to them to be redness and swelling to his face. Whilst being transported to hospital in the ambulance, the Mother initially reported that she noticed bruising to F's face. This was not seen by any health professional. I will need to decide whether she did see bruising or any other marks to F's face at that early stage.

11. On handover at hospital the evidence suggests that F was stable and settled. However, when seen by the consultant in paediatric emergency medicine he was considered by her to be looking 'unwell' with the result that he was moved to another room and a resus call was put out. A resus team attended and went to work under the direction of the consultant. Intravenous fluids were introduced through a line in his leg bone. Whilst originally it was suggested otherwise, during the course of that resus routine, photographs provided by the parents showed that a mask was placed and held over his face during treatment.

12. In the hours after his admission and the resus treatment F was examined further and recorded as having facial *'bruising'* and *'scattered petechiae'* around his eyes, nose and mouth and bleeding in his eyes. The location was documented on a body map late on 24th January/ early 25th January. There is a significant dispute concerning precisely what those marks/injuries were, where they were, when they were first seen and of course how they were caused.

13. F's care whilst in hospital was overseen by a Paediatric Consultant, Dr R. She saw him for the first time on her ward round the morning after his admission (25th Jan). In her CP medical report she noted that he was admitted with an episode of BRUE (brief resolved unexplained event) likely caused by gastroesophageal reflux. Investigations revealed that he had an undiagnosed ventriculoseptal (heart) defect (a hole in his heart) and a parietal lesion identified on cranial imaging thought likely to be secondary to a healing cephalohaematoma caused by injury to the skull during assisted delivery with forceps. Her report also documents *'resolving facial bruising and subconjunctival haemorrhages for which no medical cause has been identified and is unexplained with no history of facial trauma given by the parents and no correlation with other events around the time of the BRUE'*. Accordingly, she considered that *'Non-accidental injury needs to be considered as the differential diagnosis or explanation for this bruising'*.

14. Whilst admitted there were two further 'blue' episodes during which it is said that F presented as 'breath holding' and changing colour. The first on 26th was seen by the mother and not witnessed otherwise. The second was on 27th and was seen by a student nurse who had been sent to carry out observations. She was sufficiently concerned at what she saw to call her supervisor.

15. The LA issued proceedings and on 3.2.21 I made an ICO on the basis of a plan for the Mother to travel with F to Nottingham where F was to live with a maternal uncle and aunt while the Mother stayed with another member of her family and visited daily. These arrangements proved difficult for the Aunt and Uncle to manage with care of their other children and work commitments. On 9th May F moved to live with his Paternal Great Aunt in Waltham Forest. The parents have 3 hours per day supervised contact with F during the week and 5 hours per day at weekends.

16. On 25.5.21 F was taken to hospital by his Paternal Great Aunt and his Father. The Aunt reported concern that when F cries his face goes blue and it takes roughly a minute to go back to its normal colour.

Expert evidence

17. Meanwhile in the care proceedings a series of medical experts were instructed to consider the likely cause of F's apparent collapse and his facial 'injuries'. By way of summary the reports obtained from medical experts within these proceedings provided the following summary conclusions in respect of injuries noted during F's hospital admission on 24.1.21:
    a. **Professor Lloyd (Consultant ophthalmic surgeon and paediatric ophthalmologist):** His initial view was that the sub conjunctival haemorrhages were most likely caused by trauma. The presence of bilateral injuries, in Professor Lloyd's opinion made inflicted injury more likely. Professor Lloyd describes conjunctival haemorrhages as a non-specific sign but taken in conjunction with other signs of inflicted injury they could be a "sentinel injury" and indicative of abuse.
    b. **Dr Ismail (Consultant Paediatrician):** Opined that F's injuries are suspicious of intentional suffocation through smothering and advised an opinion from an expert in this field. This lead to the instruction of Dr Irvine a forensic physician. In a second report Dr Ismail reviewed records relating to F's admission to hospital in May 2021 and advised that she did not consider that there was any cardiac or allergic cause for F's presentation with facial bruising, petechial haemorrhages and bilateral subconjunctival haemorrhages in January 2021. She also confirmed that the VSD and gastroesophageal reflux would not have contributed to F's collapse and advised that the instruction of a paediatric cardiologist was not necessary.
    c. **Dr Jayamohan (Paediatric neurosurgeon)**: concludes *"There are no brain injuries or intracranial abnormalities, and I can see no explanation for the facial swelling or the eye changes related to the brain at all. Therefore, my opinion is, fully restricting to the brain, there is no injury, and on the skull there is a subperiosteal haematoma or a cephalo-haematoma in the left parietal region caused by birth"*. In response to further questions Mr Jayamohan confirms that as result oxygen deprivation (caused by smothering) he would expect to see a global hypoxic injury to the brain without subdural bleeding. The absence of these injuries would indicate that if there was an asphyxiation it wasn't severe or significant enough to cause such injuries within the brain.
    d. **Dr Irvine (Consultant in Clinical Forensic Medicine)** considered that the injuries to the facial area, if determined to be bruising, were consistent with blunt force trauma. He considered the presence of petechial haemorrhages to both eyes were consistent with anoxic changes and asphyxia, lending support to Dr Ismail's suggestion of suffocation or smothering having been a possible cause. Dr Irvine

prepared an addendum report dated 11.12.21. This report considered updating evidence from a treating doctor and the evidence relating to activity in resus which the parents both referred to in their responses to threshold. Dr Irvine concluded that *"Overall facial bruising in a child of this age is highly unlikely to occur accidentally, and is more likely to be as a result of non-accidental blunt trauma, in this case with resuscitation activities involving the possible forceful application of a face mask across the nose and mouth area, there is a potential alternative explanation for some if not all of the pattern of bruising identified"*.

e. **Dr Keenan (Paediatric Haematologist)** recommended further blood tests which were completed. No abnormality of blood clotting system was identified.

f. **Dr Fryer, (Consultant Clinical Geneticist),** concluded that there was no evidence that F suffered from any disorder that would result in spontaneous haemorrhaging, particularly given that the bruising was so localised. He later confirmed that there is no clinical evidence for classic, rare or hypermobility forms of EDS in the family nor any evidence of any other connective disorder. He concluded that he did not think that F had any underlying genetic condition that would predispose him to unusual bruising or subconjunctival haemorrhages .

g. **Professor Bu'Lock (Consultant Paediatric and Congenital Cardiologist)** concluded that the VSD did provide an explanation for F's cyanotic episodes and combined with gastrooesophageal reflux may have presented an exaggerated response giving rise to a real or perceived need for resuscitation on admission and at hospital.

   Professor Bu'Lock did not consider that the VSD alone would explain the bruising of sub-conjunctival haemorrhages. Dr Bu'Lock suggests that the use of the mask should be explored in relation to these injuries but deferred to paediatric colleagues on this issue.

h. **Dr Millard (Consultant Dermatologist)** concluded that angioedema was unlikely to have been the cause of the single episode of facial swelling and that the images do not show obvious angioedema. In Dr Millard's opinion the facial lesions were bruises.

18. All but Dr Irvine (who was unavailable) and Dr Millard (who was not then instructed) met at an experts meeting. That meeting yielded a short summary of areas of agreement and disagreement to which Dr Irvine later contributed and can be summarised as follows:
    a. There was no single underlying pre-existing condition that explained the presentation/injuries.
    b. The VSD provides a potential explanation for the cyanosis and low SATs.
    c. There was no agreement as to the precise nature of the injuries in the ambulance, at the time of admission or later but it was agreed that this was a crucial fact and needed to be determined by the court.
    d. There was agreement that the face mask, if placed firmly or roughly, could have caused bruising to F's face.
    e. The head injury was a birth injury and there was no brain injury so any 'smothering' was not long enough to cause hypoxia.
    f. Whether the subconjunctival haemorrhages might also have been caused by the face mask or resuscitation was considered possible but also to be dependent upon the determination of when they were first seen.
    g. Breath holding could cause or contribute to SCHs.

