

Case No: ZW19C90032

**IN THE FAMILY COURT AT WEST LONDON**

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

Date: 27/10/2020

**Before :**

**HIS HONOUR JUDGE WILLANS**

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**Between :**

**THE LONDON BOROUGH OF HILLINGDON**

**Applicant**

**- and -**

**(1) THE MOTHER**

**Respondents**

**(2) THE FATHER**

**(3) THE CHILD (through his Children's  
Guardian, Ms Karen Lain)**

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**Mr Nicholas Goodwin QC & Ms Sara Granshaw (instructed by Hillingdon Legal Services)  
for the Applicant**

**Mr Cyrus Larizadeh QC & Mr Nairn Purss (instructed by Duncan Lewis Solicitors) for the  
First Respondent**

**Ms Janet Bazley QC and Ms Emma Hudson (instructed by Beck Fitzgerald Solicitors) for  
the Second Respondent**

**Ms Sandra Fisher (instructed by Beu Solicitors) for the Third Respondent**

Hearing dates: 21-24; 29-30 September; 1, 9 October, and 5 November 2020  
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**JUDGMENT**

## His Honour Judge Willans:

### Introduction

1. In the early hours of the morning of 9 December 2019 baby N was brought by his parents to the A&E department at the Hillingdon Hospital. He was reported to have suffered a collapse in his father's care whilst feeding with related breathing difficulties. N received urgent medical care before being transferred to the children's department at Great Ormond Street Hospital (GOSH). In the course of his admission N was found to have suffered a series of injuries. These proceedings and this judgment consider what happened to N and who, if anyone, is responsible for the injuries.
2. In reaching conclusions I am assisted by the following: (a) A comprehensive final hearing bundle in digital format<sup>1</sup>; (b) additional documents provided in the course of the hearing; (c) the live evidence of: (i) Mr Abdul-Jabbar Ghauri (Consultant Ophthalmic Surgeon); (ii) Mr Jayaratnam Jayamohan (Consultant Paediatric Neurosurgeon); (iii) Dr Peramul (Paediatric Registrar- GOSH); (iv) Professor Stavros Stivaros (Paediatric Neuroradiologist); (v) Dr Patrick Cartlidge (Consultant Paediatric Surgeon); (vi) the father, and; (vii) the mother, and; (d) both opening and closing written submissions together with supplemental closing oral submissions of counsel for all parties. This fact-finding hearing proceeded on an entirely remote basis (using Microsoft Teams). Provision had been made for both parents to attend Court physically to give their own evidence but in the event all parties agreed they could be afforded a fair hearing by giving their evidence on a remote basis. The hearing proceeded without any notable problems and it is my assessment that my understanding of the evidence was as good as it would have been if all witnesses and advocates had attended in person.
3. The names of the child and the adult parties in this judgment have been anonymised, pursuant to the Practice Guidance of the President of the Family Division issued in December 2018 having regard to the implications for the children of placing personal details and information in the public domain. The anonymity of the children and members of their family must be strictly preserved. All persons must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court. Within this judgment I refer to the parents by reference to their role as mother and father to N. No discourtesy is intended. I can see no reason to anonymise the identity of the professionals in the case although I will make use of labels as appropriate to simplify the judgment.

### Conclusions

4. **I find the mother was not involved in the episode which led to the trauma suffered by N [§28-29]**

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<sup>1</sup> Within this judgment references [e.g. A21] are to the relevant bundle page

5. **I find the mother has no greater understanding than the Court as to what led to the trauma experienced by N [§30-32]**
6. **I find the threshold crossed in relation to all aspects of trauma sought by the Applicant (save re the chest petechiae) [§33-35; 62]**
7. **I find the trauma proven occurred whilst in the care of the father and arose out of a forceful shaking (shake-like) mechanism [§34]**
8. **I prefer the Applicant's case and find the trauma arose out of either a loss of control on the part of the father or out of some undisclosed event, but I reject the notion that it arose out of an event, the detail/memory of which has now been lost [§41-63]**
9. **I set out the next steps for the proceedings [§64-68]**

### **Threshold**

10. It is convenient at the outset to identify the findings sought by the Applicant<sup>2</sup> as follows.
  - i) On 9 December 2019 N was admitted to hospital with the following injuries:
    - a) Acute multi-focal, multi-compartmental subdural haemorrhage and acute traumatic effusions;
    - b) Acute subarachnoid haemorrhage overlying the top and right side of his brain;
    - c) ~~Acute subpial haemorrhage in the left parietal region~~ (not pursued)
    - d) Acute subdural haemorrhage in the lumbo-sacral region of the spinal canal;
    - e) Swelling within the paraspinal soft tissues/ligaments of the upper two cervical vertebrae of the neck;
    - f) Multiple bilateral retinal haemorrhages within all layers of the retina;
    - g) Linear bruise to the right forearm with overlying petechiae;
    - h) Petechial bruising on the anterior chest wall.
  - ii) Each of the head/spinal injuries [5(i)(a-f) above] was inflicted by either the mother or father by means of a violent shaking mechanism with or without impact against a soft surface, very shortly before the emergency services were called at 0533hrs on that date

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<sup>2</sup> A66

- iii) Each of the bruises [5(i)(g-h) above] was caused through rough handling during the course of the episode in which N was shaken
- iv) The perpetrator and anyone present when such injuries were caused knew that the force used to cause them was excessive and likely to cause N significant harm
- v) Whichever parent did not cause the injuries knows (a) that the other parent did and (b) the circumstances in which they were caused, having heard and/or seen him immediately before and during the episode in which he was shaken. Neither parent has told the truth about the context in which he came to be injured. In such regard the Applicant relies upon:
  - a) the parents' physical proximity to each other
  - b) the probability that N was difficult to feed or settle immediately before the causative event
  - c) the probability therefore that the non-perpetrator was aware of the immediate prelude to the incident
  - d) and thereafter the occurrence of an untoward event by which means he/she ought reasonably to have concluded N was injured.

### **Real Issues in Dispute**

11. The issues have considerably narrowed with the parents accepting the essential medical evidence as to causation under which the injuries were likely caused by a shaking mechanism or some equivalent mechanism which mimicked a shake. I am asked to investigate and rule upon the likely mechanism and importantly the likely circumstances under which either a shake or action mimicking a shake took place. In the light of this the real issues are as follows:
  - i) Did N suffer the global injuries in question whilst in the care of his mother or father?
  - ii) Given the acceptance of a shake-like mechanism, what were the surrounding circumstances attendant upon the episode of shaking and particularly:
    - a) did the episode involve a shaking-type mechanism which was deliberate whether arising out of anger, frustration or some other equivalent emotion or (an 'abusive' shake):
    - b) did the episode involve a mechanism which mimicked (a) above but arose in circumstances in which the shake was either non-intentional or arising out of an uncontrolled panic or responsive reaction to an apparent emergency (an 'innocent' shake)
  - iii) Was/is the other parent aware of the factual nature and circumstances of the episode?

- iv) Alternatively to 6(i) above did the bruising alone occur whilst N was receiving medical care following admission to hospital?

### Legal Principles

12. Engaged in a fact finding exercise I must have particular regard to the following principles:

i) The burden of proof rests throughout on the Applicant, both as to proof of non-accidental injury and as to the identification of a perpetrator of any injury found to have been non-accidental: ***Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35***. The standard is the simple balance of probabilities, more likely than not. This does not vary with the seriousness of the issue under consideration. The inherent improbabilities are simply something to be taken into account where relevant in deciding where the truth lies. Once something is determined to have occurred on balance then it is no longer improbable. The process of fact finding is binary. Once established on balance a previous allegation is ascribed the value 1 (proven as a fact). If not established, it is given the value 0 (not proven and thus wholly ignored). There is no room for lingering suspicion or innuendo.

ii) findings of fact in these cases must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation. See the clear enunciation of the same principles by Munby P. in ***Re A (A Child) [2015] EWFC 11***

iii) when considering cases of suspected child abuse the court must consider all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. The court invariably surveys a wide canvas. 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 a conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof. In ***Re U; Re B [2004] 2 FLR 263 Dame Elizabeth Butler-Sloss P.*** observed that:

*"...the judge invariably surveys a wide canvas, including a detailed history of the parents' lives, their relationship and their interaction with professionals. There will be many contributions to this context, family members, neighbours, health records, as well as the observation of professionals such as social workers, health visitors and children's guardians. In the end the judge must make clear findings on the issue of fact before the Court, resting on the evidence led by the parties and such additional evidence as the judge may have required in the exercise of his quasi-inquisitorial function..."*

Also see ***Re B (Children) [2006] EWCA Civ 1186***

iv) 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. See ***A County Council v K, D and L [2005] 1 FLR 851, per Charles J.***

*'It is important to remember (1)that the roles of the court and the expert are distinct; and (2)it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision.'*

As was made clear in *A County Council v A Mother, A Father and X, Y and Z (by their Guardian) [2005] 2 FLR 129*, per Ryder J. the medical evidence is but part of the evidence and must not assume undue prominence:

*'A factual decision must be based on all available materials, i.e. be judged in context and not just upon medical or scientific materials, no matter how cogent they may in isolation seem to be'.*

Further, as observed elsewhere by Dame Elizabeth Butler-Sloss P

*"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 would throw a light into corners that are at present dark."*

This principle, inter alia, was drawn from the decision of the Court of Appeal in the criminal case of *R v Cannings* [2004] EWCA 1 Crim. In that case a mother had been convicted of the murder of her two children who had simply stopped breathing. The mother's two other children had experienced apparent life-threatening events taking a similar form. The Court of Appeal Criminal Division quashed the convictions. There was no evidence other than repeated incidents of breathing having ceased. There was serious disagreement between experts as to the cause of death. There was fresh evidence as to hereditary factors pointing to a possible genetic cause. In those circumstances, the Court of Appeal held that it could not be said that a natural cause could be excluded as a reasonable possible explanation. In the course of his judgment, Judge LJ (as he then was) observed:

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

- v) cases involving an allegation of non-accidental injury often involve a multidisciplinary 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.
- vi) the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability
- vii) it is common for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (see

*R v Lucas* [1981] QB 720). When considering the question of ‘lies told’ the Court must be conscious of the full understanding of the principles contained within that decision. As explained in ***Re: H-C (Children)[2016] EWCA Civ 136*** there are four conditions to be met before a lie can be taken to support the Applicant’s case.