Summary reasons

19. A great deal turns on what I can be satisfied was observed by the treating clinicians on 24th and 25th January. I can broadly summarise my main findings as follows:

    a. I am satisfied that no bruises, petechiae or purpura or SCHs appeared until after F had been through the resus procedure in the hospital.
    b. I cannot be satisfied that all or any of the marks identified by Dr S on the body map were in fact 'bruises' by which I mean marks caused by blunt trauma as opposed to a rise in venous pressure. There is particular uncertainty as to whether there were bruises or any marks across F's upper lip.
    c. Whilst it is not for the parents to prove anything, F's undiagnosed VSD in combination with the GOR and breath-holding provides a comprehensive explanation for his presentation at home, on arrival of the emergency services, on admission to hospital and later on at least two further occasions at hospital. It is central to understanding his presentations and symptoms.
    d. Similarly, his breath-holding (a Valsalva manoeuvre) provides a potential explanation for any petechiae, purpura or SCHs and the expert evidence supports the proposition that the face mask could bruises around F's nose.
    e. The timing of the first sighting of the marks to his face and the SCHs, does not lend support to the LA case.
    f. I am not satisfied that inflicted trauma is the more likely explanation for F's presentation.

The law

Burden and standard of proof

20. The local authority brings this case and seeks the findings of fact set out in the schedule. It is for the Local Authority to prove those facts. The standard of proof is the balance of probabilities. I have in mind when considering these serious allegations, *Re B* [2008] (Children) UKHL 35. At para.70, Baroness Hale put it this way:
"I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under section 31(2) or the welfare considerations in section 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies."

21. There is no pseudo-burden or obligation cast on the respondents to come up with alternative explanations: *Lancashire County Council v D and E* [2010] 2 FLR 196 at paras [36] and [37]; *Re C and D (Photographs of Injuries)* [2011] 1 FLR 990, at para [203]. If an explanation or hypothesis is put forward by or on behalf of a parent which is not accepted by the court, the failure to do so does not establish the Local Authority's case.

22. On the issue of inherent probabilities, I have been specifically referred to the judgment of McFarlane J (as he then was) in *Oxfordshire County Council v DP, RS & BS* [2005] EWHC 2156 (Fam); [2008] 2 FLR 1708. In particular paragraph 118 though considered in the light of paragraph 70 of *Re B* (as set out above).:
"No matter what the context may be, I regard smothering, to the extent that must be contemplated here given the degree of collapse, to be at the furthest end of the spectrum of probability. It is highly improbable that a parent would deliberately act in this way and very

cogent evidence is therefore required before a court, on the balance of probabilities, can say that such an event probably did take place. The degree of improbability and the cogency of the evidence is of a different order to a momentary squeezing or shaking of a baby."

Evidence

23. Findings of fact must be based on evidence and not on speculation or hypothesis. As Munby LJ, as he then was, observed in *Re A (A Child) (fact-finding hearing: Speculation)* [2011] EWCA Civ 12:
"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation."

24. I must take account of all the evidence and consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss observed in *Re T* [2004] EWCA Civ 558, [2004] 2 FLR 838 at 33:
"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."

25. The evidence of the parents is crucial. That is not to say that they are under any obligation to prove anything or to come up with an explanation. However, see ***Re BR (Proof of Facts) [2015] EWFC 41*** and the Judgment of Peter Jackson J, as he then was on the significance of the parents' accounts of events when considering the inherent probabilities that a child will have suffered spontaneous or unexplained injury.

26. There has been a great deal of medical evidence in this case about which I direct myself as follows:
    a. There is no magic in the evidence of an expert. Experts do not assume some sort of special status. All witnesses come to the witness box as equals.
    b. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence.
    c. *'The roles of the court and the expert are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence (see A County Council v K, D, & L [2005] EWHC 144 (Fam); [2005] 1 FLR 851 per Charles J). Thus, there may be cases, if the medical opinion is that there is nothing diagnostic of non-accidental injury, where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts*.' Per Baker J in <u>*Re JS*</u> [2012] EWHC 1370 para 40.
    d. In Re JS (supra) at para 41 '*in assessing the expert evidence I bear in mind that cases involving an allegation of shaking involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others (see observations of King J in Re S [2009] EWHC 2115 Fam)'.*

e. If the Court disagrees with an expert's conclusions or recommendations an explanation is required see *Re B (Care: Expert Witnesses)* [1996] 1 FLR 667 and *Re D (A Child)* [2010] EWCA 1000.

27. In *Re LU &. LB* [2004] 2 FLR 263, the Court of Appeal provided guidelines following the earlier case of *R v. Cannings*. At para.23, Butler-Sloss P. gave the following guidelines:
    a. The cause of an injury or an episode that cannot be explained scientifically remains equivocal.
    b. Recurrence is not in itself probative.
    c. Particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.
    d. The court must always be on guard against the over-dogmatic expert, the expert whose reputation or *amour propre* is at stake, or the expert who has developed a scientific prejudice.
    e. The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark.

28. Developing this theme of injuries that could simply be *"not presently known or understood"*: per Hedley J in *R (A Child)* [2010] EWHC 1715 (Fam), I am reminded that in that case, Hedley J cited Moses LJ in the case of *R v Henderson & Others* [2010] EWCA Crim 1269, CA: *"There remains a temptation to believe that it is always possible to identify the cause of injury to a child. Where the prosecution is able, by advancing an array of experts, to identify a nonaccidental injury and the defence can identify no alternative causes, it is tempting to conclude that the prosecution has proved its case. Such temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude beyond reasonable doubt an unknown cause."*
    Hedley J went on to make the point that a conclusion of *"unknown aetiology"* was not a professional or forensic failure; it simply recognises that there is much we do not know and that it is wrong to infer non-accidental injury merely from the absence of any other understood mechanisms. Thus, in cases where that possibility is realistic, a finding of "unknown cause or aetiology" remains an option for the fact finder.

29. I am mindful that some of the evidence in the case has come in the form of documents recording what people have seen or observed outside of the court room. Those documents and recordings are produced as evidence that their contents are true. That is technically hearsay evidence and must be approached with caution as there has been no opportunity to challenge or test that evidence in the usual forensic manner.

Lucas direction

30. It is not unusual for witnesses to lie. The fact that a witness has lied about some matters does not mean that he or she has lied about everything. Lies are capable of corroborating or lending evidential support to an allegation. (see *R v Lucas* [1981] QB 720).
31. The four relevant conditions that must be satisfied before a lie is capable of amounting to corroboration are set out by Lord Lane CJ in *R v Lucas* as follows:
    "To be capable of amounting to corroboration the lie told out of court must first of all be deliberate. Secondly it must relate to a material issue. Thirdly the motive for the lie

must be a realisation of guilt and a fear of the truth. The jury should in appropriate cases be reminded that people sometimes lie, for example, in an attempt to bolster up a just cause, or out of shame or out of a wish to conceal disgraceful behaviour from their family. Fourthly the statement must be clearly shown to be a lie by evidence other than that of the accomplice who is to be corroborated, that is to say by admission or by evidence from an independent witness.'

32. Whilst lies can corroborate the allegation, they cannot alone prove it. In *Re H-C (Children)* [2016] 4 WLR 85 McFarlane LJ (as he then was) stated as follows: *"[100] .... In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt."* ***Witnesses generally***

33. Peter Jackson J (as he then was) in the case of <u>*Lancashire County Council v The Children*</u> [2014] EWHC 3 (Fam), at paragraph 9 stated:

"... where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record-keeping or recollection of the person hearing and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as 'storycreep' – may occur without any necessary inference of bad faith."

34. I caution myself as to the need for care in assuming witness demeanour is indicative of credibility or guilt. See Macur LJ in <u>*Re M (Children)*</u> [2013] EWCA Civ 1147 at [11] and [12], stated that:
"Any judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so".

35. In a similar vein see the comments of King LJ in <u>*RA (A Child)*</u> [2020] EWCA Civ 1230 that the court must be mindful of the fallibility of memory and the pressures of giving evidence. Lady Justice King further observed at [30] and [41] that:
"[30] Inevitably in such cases, the oral evidence of the key protagonists, most often the mother and her partner, is highly significant. The case law has developed in a way designed to ensure that, whilst there is recognition of the fact that the oral evidence of lay parties is often critical, it also has its limitations; there are dangers in an over reliance by the judge on either demeanour, or upon the fact that a witness has told demonstrable lies.