*"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...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."*

- viii) Separately but similarly the Court has to consider the relevance of inconsistency in evidence given over time. The court needs to apply caution in relying on such inconsistencies and discrepancies to prove a matter in issue. As Peter Jackson J (as he then was) observed in the case of ***Lancashire County Council v The Children [2014] EWHC 3 (Fam)***:

*"... 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 ‘story creep’ – may occur without any necessary inference of bad faith."*

- ix) An associated point relates to the caution the Court should apply when examining witness recollection. The mind is not a camera and memories are not instant shots of events experienced. Memory develops in a much more complex and unpredictable manner and caution is required when assessing witness testimony based on recollection/memory. In the case of ***Gestmin SGPS SA v Credit Suisse (UK) Ltd and Another [2013] EWHC 3560 (Comm) Leggatt J.*** (as he then was) commented on the fallibility of human memory and went so far as to suggest that in commercial cases little if any weight should be placed upon evidence based on recollection save where supported by documents. This viewpoint should be considered though in the light of ***Kogan v Martin and Others [2019] EWCA Civ 1645*** which emphasised that:

*‘Gestmin is not to be taken as laying down any general principle for the assessment of evidence. It is one of a line of distinguished judicial observations that emphasise the fallibility of human memory and the need to assess witness evidence in its proper place alongside contemporaneous documentary evidence and evidence upon which undoubted or probable reliance can be placed.’.*

*As Baker J said in in Gloucestershire CC v RH and others [2012] EWHC 1370 (Fam at [42],*

*'it is essential that the judge forms a view as to the credibility of each of the witnesses, to which end oral evidence will be of great importance in enabling the court to discover what occurred, and in assessing the reliability of the witness. 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 elevate one kind of evidence over another.*

In considering credibility limited weight should be placed on the demeanour or manner in which a witness gives evidence: see *SS (Sri Lanka), R (On the application of) v Secretary of State for the Home Department [2018] EWCA Civ 1391 per Leggatt LJ.* In the context of children law also see *A (A Child) (2020) EWCA Civ 1230*. Rather than base judgments on demeanour the Court should be considering the evidence given, its reliability, consistency and the extent to which is it inherently consistent with other evidence.

- x) Here I am asked to consider the potential roles of both mother and father with respect to the injuries identified. In this respect I have regard to the line of authorities dealing with the concept of a “pool of possible perpetrators”. To determine an individual was responsible for an act requires a finding of this being more likely than not. Such an outcome is plainly desirable as this will be in both the public and private interests of the child concerned. However there will be cases in which the Court cannot make such a finding when choosing between two or more candidates for responsibility. In such cases the Court has to ask whether there is a likelihood or a real possibility that an individual was the perpetrator. If this is the case, then that individual is left within the pool of possible perpetrators. Whilst the Court will wish to identify with clarity the responsible party it should not inappropriately strain to do so.
- xi) The use of the terms accidental and non-accidental was considered by Ryder LJ in **Re S (AChild) [2014] EWCA Civ 25:**

*“The term ‘non-accidental injury’ may be a term of art used by clinicians as a shorthand and I make no criticism of its use, but it is a ‘catch-all’ for everything that is not an accident. It is also a tautology: the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from, say, negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of section 31(2)...The threshold is not concerned with intent or blame; it is concerned with whether the objective standard of care which it would be reasonable to expect for the child in question has not been provided so that the harm suffered is attributable to the care actually provided.”*



## Background Detail

13) I take this essentially agreed background from the Applicant's opening note. I also have regard to the Applicant's case chronology. Elsewhere within this judgment I turn to the 'wide canvas' but it is neither necessary nor helpful to overload this judgment with a lengthy background to a case which in essence has no background of particular note.

14) As the Applicant comments within its opening:

*"This is a single-issue case relating to the causation of injuries sustained by N on 9 December 2019, aged 2 months. Neither parent has any criminal convictions or history. There are no background social factors of any concern. None of the health professionals involved with the family in the period between birth and injury raised any queries about either parent's functioning or parenting. Yet, despite these positives, N was admitted to Hillingdon Hospital with serious head injuries, with no apparent explanation, together with bruising at different sites of his body."*

15) The parents are aged 26 (father) and 25 (mother) respectively. They appear to have commenced their relationship when aged about 18 and moved in together following a civil marriage about 2-3 years ago before the mother fell pregnant with N in early 2019. Their respective family histories appear happy and settled without any material features. They both speak of a happy relationship and married life and of being delighted in discovering the mother was pregnant with N. This was a planned pregnancy. They each retain strong relationships with their wider family.

16) I have regard to the chronology and note no complications pre-birth or in the lead up to birth. N was born on 6 October 2019. Over the next two-months there were the expected medical engagements and the reporting is positive with the mother receiving a good level of support from her partner<sup>3</sup> and there being

*'a warm and loving interaction ...between mother and baby with mother responding appropriately to...cues'<sup>4</sup>.*

The father helped by taking paternity leave and the family provided support to give the parents an understandable break from child care in this early period. In this period the parents experienced a level of 'reflux' when feeding.

17) On the weekend of 7 (Saturday) -8 (Sunday) December 2019 the parents spent time apart. On the Saturday the father worked during the day and that evening was at home with his brothers and friends watching a sporting event late into the night. The next morning he was not working, and his brothers stayed for breakfast before leaving. The father then went to bed as he was tired.

18) For her part on Saturday the mother dropped N with her parents and had a day out with her sisters returning to her parents late at about 11:30pm. It was normal to leave N with her parents during the weekend as they offered the couple support with N. Arriving late the mother decided to sleep the night at her parents. The next day she stayed at her parents as there was a family party planned for the

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<sup>3</sup> Chronology 8 Oct 2019

<sup>4</sup> Opening §6

afternoon. She travelled to the party with her parents and sisters. She returned home with N at about 7-7:30pm.

- 19) Between that time and around 9:45pm (when he fell asleep) N was in the care of both parents. His father spent time with him, and the mother gave him a bath. When N had fallen asleep the father brought the mother some pizza to her bedroom before she went to sleep at about 11pm. The father returned downstairs to continue watching TV / playing video games. The parents' planning was for the father to give N his 2am feed and for the mother to give him his 5am feed. The father refers to the mother giving N an 11pm feed whereas the mother does not recall giving such a feed. I understand in broad terms this was a routine the parents generally deployed for feeding.
- 20) The father sets out that rather than going to bed he decided to stay up prior to the 2am feed. He was called at this time by the mother and went upstairs to feed N. However, both parents report there being a mix-up over the feed preparation and the mother ultimately giving N this 2am feed. As a result both parents agree the father was instead to give the 5am feed. There is no report of any issues arising over the weekend; during the preceding evening or during the 2am feed.
- 21) Come 5am the mother was woken by N and aroused the father to feed N. Both parents agree the father took responsibility for the feed and took N to a separate bedroom set up as a baby room. The upstairs area in their property has a small landing at the top of the stairs with two bedrooms and a bathroom off the landing – all in close proximity. Each of the rooms has a glazed panel over the door. The father had the hall light on which allowed a low level of lighting into the baby room without fully waking N. He had already prepared a bottle and proceeded to feed N. The father explained the feeding process (5oz) which broke into two parts. The first part was without event with the father feeding N whilst sitting in a rocking chair in the room.
- 22) What is said to have followed is central to this judgment. I take this account from the father's statement. He reports breaking the feed to allow N to wind on his shoulder and changing his nappy on the changing mat. He reports N showing no signs of distress and appearing content, smiling and kicking his legs. He then picked N up and resumed his position in the seat to continue the feed. At this point N began to choke in a similar fashion to his normal reflux. The father stopped and stood and began to wind N. However the father reports that whereas he would normally hear associated noises from the child, on this occasion he heard nothing. At the same time he could feel N was very hot against his shoulder. He could not hear N breathing and N was positioned supported from the back against his shoulder. Due to the lack of noise the father lent him forwards, but N went floppy in his hand. The father comments on N not having any control over his neck as a result of which he did not have time to get his hand up to offer further support. Both N's arms and head were flopping back, and the father caught his head. N was red and sweaty; his eyes were closed, and he did not appear to be breathing. The father reports offering limited CPR instinctively as he supported N over his left arm. N then began to breathe, but with a different quality to normal, being longer and deeper. He took N to the bathroom and put cold water on his neck and head to attempt to cool him. The bathroom is the door between the two

bedrooms. The father reports being in shock and scared. The situation had gone from normal reflux to something different to his normal experience. He knew it was serious and brought N into the parents' bedroom alerting the mother explaining something was wrong. Both parents became upset and emergency services were called. However, the parents decided it would be quicker to convey N to hospital themselves. The parents got into their car with the mother driving and the father holding N. On arrival at hospital the mother took N into the A&E department. This was the first time she had handled N since he was woken for his 5am feed.

## Medical Treatment

23) Having regard to the limited matters in dispute I intend to deal with this aspect of the case in relatively short detail. The overall picture is that N was admitted into the A&E ward at Hillingdon before being transferred for more specialist care at GOSH. I note the following:

- i) N arrived at the A&E ward at 6:07am<sup>5</sup> and was seen to be irritable with both upper and lower limbs hypertonic and a bulging fontanelle was felt. He received medication and multiple cannula investigations. N received significant medical care from Dr Perumal (Dr Qureshi (SHO) and Dr Raof (consultant)). In the course of Dr Perumal's investigations marks were noted including a mark on the right arm which the doctor considered to be a bruise. The totality of the evidence is of a worrying admission and a team working hard to ensure N was stabilised. In the course of this period of admission accounts of prior history were given. N later received a CT scan and intracranial (acute subdural) bleeding was noted. These results were forwarded to GOSH as it was considered N would need the support of a specialist neurological team. The results led to the Applicant being contacted due to developing child care concerns around the possibility of an abusive head trauma (AHT). Prior to transfer to GOSH the parents were informed as to concerns as to the possibility of a 'non-accidental injury'.
- ii) N was transferred to GOSH on the same day where he was placed under the care of a team led by Dr Kaliakatsos (consultant paediatric neurologist). He has provided a medical report detailing the history<sup>6</sup>. An MRI scan (10 Dec) confirmed bilateral subdural collections; spinal bleed and bilateral retinal haemorrhages noted on ophthalmology examination (10 Dec). I detail the results below. No skeletal fractures were found. Various blood and urine tests were performed to consider underlying conditions which might explain the injuries.
- iii) N remained at GOSH until 22 December 2019<sup>7</sup> where he remained for a short period prior to being discharged on 24 December 2019. He has received subsequent follow-up care, but I understand there are no particular causes of concern and he remains under review to ascertain whether he has any lasting effects of the matters which led to his admission.

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<sup>5</sup> H168

<sup>6</sup> I1457

<sup>7</sup> N102

## Legal Process

- 24) I would generally refer to section B of the bundle which holds the case management orders which apply to this application. However I briefly note:
- i) The application was issued on 19 December 2019 (as above just prior to discharge) and was allocated to me for case management. Save for a hearing on 26 March 2020<sup>8</sup> it has been case managed by me throughout. The application made clear a section 20 agreement was in place for N to be cared for by the maternal grandparents.
  - ii) On 8 January 2020 I held a CMH<sup>9</sup> and on 3 February 2020 a follow up directions appointment<sup>10</sup>. By 3 February 2020 all the appointed experts had been identified and were approved. Interim contact arrangements were considered and determined. A PTR was fixed for 3 June 2020 and this hearing was fixed to commence on 15 June 2020.
  - iii) On 20 April 2020<sup>11</sup> I approved a consent order which re-fixed the hearing dates in the light of problems surrounding expert availability. On 30 July 2020<sup>12</sup> I heard an application for disclosure made by the Metropolitan Police. The PTR was heard on 19 August 2020<sup>13</sup> and confirmed this hearing's listing. The hearing has proceeded as per a witness template agreed on that date. Initially it was thought it would be better for the hearing to proceed by way of Zoom however subsequently this was varied in favour of Teams. Also provision was made for the parents to attend in person to give evidence (with the balance of the hearing being remote) – this was also subsequently varied by unanimous agreement.