...

[41] The court must, however, be mindful of the fallibility of memory and the pressures of giving evidence. The relative significance of oral and contemporaneous evidence will vary

from case to case. What is important, as was highlighted in Kogan, is that the court assesses all the evidence in a manner suited to the case before it and does not inappropriately elevant one kind of evidence over another".

THE EVIDENCE

36. I do not intend to recite all the evidence here, simply enough for the parties to understand my reasoning. The papers are contained in 2 separate Bundles. I can confirm, however, that I have read everything to which I have been referred and I have skimmed through much of the remainder.

The broader evidential canvas

37. I am going to start with the unchallenged background evidence and what is objectively known about this family. F was a much longed for child. His parents had already suffered the loss of one pregnancy. I will deal with the alleged family pressures on them to have a child below but whether there were external pressures or not, the fact is they wanted a child of their own. F was, I am satisfied, a precious addition to their family.

38. Before he was admitted to hospital on the evening of 24th January 2021, there was no concern as to F's welfare. Whilst there was documented friction between the mother and her sister-inlaw L, to which I have to return, there were no red flags concerning F or the relationship between his parents. No allegations of domestic abuse or tension as between the parents. Indeed, no tensions other than set out below with the sisters in law.

39. F and his mother stayed in hospital post birth for 5 days and no concern was expressed about his care. He was seen by the health visitor in Nottingham – online and in person. The health visitor spoke to mother, and no concerns were noted. He was seen by the GP on 11th and 19th January 2021 and no concerns were noted. He was in hospital with his mother (with his father visiting) for 12 days after his admission on 24th January and, as before, no concerns were noted. This is important. No signs of odd behaviour as hinted at by the LA in their evidence from the sister-in-law and no signs of post-natal depression or any form of mental illness in the most pressured of settings and whilst subject to close observations.

40. The paternal family home was clean and comfortable as confirmed by the first responders and whilst reference is made to 'clutter' in the bedroom, there was nothing of concern to their experienced eyes when they attended on 24th January.

41. Having seen the paternal family, I consider them to be supportive and loving. They were aware of the mother's teenage depression and sensitive to the difficulties she encountered then. As I shall explain, I consider their encouragement of her visits and stays with her family and their solution to the domestic issues as between the two sisters in law to demonstrate a desire to support her, not to undermine or isolate her, or even ignore the impact of the tension on her. Indeed, it is a positive part of the LA case that this family was practically very supportive of this mother in her care of F – actively sharing in the care of this newborn to enable the mother to sleep and rest where possible.

42. However, it is the LA case that this mother was living in unpleasant, unhappy and pressured circumstances in the paternal home and that bubbling under the surface were continuing mental health problems which were somehow unresolved from her teenage years. Mr Twomey QC argues that I do not have to resolve these matters because they provide no assistance to me whatsoever in the determination of the issues. I have some sympathy with that position. Indeed, it is a position with which the LA would agree. I sought confirmation from Mr Woodward-Carlton QC that in the event that he did not manage to cross the evidential threshold in other evidence then this broader canvass evidence was not capable of making his case. He agreed. However, the whiff of something not right here has hung around throughout this case and given the time devoted to it I consider it only fair to these parents – in particular, this mother - that I set out my assessment of essential parts of this evidence where I can. I have dealt with those issues to the extent that I feel is necessary or important, at the end of the Judgment. First some observations about the parents and extended paternal family as witnesses.

<u>The parents as witnesses</u>

43. The evidence from the parents is of critical importance. That is not to say that they have an obligation to persuade me of anything. It is the LAs task to prove the case and to disprove their protestations that they have done their child no harm.

44. The parents in this case have both been impressive witnesses in their own ways. Whilst I have found the father to be the more reliable as a historian that is not because I consider the mother to be dishonest. She is not. This mother is to my eye visibly impacted by this trauma. In my view, her barely concealed inability to accurately recount the details of the evening that her son was taken to hospital are caused by a simple lack of recall regarding that traumatic event; her seeming refusal to admit the full impact upon her of the pressures of conceiving, or of having a poor relationship with a family member or of being the parent of a new born is rooted in a fear of the consequences should she admit that she has succumbed to even the most common of life's stressors. She is quite obviously concerned at how she would be perceived and that this might be thrown into the mix to make a case against her – in the way that her teenage depression has been. Significantly, the father's recollection is better. His relaxed acceptance of the pressures that she faced coupled with his sensitive understanding and practical hands-on support leant powerful support to the credibility of them both. It also confirmed the strength of their union. Overall, my observations of them in the witness box was of two very dignified young people, still respectful of the process and trying their very best to tell me everything that they could despite their justifiable and growing frustration at the circumstances in which they find themselves.

The events leading up to hospital admission: the evidence from the family

45. The mother has been fully and very ably challenged by Mr Woodward-Carlton QC in cross examination and further tested by Ms Stone QC. She was a poor historian. She was muddled and she found it difficult to admit that the circumstances in which she was living were challenging. Her muddled accounts were not in my view muddled because she was seeking to hide something. I am shored up in that by the fact that often the muddle left her with an account less favourable to her position than what turned out to be the truth. One example of this is the timing of the eating of a takeaway that afternoon. She placed that event very close to the time when she was due to eat with the family giving the LA the opportunity to use it to

suggest that she did not intend to join the family that evening, and the story of a family gathering was a façade hiding the true position. When the father gave evidence, he said that this timing was not right, and he suggested that her Uber Eats account should be checked. It revealed that the takeaway had arrived a good 2 hours earlier, weakening the suggestion that this was evidence that she was isolating herself from the rest of the family.

46. I am not critical of her about this. It was and still is very obviously the most traumatic event of her life. Do I think that her lack of consistency is indicative that she is not telling the truth and seeking to hide what happened? No, I am not satisfied of that. My sense is that she no longer accurately remembers what happened on that evening and I need to look elsewhere than her oral evidence before me for what happened on that day. The father, by contrast was calmer and clearer.

47. Moving away from the oral evidence in court and examining the various accounts given to other witnesses along the way reveals, in my view, a central consistency. There are minor discrepancies. For example, concerning the extent of the swelling seen and whether there is consistent reference to breathing problems or 'blue' colouring, but I do not consider these minor discrepancies to be of any real significance. What is highly significant in my view is that these descriptions broadly paint a picture of events which is entirely in keeping with the way in which Prof Bu'Lock describes a baby with F's health issues would present and at a time when no one was aware that he had a hole in his heart. Indeed, even the instructed consultant paediatrician was unable to recognise the significance of this until the instruction of the cardiologist in the case. These parents cannot have made this up. This then is my assessment of what more likely than not happened on that day.

48. We know that the mother ordered a takeaway which was delivered at around 16.30. The father woke up around 17.30/18.00. He went to take a shower. M was downstairs in the kitchen preparing food with L. She thought that it was whilst the father was in the shower that she went up to ask the mother to bring F downstairs. F was asleep and she suggested that when mother brought him downstairs, she might dress him in the outfit that she had bought for him. This was an outfit that made some reference to her as a special aunty. It was a touching suggestion.

49. Father returned to the bedroom before going downstairs to get a snack. The food was not ready, and he was very hungry. Whilst he was eating, he received a call from the mother asking him to come upstairs. The phone records show that this call was made at 18.57. He did not leave the kitchen immediately. The mother called a second and third time. She was obviously concerned with what she had seen. He arrived as the third call was being made – 18.58.

50. The picture that emerges from the various accounts given by both parents was that the mother had called because F did not look right – he seemed to have a swollen face to her, and she was concerned at his hysterical crying. The father picked him up, looked at him, saw nothing unusual, put him down and turned to go back downstairs. What is of interest here is that the father did not see the swelling. That does not raise any suspicion for me. It simply illustrates how differently F looked to even those who knew him well. Nor does the fact that the father was unconcerned mean necessarily that there was nothing to be concerned about at that point.