## Medical Evidence

- 25) The medical evidence has been both considered and tested by specialist and highly experienced leading counsel. In closing the following concessions were made:

*Having tested the medical evidence during the hearing and having reviewed the expert opinion in light of their live evidence, the Mother accepts their conclusions that the brain, eye and ligamentous and spinal injuries suffered by [N] were caused as a result of a single event at some point during the 5am feed...She accepts that a single shake could have caused the injuries and that repetitive shaking was not required to cause the constellation of injuries to [N]. She accepts that significant force would have been necessary and that the force applied by the father would have been inappropriate and misguided. [Mr Larizadeh QC for the Mother]*

*By the end of the expert evidence, it was clear (and the Father accepts) that: The mechanism for [N]'s head and retinal injuries is likely to have been a vigorous backwards a (sic) forwards movement involving extension and flexion of [N]'s head...[H]aving heard the medical evidence, the Father accepts what he did must have mimicked the shaking mechanism described by the experts.... [Ms Bazley QC for the father]*

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<sup>8</sup> B82

<sup>9</sup> B58

<sup>10</sup> B66

<sup>11</sup> B87

<sup>12</sup> B104 & B107

<sup>13</sup> B109

Given these concessions - which are realistic - I am not required to spend significant time analysing the expert medical evidence. However, I would wish nonetheless to make clear my gratitude to each of the experts for the care they have brought to this case. I would expect nothing less of clinicians who are pre-eminent in their field, but it remains the case that these sorts of cases demand the upmost care and consideration alongside an open and wholly undogmatic mind. They require experts who are masters in their own field but are willing and ready to acknowledge the limitations of their expertise. Each of the experts before me wholly fulfilled the expectations placed upon them. Perhaps most importantly of all these parents know their child's collapse has been comprehensively examined and that they have received the best help possible in understanding what happened.

26) The expert evidence informs me as follows:

- i) There is evidence of an encephalopathic symptoms (malfunction of the brain) at home and continuing at the time of admission to hospital. The symptoms described by the father at the time of winding (and said to be illustrative of an apparent life-threatening event (ALTE)) could equally be symptoms of encephalopathy: See Dr Cartlidge and Mr Jayamhoan in particular;
- ii) It is noted the suggested ALTE and encephalopathy are in close temporal proximity. But if the encephalopathy resulted from a panic response to an ALTE then close proximity is to be expected in any event: Dr Cartlidge;
- iii) An ALTE is generally a relatively short-lived event and will resolve itself in a short period after inception. On the facts it was unlikely to be in play when the parents were leaving the property many minutes after the initial collapse. As such any symptoms on the way to the car – en route to hospital are likely to be consequent on encephalopathy not ALTE: Dr Cartlidge;
- iv) As to timing all experts were of the view that the trauma likely arose during the 5am feed and would have been unlikely to have arisen prior to a time when N was presenting as content (feeding etc). It is unlikely the child would have experienced a 'lucid interval' between the injury and deterioration and the trauma is likely to have arisen at the time of significant change in N's behaviour: Mr Jayamohan. N would have been obviously unwell immediately after the causal event: Dr Cartlidge. All experts rule out birth related trauma.
- v) Equally the evidence supported one episode of trauma: all experts save Dr Ghauri given that ophthalmic haemorrhaging overlays previous bleeds.
- vi) Dr Ghauri was of the clear view - absent organic explanation - the retinal haemorrhages found, comprising of bilateral, multi-

layered haemorrhaging which was widespread and with too many to count were indicative of severe head trauma. The findings lacked the characteristics of accidental trauma (unilateral/single layered/confined to the posterior pole). He did not consider the haemorrhaging to be secondary to raised intracranial pressure generated by subdural bleeds and they were informative as to cause in their own right.

- vii) Mr Jayamohan noted N's increased tone, bulging fontanelle, abnormal posturing and later discovered subarachnoid and subdural bleeding / acute subdural effusions as only being explicable by a significant traumatic event<sup>14</sup>. He also noted the evidence of bleed in the lower spine and raised the question as to whether this was a de novo trauma (although it is accepted on the evidence of Professor Stivaros that this may reflect tracking from the brain bleed). Further he noted ligamentous change seen in the upper spine as being indicative of a traumatic event requiring significant flexion<sup>15</sup>.
- viii) Professor Stivaros' evidence mutually complemented that of Mr Jayamohan. The imaging patterns on which he has specialist skill was typical of abusive head trauma. It was not of particular relevance as to whether the blood in the lower spine was de novo or not as in either case it was indicative of an inflicted injury. The evidence was of an initial acute subdural bleed with the development of associated acute traumatic effusion (via a tear in the arachnoid membrane). This all pointed towards recent rather than older harm. There is evidence of bleeding in the spinal canal low in the lumbo-sacral region which is increasingly recognised as a signal of a shaking injury and swelling in the neck region (the ligamentous injury referred to above). As with the lower spine bleed there was a limited debate as to the significance of a feature referred to as either a lollipop or tadpole. By the end of the evidence this debate whilst interesting was entirely academic as it was agreed this had no bearing on either the mechanism or force of the incident (save that it required more than a low level of force – which was of course a conclusion drawn from the other evidence in any event).
- ix) Dr Cartlidge ruled out any reasonable grounds for suspecting genetic/organic causation/disorders. In any event I agree with the Applicant that were there such a basis then it would be 'vanishingly improbable' for these separate injury components to have arisen coincident with a significant encephalopathy. The spinal/cervical injuries were caused by hyperflexion-hyperextension of the neck, typically seen in a shaking injury