51. Before he left the father got the changing mat out, and in the time the mother took to gather the things she needed to get him ready to go downstairs he had started to cry in a 'silent cry'. She has variously suggested that he seemed to have trouble breathing, he was turning blue/purple in colour and his face was swollen. She called father again. Father's evidence was that he had not even made it to the foot of the stairs when this call was received. The phone records show that the mother called the father at 19.03 – barely 5 minutes after he had last entered the bedroom. It is during these minutes that the LA suggests that the mother must have placed something over F's face. This time the father did think that F's face looked swollen, and he immediately called for the paternal grandmother and M.

52. The observations of paternal grandmother and aunt are in keeping with those of the parents. Mother told the police that: *"It was as though he was trying to cry but couldn't. Like he was in shock. We were calling his name trying to rouse him, eyes were half open*". The Paternal Grandmother's first description of F was that he was *"…. crying lots, struggling to breath and very distressed so I told them to call an ambulance. There was no bruising to his face it was only swollen"* . Aunt M described swelling, no bruising and that he was '… *crying and going purplish".*

53. At 19.05 the 999 call was made. F can be heard crying in the background at the beginning of the call and intermittently throughout it. The Mother informs the operator that *"his face is swollen"* that he is "*breathing"* and that he is *"crying"*. The Father says that he is having '*difficulty breathing … his face is swollen and he's not really breathing properly".*

54. Any further analysis of the detail here beyond those central consistencies is unhelpful in my view. The LA invites me to salami slice the narrative yet further so as to conclude that there was a distinct difference between F's presentation the second time – supporting their suggestion that something must have happened to him in those minutes between father leaving the room the first time and being called back. The only thing that I can conclude is that his presentation the second time was worse in the eyes of the father. It may be that he did not see what the mother saw the first time around.

55. More significantly these accounts have been confirmed by Prof Bu'L as entirely consistent with a natural cause for his collapse at home, i.e. breath-holding resulting from his screaming, a rise in intrathoracic pressure between screams, a Valsalva manoeuvre and his changing colour as a result of de-saturation of oxygen levels (see further below). And what we know from her evidence and can see from the history of his time in hospital is that these changes can and do happen very quickly.

What was observed by health care professionals Emergency

services

56. At 19.09 the first responder was on the scene. By 19.16 the first responder had been joined by an ambulance crew and I heard evidence from one of the two-man team, a Paramedic. These are experienced health professionals who are well used to attending difficult, emotional situations in pressurised circumstances. The first responder's job is to assess and if necessary, treat the emergency problems to be able to hand on to the crew. The crew need to sustain the stability of a patient to get that patient to hospital, if that is indicated and as the Paramedic

described, this baby was always going to be taken to hospital, no matter whether he had improved in his presentation during their attendance, because that is the protocol for babies. Whilst they are focused on stabilising patients who need taking to hospital, they are also trained observers and are watchful. They are equally aware of the importance of accurate recording. I have already set out their evidence about the unremarkable home surroundings. What they recorded about the mother arriving for a visit from Nottingham is of no interest to me.

57. The First Responder's evidence was that F's skin was *"extremely flushed"* with *"swelling to eyes and upper lip"*. He did not consider the swelling to F's eyes was in-keeping with a child who had been crying significantly – he said it was *"much worse"*. He thought it was an allergic reaction. The First Responder examined F's skin and found no rash, no bruising and no petechiae. He ruled out any suggestion that F had appeared purplish or bluish – he said that he did not recall anything other than redness to F's face.

58. The Paramedic had very little independent recollection by the time he came to give evidence to this court. He could not recall any particular part of F's face that was swollen or red, although he was sure that there was reddening around the eyes. He said that this reddening was *"potentially"* consistent with F having cried a lot, in contrast to the evidence of The First Responder as outlined above. Importantly, like Mr C before him, he did not note any petechiae, nor any cyanosis and could not recall seeing any bruising; he said that, if he had, or he had been told about any bruising (for example, by mother while they were in the ambulance on their way to hospital), he would at least have informed the hospital and, more than likely, followed safeguarding procedures.

59. Neither the First Responder not the Paramedic observed anything concerning about the whites of F's eyes. Mr C accepted that he had not been able to examine them fully because of the swelling but he did undertake some examination of F's eyes because he recorded F's pupil size to be normal and the pupils reactive. As is pointed out on behalf of the G – the bedroom was not well lit, and it was dark outside. Further, as Prof Lloyd said, it would not be particularly unusual for subconjunctival haemorrhages to be missed on initial examinations – but I cannot ignore that this first responder did examine the eyes.

60. Finally, it is significant in my view that both emergency responders describe an improving presentation during the time of their attendance. Crowley noted a reduction in his elevated heart and respiration rates and a change in colour from flushed to good between his observations at 19.10 and 19.24 respectively. F was not "blue lighted" to hospital. On leaving for hospital, the Paramedic said that F was stable and described F as being quiet and not particularly distressed. He confirmed that in his view the child did not seem very ill.

61. The LA relies heavily upon the mother's initial comments that she saw the 'bruising' to F's face developing in the ambulance. The mother's recollection was that she raised it with the crew, but they have no note of that, and it is something that they would have noted. Looking back, she is now not certain that this is what she saw. This is relied upon by the LA who argue it is an attempt to conceal the early development of injuries. I am afraid that this makes no sense to me. The identification of early bruising was certainly contrary to the mother's interests. Maybe she would not have been aware of this. However, she is the only person who

sees these 'bruises'. They were not observed by the ambulance crew and they were not noted on handover at the hospital or during the intensive intervention in the resus room. It seems highly unlikely
to me that they would have been missed and I do not think that she can have seen bruising at that point.

62. Drawing all that together the evidence from the health professionals first on the scene is completely consistent. Their main observation was of a child presenting with a swollen face – including around his eyes and upper lip - and very red skin. They disagree as to whether this could have been because of crying. It is beyond challenge that they observed nothing that could be described as bruising or petechiae. Nor did they observe any bleeding in the eyes. Finally, the picture is also of a child who was improving during their visit. F was settled and stable on hand over at the hospital. Again, I refer to the section below and Prof Bu'Lock's description of how F might look after recovering from a breath holding episode. The key element being the red and flushed appearance. This fits remarkably with the facts as recounted by these witnesses.

Hospital admission and resus team

63. F arrived at hospital at 20.03. There was a clinical handover at 20:07 where the information from the ambulance crew was recorded by the staff nurse. The swelling to F's eyes and lips was said to have reduced by this time, although there remained documented swelling to F's lips.

64. It was established during her oral evidence that F was probably seen by Dr D the consultant in paediatric emergency medicine within 30 mins of his arrival, so by 20.30. Staff Nurse R records that F was brought in with a possible allergic reaction and significant swelling to eyes and upper lip. Her note reads as follows:
Moved to ER, initial assessment done, observations done by STN – ***within normal limits at the time****.*[my emphasis] *Patient was asleep but rouseable when undressed and handled, no mottling noticed at the time. Shortly thereafter PEM consultant Tessa informed me that F looked very unwell. Monitoring attached and access attempted. Moved to resus and crash call put out*

When Dr D did examine F, she noted:
LAS brought in: ? allergy with swollen eyes
Seen by me: looked unwell, mottled, discoloured around face and eyes
Eyes swollen with discharge
Tachycardic

65. Dr D explained that F was moved from ER2 to the resuscitation area, where there was more space, and it is set out with emergency equipment. Although an "arrest call" was put out, Dr D explained this does not connote panic, but rather an 'escalation of care', where it was felt that more input was needed. My observation of her as a witness was that Dr D is a highly experienced and well-trained emergency consultant. She struck me as 'unflappable' which I expect is a necessary quality to have in paediatric A&E. When she describes an escalation in care as not being something to be panicked about, I am not at all convinced that this means that the situation is not very serious. Dr D performs in a theatre of life-threatening events and it is likely that all events are greeted with calm and clinical expertise.

66. There is a note made by the next treating doctor (Dr S) – to whom I shall turn in a moment – which records her as being told on handover by Dr D that F had suffered a *'serious hypoxic event'*. Dr D denies saying that although it is a little difficult to see how she would remember so clearly given her understandable reliance upon the notes for all other details. It may be that she does not recall because looking back this is not how she would describe the event now. She was clear that F did not stop breathing. For my part, I find it surprising that Dr S would record this had it not been related to her by someone. This also fits with the fact that F's lactate levels were elevated at 4.2 – something that can indicate reduced body tissue oxygenation, although I am told that this is not a specific marker for any particular diagnosis. It seems likely to me that this is what Dr D told Dr S, as Dr S was careful to note it. The explanation that it might have referred to events at home seems unlikely as no one up to that point had described what happened at the home in that way and the parents would not have used that phrase. It may not matter.

67. Was there a deterioration in F in the hospital? I have been cautioned about my approach to this. I accept that I have no one account of how F presented when he arrived at A&E and in the lead up and after. No one person who could compare how they saw him progress. However, I do have the detailed observations of the health care professionals whose job it was to monitor that progress and did albeit from differing perspectives. There is clear evidence that F had improved in presentation whilst being observed and transported by the emergency services as set out above. It is also clear that on delivery the first set of observations carried out by a nurse supported the assessment made by Mr K, the ambulance crewman, that F was stable and ok. What followed was a clear instruction that this child was to be moved to a place where access to emergency equipment and monitoring was better because he looked 'unwell'. As I have already commented, my assessment of Dr D is that 'unwell' to her connoted something that had to be taken seriously and indeed it was sufficiently serious for her to put out a crash call. As she described, a crash call pulls professionals from all over the hospital away from what they are doing, straight to her department. They are not just within the paed emergency team. Dr D would not have called for them to attend had she not considered their intervention necessary. What then unfolds lends support to that. In my view this is very clear evidence that this baby suffered a sudden deterioration in his condition which caused experienced medics to deliver an escalation in care through the resus procedure.

68. I am supported in this by the evidence of Professor Bu'Lock who also considered that there had been such a deterioration, which ultimately required the insertion of an interosseous needle and treatment in the resus area. Dr Irvine likewise confirmed that the fact the registrar was unable to gain intravenous access, meaning an interosseous needle was required to administer fluids and medication, was an indication that the child's condition had deteriorated.

69. Dr D did not carry out a detailed examination of F beyond supervising the crash call. She was, however, observing him throughout and sufficiently to observe and note discoloration and mottled skin. Dr D did not use the word "bruises" to describe that facial discoloration. At no point did she believe F may have stopped breathing, nor did she observe cyanosis. No petechiae were observed by her.

The mask

70. Dr D informed the court that a paediatric standard-sized non-rebreather mask was applied. This type of mask does not require a seal and does not need to be pressed down on the face at all, although if the mask moved out of place then it would have to be manually adjusted so that it sits on the face and over the nose. She thought it unlikely that the child was 'thrashing around' but conceded that a child need not be distressed for the mask to move. It is as well to remember that an intraosseous needle was inserted into F's leg – into the bone – because it had not been possible to get a line into him by any other means and he needed fluid. As Prof Bu'Lock observed – that would have been painful. All of the masks used on children are made from the same material as the sample mask provided to the Court – i.e. a soft, malleable material. She did not observe any pressure being applied or rough handling of the mask and she has never seen a mask leave a child bruised but she accepted that the only person able to comment on how firmly it was being held that was the person holding the mask.

Post-resus examination and monitoring

71. Dr S, became involved at around 10pm after receiving a paediatric arrest call. She was then a general paediatric registrar (specialist registrar year 5 as at the date of her statement – 22nd May 2022). I consider her to be of sufficient experience and do not accept the implied criticisms made about her being a junior doctor by Prof Bu'Lock. I accept the evidence of Dr Irvine that all things being equal, I must consider the noted observations of a clinician very seriously.

72. Dr S records her *'notable findings on examination'* as follows *'evidence of significant bruising and petechial marks [small bruises <2mm] around the eyes, forehead and bridge of nose'* and *'bilateral subconjunctival haemorrhages [blood visible on the white of the eye]'*. I note that there is no reference to marks across the upper lip in this summary. A blanch test was performed *'on the areas of concern noted on the patient's face….. In this instance, a blanch test confirmed non-blanching skin changes in keeping with bruising ("purpura" and "petechiae")'.* On the body map itself the marks around the eyes, on the forehead, close to the eyebrows and either side of the nose are drawn using hatched lines. Dr S confirmed in her evidence that whilst not all marks were labelled it is her common practice, when there are multiple marks of a similar nature, to record those in a similar manner – here with hatched marks – and that she blanch-tested every one of those marks, including the skin between the upper lip and nose. Curiously, the mark over the upper lip is not marked with the same pattern. The shading is single lines with no hatched lines across. Dr S was not asked about this. That mark is, however, labelled with an arrow and a note *'Bruising. No explanation given'*.

73. Dr S went on to confirm precisely what she meant by 'bruising' on this occasion. As suggested in her notes, she told me that when using the term 'bruising' she meant purpura and petechiae. As will become apparent when I come to the expert evidence, the potential causative mechanisms for petechiae, purpura and/or bruising are generally considered to be different.

74. F was examined by another doctor after Dr S and before Dr R's ward round. Dr K – a clinical fellow in paed critical care. I cannot discern the time. I understand the note was completed at 10.21 though retrospectively. This was only minutes before Dr R, the paed consultant first saw F. I have had no evidence from this doctor. I do not know whether 10.21 was when he

examined F or made the note. Dr R thought the examination was probably during the night shift. Either way, his examination was close to one or other of Dr R or Dr S. He reports *'purplish discolouration to periorbital, paranasal and paraoral skin. Nonraised lesions…… discolouration to eyelids…off yellow discharge from Rt eye…'* [my emphasis]. This is what he saw. Of note is the very clear distinction made between the orbital marks which are said to be around the eyes and the nasal and oral marks which are said to be either side (para) of the nose and mouth. This would imply nothing over the upper lip and what there is, is not described as 'bruising'.

75. Dr R, paediatric consultant, completes her ward round at 10.23. Owing to the passage of time, Dr R was mainly reliant on the notes of her dealings with F, rather than having an independent memory of this. Her registrar took the primary note at this examination contemporaneously. That note reads as follows: *'facial bruising seen, resolving'* [I491]. No further detail as to location is given. It is not until the first child protection medical letter [E13] that there is greater detail regarding where the 'bruising' was seen – *'around both eyes, in the creases between the eyes in the creases between the nose and cheeks bilaterally and circumferentially around the mouth'*. In her oral evidence Dr R maintained that what was recorded in that report reflected her examination and what she saw and was not a rehearsal of what was recorded on the body map. There was no explanation for why it did not appear in the source note.

76. Dr R said she may have done a blanching test, but she would not expect to have to perform this every time, because, from her clinical experience, some of the characteristics of marks are classic of bruising without having to do a blanch test. She said that the discolouration appeared to her to be bruising. This witness also gave evidence before we heard Dr S explain that what she saw was petechiae and purpura and so she was not able to be asked about this.

77. Dr R made no witness statement. Her CP report, as Mr Twomey QC and Ms Stone QC observe, is 'problematic'. It is incorrect in its detail and at times misleading, in significant particulars. Mr Twomey QC rightly highlights that this was a summary report and suffers as a result. The inaccuracies have infected the evidence of others but for me it also influences my assessment of Dr R's own evidence. I highlight three very significance errors:
    a. The report fails to record the fact that no medic identified bruising to the child's face prior to resuscitation and, consequently the reference *"no new bruising has been noted during his admission"* is incorrect and misleading;
    b. The report fails to identify that F arrived in hospital well and stable and, consequently, his later need for resuscitation represented a deterioration in his condition;
    c. The reference to him presenting with *"discolouration in keeping with bruising"* is simply wrong and not what Dr D recorded.

    Without wishing to be critical of Dr R I find myself unable to be satisfied that she did carry out an extensive examination of F beyond what she had seen in the body map prepared by Dr S. I am inclined to accept the submissions on behalf of the mother on this point that it is more likely than not that Dr R conducted an overview type of examination and the original note reflects the extent of it.