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<sup>14</sup> E179

<sup>15</sup> E180

episode. The intracranial bleeding, retinal haemorrhaging and neck injuries were likely caused by shaking.

x) As to likely mechanism all experts pointed to a shaking episode or logically an event, which whilst not a classic shake, had the characteristics of a shake with a rapid hyperflexion-hyperextension of the neck (involving acceleration and deceleration). All agreed the mechanism would fall outside the reasonable handling of a parent and would generate alarm to a watching bystander. All agreed the trauma could have arisen from a single 'shake' so long as the force deployed was sufficiently significant. As to mechanism Dr Cartlidge made clear the movement need not be simply back and forwards through a single axis and that such an episode would typically involve varying degrees of rotational force.

xi) In the course of evidence the father had provided a series of videos to assist in the understanding of the process he had undertaken with N on the night in question. All the experts were of the view that they could see nothing in the suggested procedure that could have accounted for the injuries sustained in this case. Having considered the videos it is clear the process demonstrated by the father would not fall out of normal handling and could not generate anything like the forces required. This is conceded by the father in closing as was noted by Ms Bazley QC:

*By the end of the expert evidence, it was clear (and the Father accepts) that:-  
...The Father's descriptions in his videos and to the police do not demonstrate either sufficient movement or sufficient force.*

xii) By the conclusion of their evidence it was clear (and is now accepted) that N suffered a shake like episode involving significant forces, and whilst this might have only required one 'shake', this 'shake' would have been of such force as to alarm a bystander and involved a significant hyperextension-hyperflexion to cause the constellation of injuries experienced by N. The descriptions to date given by the father, both orally and 'theatrically' fell significantly short of what was required. The injuries had an explanation other than that directly presented to the Court.

xiii) In reaching their conclusions it is plain the experts considered there to be a threshold of force required to explain the trauma suffered. Beyond this the picture is uncertain and it is clear to me one cannot proceed to correlate actual harm against force used. As such one cannot say with confidence that a child suffering a very serious level of injury experienced twice as much force as a child viewed to have suffered injury approximately half that level. That is territory into which the expert evidence cannot

confidently tread. Dr Carlidge addressed this point<sup>16</sup> and those acting for the father draw attention to the point in closing to suggest that peculiar vulnerability in the victim may mean the forces required are both unclear and potentially lower than might otherwise be expected. In the ultimate assessment I do not consider this point counts for much. Most importantly because all the experts agreed the forces required would be at a level to cause concern. None of the experts suggested there was a vulnerability in N which might explain his injuries by reference to a force that fell below the level of unreasonable handling. In my assessment Dr Carlidge did not modify his conclusions in such regard. Additionally, I am not sure the experts agreed with the extreme variability posited by Dr Carlidge, when he spoke of the possibility of one child suffering a fatal reaction to a force which might leave another child with only mild injuries. To the extent there was disagreement on the point I would be cautious to accept such a viewpoint, although I do not consider it is engaged on the facts of the case. I suspect for such a point to hold there would have to be other factors in play which influence the range of response. In this case the only point noted is the additional loss of muscle tone that may have arisen on an ALTE. It is hypothesised this may have led to greater vulnerability. However the expert evidence (and indeed the father's live evidence) was as to N having no material neck control and I do not find this to be a point that provides a meaningful alternative explanation or rationale for the level of forces required. In the ultimate assessment I find nothing turns on this particular point.

- xiv) Dr Carlidge dealt with the bruising issue. His evidence was that to the extent the child had suffered bruising either a shaking or shake-like episode would provide likely explanation for the bruise. The injury did not require a separate episode and in that sense the bruise was consequential to the episode. He was of the view the arm mark was a bruise. He accepted the process of emergency treatment was such that bruises and marks might naturally be occasioned without grounds for complaint.

## Discussion

- 27) In reaching my conclusions I have conducted an analysis of the evidence before stepping back and reflecting on the various points and how they interact with each other and before reducing the same to the paragraphs that follow. However, a judgment by its nature must have a sequential structure and this is my analysis of the evidence.

### Who was present with N when he suffered his encephalopathic response?

- 28) The evidence is clear and points in my judgment to the father. I am satisfied in this respect to a high standard and materially beyond the balance of probability.

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<sup>16</sup> E319



In reaching this conclusion I have considered the following points (and resolved them accordingly):

*Points suggestive of the mother*

- a) *The parents disagree (albeit not forcefully) as to whether there was a 11pm feed on the preceding night. The Applicant questions whether this undermines the parents account of the feeding routine during the relevant period. The parents challenge the material relevance of this disagreement:*

I do not consider the limited uncertainty around the 11pm feed sheds material light on this question. Were there to have been an 11pm feed then the father would have been due to give the 2am feed. But this is agreed in any event and it is the events surrounding the 2am feed which are material. I can well understand how there may be some confusion as to whether there was an 11pm feed and note the confidence of the mother that the same did not take place. It is noteworthy the father was in any event elsewhere in the property and may well have assumed the feed was given, when in fact it was not. This was of course a child who would have been proceeding through regular changes in feeding pattern and it seems highly likely the father simply (and innocently) interposed into the feeding routine a feed that in fact did not take place.

- b) *The Applicant asks me to assess whether the parents account of the changing of responsibility for the 2am/5am feed is concocted to shift responsibility to the father. I am asked to assess whether the explanation given of a miscalculated feed is correct or an intended distraction. The purpose of the same is to distance the mother from what would have been her feed responsibility at 5am. The applicant question whether it was in fact the mother who conducted the 5am feed. The parents stand by their account of the events of the 2am feed, with consequential impact on the 5am feed:*

Having heard all the evidence I accept the unchallenged accounts of the parents as to the responsibility they each took for the respective feeds at 2am and 5am. I accept the account of an error shifting responsibility for the 2am feed (and thus the 5am feed). This seemed to me a plausible account which had the ring of truth about it. I pause to note there would be a host of alternative, and simpler, explanations which could have been used. A simple explanation would have been to suggest the father was slow to wake at 2am. I consider there was no need for the convoluted account and having listened to both parents I accept their consistent account in this regard. I found the explanation robust, genuine and plausible. It spoke of the type of mistakes and confusions that regularly arise in the early days of parenthood. That the mother then assumed the feed, having awoken, was equally plausible.

- c) *But did the mother give the game away in police interview when discussing the 5am feed when she replied to questioning as follows<sup>17</sup>:*

- Q. Okay. My last question is what has...[the father]...told you about what happened whilst he was feeding N?
- A. So the only thing he told me was is he was feeding him, obviously naturally I'm going to say what happened when I was asleep.
- Q. Yes, of course?
- A. **I was feeding, he was feeding him.** He sometimes, what happens with N, and this has happened many a times, even with me, he sometimes chokes a little bit, it because he needs to burp, so we take the milk away and put the milk down and burp him, so that's what he did, and [the father], what he does, he feeds half the bottle, whether it's four or five ounces, he gives half, he changes him, because sometimes he gets a little bit sleepy and wants to go to sleep, but we try and encourage him to stay awake for his feed. [highlight added]

The Applicant suggests this error has potentially revealed the truth of the mother carrying out the 5am feed. The parents suggest it was a mere mis-speak in the course of a police interview late at night<sup>18</sup> and after a traumatic few days for the mother.

In my assessment this is a very fine thread on which to construct a case against the mother given the obvious potential for mis-speaking in the context of an interview in which the mother was moving between giving general accounts of her behaviour and the behaviours on the night in question. It would of course be the easiest of errors and is one the Court sees very often. The mother immediately corrected herself mid-sentence and it is plain the investigating officer (who would be alive to the responses) made nothing of the error. I consider it to be no more than an error. Having read and viewed the interview it is entirely probable the mother was simply jumping between tenses in explaining what she had been told and hence went from saying what she was told in the first person by the father ("I was feeding...") to translating it into the second person for the officer ("he was feeding..."). This has potential as in the preceding answer the mother sets the scene for an explanation as to what she had been told.

- d) *A point made (but to a lesser extent) asks me to consider the likelihood of the mother taking such a non-hands on role in handling N following the suggestion of her being alerted to his difficulties. On the parents evidence the mother did not handle N throughout this period, only in fact taking active hold of him on arrival at hospital. I think I was asked to consider whether this was plausible and whether it might in some way point towards the mother in some way distancing herself from N having caused him harm.*

The difficulty with this point is that it hinges on the normalcy of response in circumstances which are anything but normal. This was for both parents, on any case, an extreme situation and outside their experience. I question the value to be obtained by applying stereotypical analysis as to what is to

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<sup>17</sup> G69

<sup>18</sup> Interview conducted between 22:16 – 23:46hrs

be expected from each carer. An important facet of the case was that the father does not drive, and this feature undoubtedly fed into their respective roles as they approached the question of transporting N to hospital. Viewed clinically and in the cold light of the day it is a little unusual that the mother did not take hold of N, but I find little assistance in this and guard myself against imposing an artificial level of composure on what would have been a stressful period of time. The evidence is not of the mother simply sitting and waiting for things to happen. Instead she was active and engaged and had other important things to do. This sufficiently explains the role she undertook.

*Features to the contrary*

- It is striking to me that the above points are rather fine points rather than firm pointers towards the mother. Taken cumulatively they add little to my understanding of the case and I consider this itself is a pointer against the mother being the carer for N at the relevant time
  - I also consider the parents' account to be sufficiently consistent throughout as to support the intrinsic truth of their respective responsibilities. Subject to the most modest points (noted above) both the mother and father have consistently accounted for the 5am feed in terms of the father being responsible with the mother in bed. This has remained the case despite other challenges to the account.
  - My assessment is that the account regarding the 2am feed is a genuine account from both parents. In reality this sets the scene for the 5am feed.
  - The alternative proposition requires a willingness on the part of the parents to collude to shift responsibility to the father. Unlike the assessment of what happened with the father, this would inevitably bring into the parent's direct focus some level of understanding as to an improper act. It is difficult to see why they might proceed through this process in circumstances in which the mother had immediately reported an accident to the father. It really does require collusion between the parents in the knowledge that they are covering something up. It does not require the father to know the full details, but it would plainly suggest the need for the truth to be hidden. Whilst of course this could happen (it is a possibility), I do not find it likely having heard and assessed all the evidence. In my assessment the evidence was sufficiently consistent to rule out such a proposition.
  - The account given by the parents is in isolation logical and makes sense. If I, as I do, accept the mother took on the 2am feed then it is likely the father took the next feed. In my judgment all the evidence points to this being a true account of what took place.
- 29) I should note that it has been no part of the case to suggest that the trauma was suffered whilst N was in the joint care of his parents. I rule out such a proposition as being inherently unlikely and wholly inconsistent with the evidence put before me. On everyone's case these are parents who very much

love their son. Whilst there is plausible room to examine a loss of control on the part of one parent in isolation, I consider it most unlikely both parties would have fallen into such a state when in company or importantly that one parent would have separately lost control in the presence of the other. In my assessment the presence of the other would likely have prevented a situation developing, e.g. were the father to have become increasingly frustrated then the mother would likely have reduced the tension by stepping in (or vis a versa). Equally I consider the mere presence of the other would have been an important factor in reducing the prospects of trauma. There are all sorts of social factors which control individual behaviour in company rather than when alone which would have likely been in play were this to have been the case.