78. My review of the evidence of the treating doctors leads me to conclude that:
    a. When F arrived at hospital, he was well;
    b. He suffered a deterioration within 30 mins of arrival;

c. That deterioration was later described as a *'significant hypoxic event'*;
d. The first sighting of facial markings was by Dr S who saw non blanching type marks on F's face but at that point she identified all of them as purpura and/or petechiae as distinct from 'bruising'. This was also the first that bleeding in the eyes was seen.
e. The examination carried out by Dr R was more likely than not an overview. I am not satisfied that the detail which appears in the later CP medical report, written some days later, was from direct observations and consider it highly likely that the expanded detail comes from the body map to which the report refers.
f. If what Dr R saw was bruising, I cannot be certain of where it was seen and it was not noted as such by either Dr S or Dr K.

The experts

79. Before I examine the evidence from the experts, I will deal with some of the criticisms that have been made of them by Counsel in the case, where it is of importance. I did not hear oral evidence from Drs Fryer (consultant in genetics) and Keenan (paediatric haematologist). I found the evidence of Prof Lloyd and Mr Jayamohan very helpful. They were both very careful to remain within the bounds of their expertise and their responses were clear and fair. Neither was dogmatic nor unprepared to accept the possible whilst being unafraid to distinguish the impossible. Dr Millard was most helpful on the issue of angioedema. Criticism has been levelled at Prof Bu'Lock by the LA and at Dr Ismail by those acting for the mother.

80. Prof Bu'Lock is without doubt a highly regarded expert in her field. I consider that there is some basis for the criticisms levelled at her by Mr Woodward-Carlton QC when it comes to straying outside of her instruction and expertise. However, she does have extensive clinical experience as a paediatric cardiologist and whilst I found her assumptions about the relative experience of junior doctors and willingness to comment on facial marks from sub optimal images unhelpful it did not detract from the crucial evidence that she has provided on the significance of the cardiology in this case. Evidence, without which, the picture may have been very different.

81. I am afraid that Dr Ismail was less impressive. Her role as the consultant paediatrician was to pull the clinical observations and assessments together and to give a paediatric overview of the case providing a full assessment of the nature, causes and mechanisms of any injuries caused. She was expected to apply her knowledge as a generalist to the likely differential diagnoses. Her clear conclusion was then and has remained that F's injuries were '*suspicious'* of intentional suffocation. She based her conclusions on the CP medical and without seeing the hospital, or source material. As we have seen the CP medical was fatally flawed. However, when the detail was put to her in cross-examination she refused to shift her position or more importantly, accept that her failure to rectify the errors in her report as a result was in any way unhelpful. Dr Ismail gave the distinct impression that she was wedded to her decision that this is smothering, and nothing would change that. She advised against the instruction of a cardiologist, apparently on the basis that the treating cardiologists at GOSH considered the VSD was not of significance here and has barely modified that position in spite of the clear and unchallenged evidence of Prof Bu'Lock that the VSD is very much in play here. On the issue of mechanisms and forensic analysis, where her opinion differs from Dr Irvine, I have preferred his evidence.

The significance of the cardiology

82. F had an undiagnosed ventricular septal defect (VSD). This means that there is a hole between the right and the left lower pumping chambers in the heart. In Jan 2021 it was a significant size. The hole allows blood to flow (shunt) from one side to the other. It is documented that F's VSD was shunting bidirectionally on the first few scans.

83. Prof B opines that right to left shunting across a VSD is not common but mainly occurs in the newborn period or when something occurs to cause an increase in the pulmonary vascular resistance; eg pneumonia or breath holding. When this occurs then the baby's measured oxygen saturations may drop from their usual 98-100%, due to mixing of deoxygenated blood with the arterial circulation. This is known as cyanosis. If transient it is of little consequence other than imparting a blue tinge to the skin, but if prolonged then it may reduce the body's tissue oxygenation causing acidosis and circulatory compromise.

84. F had gastro-oesophageal reflux (GOR). GOR causes the inhalation of acidic stomach contents and is a *'fairly potent stimulus both to breath holding (apnoea) and a transient increase in the pulmonary vascular resistance'*. That in turn is likely to have resulted in the reductions in his oxygen levels as set out in the paragraph above. Although gastroesophageal reflux is common in babies, right to left shunting across the VSD might well explain his exaggerated response to these events and the perceived or real need for resuscitation both on admission and in hospital. Prof B opines that it is likely that throughout this time he was having transient reductions in his oxygen levels. At home, this would have caused F to look 'frighteningly blue' in his cot.

85. As Prof B rightly observed it caused significant anxiety in the nursing staff when it occurred on 27th Jan in hospital. Prof B goes on to note that this *'does not seem to have significantly recurred after starting omeprazole'* which fits because that will have reduced the gastric acid secretion. Thus, it seems that the VSD does provide an explanation for F's cyanotic episodes at that age. It fits with the description of the collapse at home, with what the first responder saw, with how he deteriorated after arrival at hospital, and again on 27th. Indeed, all of the experts agree that the VSD and the mechanism set out above provides a 'potential explanation' for cyanosis.

86. It is worth adding a word about 'discolouration' here. A term used frequently by the treating medics – Dr D and Dr K being two examples. As I have already set out Professor Bu'Lock was clear that F's VSD meant there was potential for blue blood to cross from the right to left side of the heart, particularly if he was breath-holding or gagging or experiencing a Valsalva manoeuvre, which in turn would cause him to look blue because oxygen saturations in the arteries are reduced. She went on to explain that this would cause the baby to look "*very different from how they would look normally*". Further, as the shunting stops, circulation returns to normal and the child may become flushed as part of their recovery. That results from re-oxygenation, meaning that a baby may well look red which is precisely what the first responder observed.

87. It is not for the parents to prove that there is an alternative explanation but with such a comprehensive explanation for the collapse, I must consider whether the LA has satisfied me

that it is more likely than not that this is not the explanation for F's presentation at home on the evening of 24th Jan. As Counsel for the mother has observed:

'... exceptionally in this case, we have clear exculpatory evidence of (a) why the child collapsed at home; (b) why he collapsed at hospital (at least twice) and (c) why, once his reflux was treated, he largely recovered. In contrast, there is no or no reasonable explanation, on the local authority's case, as to how the alleged inflicted event precipitated later collapses. On the local authority's case, the alleged infliction of injury coincided with natural events at home, repeated in hospital: an extraordinary coincidence…'

88. It is accepted, however, that the VSD does not <u>of itself</u> explain 'bruising' and subconjunctival haemorrhages.

Bruising or petechiae/purpura?
Definitions

89. As I have already identified there is considerable confusion amongst the treating health care professionals as to what was actually seen on F's face, where it was seen and when it was first seen. At the experts meeting those attending agreed that there was confusion – it was evident from a reading of the hospital notes - and they concluded that the appearance of F's face before and after resus was a matter to be determined by me. That confusion is made worse by what seems to be a lack of consistency in the use of the terms bruising, purpura and petechiae.

90. I have considered the evidence given, largely by Drs Irvine and Ismail on this issue. For the reasons set out, I prefer Dr Irvine's evidence. Dr Irvine advised that purpura and petechiae are similar. Petechiae are very small and often referred to as 'pin-prick' marks; purpura are a larger version of similar type marks. Both are generally caused by an increase of pressure and small venal ruptures or venous pressure, but not by external applications of blunt force – unlike haematomas or what he would term, bruising. Dr Ismail's evidence on this was confusing. She was far less clear about the differences between the two although at one point agreed that purpura and petechiae would not usually be caused by external trauma.

<u>Assistance from the photos</u>

91. There is a devastating absence of formal medical photography of F's face during his admission to hospital. The difficulties encountered in assessing what was actually seen by clinicians some 18 months on has been very clearly demonstrated in the paragraphs above. With proper medical photographs, taken in accordance with the RCPCH guidance, asking the instructed experts to comment on what appeared to be there, might have been more acceptable. I am left with imperfect imaging, predominantly taken by the parents on their mobile telephones, in different lighting conditions, with varying backgrounds and at different angles. I agree that the photographs are still evidence and need to be considered in the context of all the other evidence. They have been very useful in establishing for example that a face mask was used during the resus procedure – something that was initially denied. However, I must surely be cautious in considering any evidence from the instructed experts which seeks to determine the nature of those facial marks by reference only to the photographs.

92. One such example would be Prof Bu'Lock who suggested at one point that what could be seen on the photographs was clearly at odds with the documented accounts by the clinicians. The LA rightly invites me to reject this, and I do. However, it seems to me that equal caution should be applied to the evidence of Dr Millard on this point. Instructed predominantly to consider the possibility of angioedema, having rejected that as a possibility, and on the strength of one sub optimal image he opines:
'There are, however, some subtle, angulated purplish, bruise-like lesions in the paranasal areas (each side of the nose) and across the bridge of the nose and upper cheeks/ lower eyelids. My opinion is that these are bruises.'
When asked how he had come to such a firm conclusion that these were bruises he said that this was *'based on their angulated shape and because they were described as bruises by the doctors who saw them –they were also an appropriate colour'*
He accepted in cross examination by Mr Twomey QC that he would *'primarily rely on the treating doctor's accounts where images were suboptimal…'*

    Given those comments and my findings about what the doctors saw or were describing, that evidence cannot stand in my view.

93. I consider the comments made by Dr Irvine to be most helpful here. He said that the absence of proper photographs made him cautious when considering the photographs and videos he had viewed in the bundle adding that additional caution should be taken, because of F's ethnicity, possible anaemia, and that he may have suffered from cyanosis and/or redness as a result of crying, breath-holding or general distress. In the experts meeting he said that:
'photographs are difficult to interpret …there is evidence of purple red discolouration around the eyes, the bridge of the nose and over the upper lip…consistent with and supportive of the description of bruising….' But later went on to say it was *'Far from clear whether this was actual bruising or simple discolouration due to cyanosis or pigmentation'*. It was this position that led him to advise that the best evidence would come from the clinicians who carried out the observations. Dr Ismail seems to have largely agreed with that view though by going back constantly to the limited CP report.

94. So, the instructed experts are unable to provide any further clarity on what was actually seen. Whilst not ignoring the photographic evidence, it seems to me that it does not really change my assessment of the clinical evidence.

Mechanism and timing: petechiae and purpura

95. The expert evidence was that petechiae can be caused by an acute rise in venous pressure. Breath holding, which is a form of Valsalva manoeuvre, causes such a rise. Prof Bu'Lock said that she had seen petechiae in babies with prolonged screaming involving periods of holding of breath; Dr Irvine agreed that coughing and sneezing, gagging and choking and breath-holding could indeed cause petechiae.

96. Dr Irvine went on to describe how petechiae appear almost instantly and so timing of when they were first apparent was important. This was agreed by Prof Lloyd who said that there is typically a rapid formation of petechiae following a rise in venous pressure. Thus, if petechiae were present prior to arrival at hospital, breath-holding during the incident at home was a potential explanation for them but if the petechiae were not present before resuscitation,

they were probably caused during resuscitation and the absence of petechiae prior to resus is highly significant in this regard.

97. The same applies to purpura, namely that they are most likely caused by a rise in venous pressure rather than blunt trauma though there was some disagreement about this from Dr Ismail. On balance I prefer the evidence of Dr Irvine on these matters.

Bruising and the mask

98. The instructed experts are agreed that if there was bruising it was caused by blunt force trauma. Further, any bruising or redness could, they agreed, have been caused by the application of a face mask if applied with some pressure. This point was raised by Dr Irvine before he was told that there had been a face mask used in treatment. This was subject to the view of Dr Ismail that if there was found to be bruising across the upper lip then this did not fit with the application of the mask as it would not have fitted across the upper lip. There is also an issue about the bruising at the edges of the brows falling outside of the face mask area. So, there is unanimity amongst the instructed experts that subject to the location of the 'bruises' the firm application of the face mask would be a blunt force trauma capable of causing bruises to F's face.

Subconjunctival haemorrhages ["SCHs"]

99. The key evidence from Prof Lloyd about his area of expertise, the SCHs, can be summarised as follows:
    a. What was identified was bilateral SCHs
    b. The fact that they were 360 degrees and bilateral really ruled out a localised cause in favour of a more systemic cause
    c. There is a lack of comparative literature regarding these non retinal ocular injuries. The 2017 study cited focused on cases in which there was confirmed maltreatment.
    d. SCHs are a 'relatively non specific sign but **taken in conjunction with other signs of inflicted trauma** may be a 'sentinel' injury and indicative of abuse. A sentinel injury is a 'relatively minor injury which is a marker of more severe injuries.' As my emphasis demonstrates, however, SCH become sentinel injuries only in conjunction with other signs.
    e. He confirmed that one of the research papers upon which he relied addressed the prevailing view that isolated SCHs, that is with no other eye abnormalities, was not linked with child abuse. The paper provided an exception in cases where children obviously suffered prolonged chest compressions (involving fractures).
    f. Crucially, you can get bilateral SCH from Valsalva-type manoeuvres or where the intrathoracic pressure is elevated, thereby obstructing venous return from the head. As he observed *'You can see this in people that have been strangled…..but also in people with whooping cough….and so it is certainly possible that if it was a difficult resuscitation and that the intrathoracic pressure in this infant was elevated, that the bleeding in the conjunctiva was caused by that, together with the petechial bleeding around the eye….*' In oral evidence confirmed that a significant Valsalva is a theoretical explanation – but still one of a range of possible causes. It is notable that in the experts meeting he categorised other suggested 'causes' such as colic for example as 'unlikely'.

g. An oversized face mask applied firmly – can traumatise the medial caruncle, which is the medial part of where the eyelids meet – and could cause bleeding. He considered this feasible but extremely unusual.

The swelling

100. Professor Bu'Lock did not consider that, of itself, F's VSD explained the facial swelling. When cross-examined on the father's behalf, she said that it would be *"very unusual"* if F's VSD had caused any puffiness to his face, and it was *"very unlikely to be relevant"*, even when reminded of the GOSH "Red Flag" document provided by the mother [A12] and reproduced in Professor Bu'Lock's report. I am bound to say that this has left me a little confused. Why would GOSH produce a list of things to look out for, aimed at preparing parents of children with heart conditions and include something that does not feature? Many of the items on that list have been seen in F. But that was her evidence.

101. Mr Twomey QC makes the point that swelling is a subjective matter, with little independent medical recording; no reliable photography and a non-specific finding if established. There is no expert evidence to help with causation of one isolated incident of swelling save that crying babies' faces can appear to be swollen and F's eyes appeared to be swollen where he had some discharge.

102. I certainly have no evidence as to how or why facial swelling would be brought about by an attempt to smother or apply pressure over the child's face. There is no evidence that this is a classic sign of smothering or asphyxiation.

Returning to the broader evidential canvas

<u>The dynamics within the paternal home and the mother's history of mental health</u>

103. The LA has tried to build a picture of this mother as someone with 'unresolved' mental health issues who was living in <u>unbearably</u> stressful circumstances. Pressured by the 'weight of expectation' to have a child and by the bad feeling between her and her sister-inlaw. So badly missing her family that she was effectively isolated in the paternal home and fearful that her husband was about to go away. It is a dramatic picture but does not bear scrutiny, in my view.

104. It is my assessment that the mother's historical depression and her occasionally anxious responses to life's pressures have been unnecessarily blown out of proportion in this case. There is no evidence that she was carrying unresolved mental health issues with her from her teenage years, and I am not satisfied that the stresses of life that she encountered were anything out of the ordinary or were having any greater impact upon her than any other expectant mother during the pandemic. What is more, I consider the paternal family (with the exception of L) to be extraordinarily supportive of her and not the contrary.

105. There is no dispute that the mother historically suffered with situational depression arising from incidents in her school years. She was badly bullied at school and she became depressed as a result. She was deeply unhappy, and this prompted her to take an overdose of paracetamol. There is no evidence that the problems that she suffered then remained, as at Jan 2021, unresolved.

106. The suggestion that she had attempted to conceal the extent of her depression was discredited by Mr Twomey QC in his questioning of the now abandoned psychiatrist. As a result, it must now be accepted that she did not receive anti-depressant medication beyond her teenage years. It is right that this mother did not mention this history initially to the social worker but there seems to have been no attempt to work out why. Rather than considering the possibility that like large parts of the population, she finds it difficult to admit these historical problems with mental health, assumptions were made that she was seeking to hide something.

107. The LA has sought to draw upon the hints of a 'lack of stability' and 'strange behaviour' reported by the sister-in-law to the police. She suggested that the family had been looking to have a mental health assessment of the mother. This was denied by her in evidence but more significantly this suggestion was also denied by the family and greeted by them with complete surprise. It is notable that the paternal family were all fully aware of the mother's struggles as a teenager. They were asked in evidence about that and volunteered that she had been open with them about it. As I will set out, the allegations made about her odd behaviour are completely without evidential foundation and there has been no real attempt by those within the LA relying upon this information to objectively assess the validity of these claims.

108. The LA boldly asserts that the mother's ongoing mental health difficulties were demonstrated by her continued health anxieties and her expressions of anxiety to her GP about life and family stresses. I am not satisfied that these complaints to the GP demonstrate that this mother was unhappy or 'unsupported and isolated' in the paternal family. The fact that she was homesick and missed her family does not automatically demonstrate this to be so. In my view it was an entirely sensible suggestion that she should spend the time immediately after F's birth with her family and for me it demonstrates how thoughtful and supportive this family was. Culturally, it would not be unusual for the paternal family to insist that the mother should be with them following the birth of their grandson, no matter what. It is notable, in my view, that this was not a family that insisted on this. The father himself alluded to his 'relaxed' attitude to the time the mother spent with her own family – taking her there himself. I took that to mean 'relaxed' as compared to cultural norms. This obviously did not stop her from feeling homesick but at least that anxiety was not increased by the attitude of the paternal family. It was understood by them, in my assessment.

109. Much has been made of the 'pressure' upon her to have a child. It seems to me highly likely that this mother felt her own pressure to have a child simply because she had found it so difficult to conceive and when she finally did, she lost her first pregnancy. The mother was reluctant to admit that she felt this pressure, but it is entirely normal and natural to feel that way. The father's evidence was again more open and insightful on this issue. He accepted that his grandmother, to whom he is close, had said she would like to see him with a child. He agreed that this was probably an added pressure, but he told me how he had explained to his wife that it was not to be taken that way. He demonstrated enormous sensitivity and understanding about this issue and I cannot believe that his wife would not have seen the same. Again, that does not remove the pressure that she placed upon herself but to seek to suggest that the paternal family colluded in bringing that pressure to bear is a step too far in my view.

<u>The bad feeling between the mother and L</u>

110. Much has been made of the problems between the mother and L, the eldest brother's wife. I heard evidence from L. She struck me as rather embarrassed by having to explain

why she had approached the police when she could not identify a great deal of substance in her complaints. I also heard from the paternal grandparents and the elder paternal aunt, Aunt S. I considered that they were all honest and decent witnesses. The suggestion has been made that they have played down the issue as between the mother and L. That may be right. It is their family business. However, I believed Aunt S when she told me that in her view this issue between the two women had its roots in domestic pettiness. She reminded me that L had been the only sister-in-law in that household for more than 8 years by the time the mother arrived. L herself commented that she considered the mother was given *'some leniency in terms of daughter in law duties'*.

111. The clear impression that I have is that the reporting of these 'incidents' to the police says more about L than about the mother. An examination of the detail of allegations of the alleged erratic behaviour reveals them to be petty in the extreme and I do not consider the mere fact that she felt the need to report them somehow make them credible complaints. The police could not get L into the station to make a complaint and they finally concluded that there was no crime, suggesting that L visit her GP for her anxiety. Most telling for me is the recording that L told the police that family were *'pushing for a mental health assessment'* of the mother. I am sure that was said. It would be a strange thing to note, if not. But having heard the evidence of the paternal grandparents, I am quite satisfied it was not true. It demonstrates L trying to infuse her rather pathetic domestic complaints with the flavour of mental instability. No doubt she knew about the mother's history of bullying. She now says that she did not say that.

112. I agree that the relationship between the mother and L was fraught and continued to be so even after F was born and I also agree that this must have been unpleasant for the mother. The root of it was as Aunt S recounted, domestic pettiness. However, it is my view that the paternal family acted to support the mother from the impact of this. My sense is that L was the outsider here. The photo taken of the family together on the mother and F's return demonstrates this – L standing awkwardly on the edge. It was her family that was given a separate kitchen.

<u>The visit to Pakistan</u>

113. Finally, there is the plan for the father to go to Pakistan. I was worried about this for the mother. However, it is testament to his openness that he admitted that this was something he did suggest and that he wanted to do. I think that this was probably worrying for the mother but listening to the father made me realise that this was a difficult decision for him, because of his closeness to his own grandmother, but it was not made in ignorance of the impact upon his wife. Nor would he have gone away without ensuring that she was happy and cared for and quite possibly back with her own family.

114. As Mr Newton QC submitted –the issues relied upon by the local authority to support the contention that the mother had been brought to such an anxious and separate state of mind that she would decide to suffocate her son, do not begin to get off the ground. Indeed, the evidence about the family and this mother point in the other direction in my assessment.

Discussion and analysis

115. Occam's razor is the principle that a single explanation is the most likely in medicine. It assumes that when a patient has multiple symptoms the clinician seeks a single diagnosis

rather than diagnosing multiple and different ones. It is a philosophical tool for 'shaving off' unlikely explanations. Essentially, when faced with competing explanations for the same phenomenon, the simplest is likely the correct one. It doesn't prove or disprove, it simply leads you down the path that's most likely to be correct. That is how Dr Ismail has approached this case.

116. In many instances the simplest explanation is the most likely. When a non-ambulant child presents with multiple rib fractures and a skull fracture, no underlying condition and no history of a major traumatic event such as a car crash, then the simplest explanation of nonaccidental injury often is the most likely. There are situations as encountered here, however, where the medical picture is more complex.

117. This child has an underlying heart condition. Whilst it is right that his treating cardiologists describe his VSD as stable the chain of medical consequences that could flow from having a hole in his heart as a newborn combined with gastric reflux and observed breath holding provides alternative explanations worthy of examination. And yet in this case because those explanations do not necessarily provide explanations for all presenting symptoms, they are considered unlikely. Of course, that is not the test. It is not for these parents to provide an explanation for every symptom. It is for the LA to prove that smothering is the most likely explanation here.

118. Starting with the proposition that it is inherently unlikely that this mother would try and smother her child and adding to that what we know about his heart condition, GOR and predisposition to breath holding as a result, it seems to me self-evident that smothering is not the most likely explanation for this child's presenting symptoms at home, when seen by the first responder and ambulance crew, for the sudden decline after admission to hospital requiring resuscitation and for the similar incident witnessed on 27th.

119. But what of the marks to his face and the SCHs? Any bruising/ petechiae or purpura or SCHs, on my findings, were not seen until after the resuscitation procedure. Prior to that, the discolouration and redness observed is in keeping with the progress and resolution of a right to left shunt across his VSD. I repeat that it is not for the parents to prove that these are not inflicted injuries. It is for the LA to prove that despite the likelihood that F's presentation on those occasions was related to his unusual combination of health issues, these additional features make an attempted smothering more likely on the evening of 24th January.

120. I am not persuaded of that because:

a. I cannot be satisfied of what was seen on his face and where it presented;
b. Petechiae, purpura and SCHs can follow a rise in venous pressure of the sort likely to have happened here.
c. If there was bruising that might equally have been caused by the use of a face mask and I cannot be certain enough about where it was to exclude that possibility.
d. What I can be satisfied of, however, is that these marks did not appear until after the resuscitation and given the speed with which petechiae, purpura and SCHs arise, that makes what happened to him during the resus the more likely cause.

121. Still, I am left unable to explain the swelling observed on F's face at the outset. It is no more my responsibility to explain that than it is the parents'. The swelling is a conundrum. I agree that it is a non-specific symptom. Importantly, I have no evidence to suggest that swelling is a clear marker for smothering such that when thrown into the balance it makes a traumatic event the more likely explanation.

122. I end with the comments made by Mr Twomey QC at the conclusion of his submissions:

'The mother and father had to wait for 3 years before F was born to them: he was a much desired, cherished child viewed, as both parents indicated and his name reflects, as a gift from God;……F comes from an exceptionally loving and supportive family.

It is time for him to be returned to them.