Has the mother underplayed her knowledge of the episode?

- 30) The Applicant (see threshold and §5(v) above) asks me to consider whether notwithstanding the conclusion above, the mother knows more than she is revealing. The suggestion is that she is aware of the father misconducting himself and has chosen to collude with him for their joint advantage. The Applicant in closing observes:

*Our particular concern is that the mother is surely likely to have heard an incident involving the father in the next bedroom. The evidence establishes that that is more likely than not: (a) The house was small; (b) She was not a heavy sleeper; (c) Once awake (as she was at 5am) she took a long time to get back to sleep; (d) She was sensitively attuned to [N's] movements and the sounds he made, even to the point of waking up when his head rustled against his bedsheet; (e) If the father injured [N] in a momentary loss of control when frustrated, there is likely to have some prelude to the event. It is unlikely to have occurred out of the blue.*

- 31) I have not been persuaded by this line of argument. To a significant regard it rests on the 'prelude to lose of control' point at (e) above. In reality this is a proposition with a number of stages, in respect of which, the failure of any one would rob the theory of its capacity to predict what happened. It works backwards by theorising a loss of control. It then speculates as to the form of the loss of control and the preceding circumstances that may have led to the loss of control. Next, it seeks to build into the circumstances an attendant level of noise or other disruption that would have accompanied the event. Finally, it imposes onto the circumstances of the mother a series of points that are required to hold such that she experienced the disruption noted above. Of course it presumes the father in losing control at the same time had no concern to mask his deteriorating lack of control. I readily accept there will of course be many cases in which such loss of control is accompanied by surrounding disruption that would inform third parties. But there are equally cases in which such behaviour goes un-noted by those otherwise in relatively close proximity. I consider it unwise to stretch the hypothesis too far.

- 32) To the contrary I am more persuaded by the following points:

- I do not consider the geographical proximity point to be as powerful as it is suggested to be. The father was in a separate room with a small hallway and door separating the parents. This is more than sufficient to mask noises. Indeed as I understand the evidence the point of decamping to the other

room was to leave the non-feeding parent the opportunity to sleep. This speaks of the potential for natural noises to be deadened for the benefit of the sleeping parent.

- Whilst the mother agrees she is attuned to the noises of her son waking in synchronicity with him this does not mean she would remain attuned in circumstances in the middle of the night where he had been removed by the other caring parent to be fed. It is easy to see how a tired parent in such circumstances would fall into sleep. Indeed as noted above this was the very purpose of the shared routine. The mother had been awake at 11am and had carried out the 2am feed. She had experienced a busy weekend. It would not be surprising if she fell into sleep.
- The evidence of the mother struggling with sleep generally is noted but it only goes so far. It does not rule out the mother actually falling asleep.
- As noted above I accept that losses of control / indeed dramatic accidents/episodes may be accompanied by disturbance and uncontrolled noise. But they need not be. A person misconducting themselves may be conscious to ensure they are not overheard. A loss of control may be sudden and quiet and the impact on the child may be to quieten the child rather than cause it to scream. Given the mechanism in this case is on any account potentially short-lived and sudden in character it is entirely possible that it was not surrounded by disturbance at all.
- I also bring into my assessment the mother's evidence and the wider canvas insofar as it concerns her. Having heard her evidence I find it most unlikely she would have colluded or deliberately covered for the father, were she to have been aware of a different account of what truly happened.

- 33) On balance I find the mother was neither involved in the episode leading to the trauma suffered nor did she (or does she) have a fuller understanding of what happened to N, beyond that presented to the Court.

#### What happened to N?

- 34) I accept the medical evidence placed before me. All parties agree it provides the explanation of the trauma suffered by N. It is quite clear to me as follows:
- Prior to his 5am feed N was in good health and without injury
  - The injuries (excluding bruising) considered within this judgment were occasioned during the period of that feed and had occurred prior to the 999-telephone call timed at 5:33am<sup>19</sup>
  - The injuries arose whilst N was in the sole care of his father
  - The injuries arose out of a shake or shake like mechanism under which N underwent a forceful acceleration/deceleration motion causing hyperextension-hyperflexion of the neck
  - The injuries may have been occasioned by a single 'shake' so long as that shake had the significant force required as explained by the experts
  - The 'shake' episode fell outwith reasonable parental handling and would have been such that it would have alarmed a watching bystander

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<sup>19</sup> G251

- For the avoidance of doubt the injuries (excluding bruising) are as detailed within the expert reports and as sought by the Applicant (as modified) involving acute subdural haemorrhage / acute traumatic effusions; acute subarachnoid haemorrhage; ligamentous swelling to the soft tissues of the upper vertebrae of the neck; acute subdural haemorrhage to the lumbar-sacral region of the spinal canal; multiple bilateral retinal haemorrhages within all layers of the retina.

Does the evidence shed any greater light on the circumstances surrounding the ‘shake’?

- 35) It is important to note that these findings establish the threshold as being met: see **Re S** (at §12(xi) above). Travelling beyond this is to travel into the territory of seeking to ascertain whether the circumstances flowed from accident or from a more troubling set of circumstances.
- 36) The focus of the hearing to a very large extent was engaged with this secondary question. The competing cases ask me to consider whether the father caused the trauma in a moment of anger or frustration out of a loss of control or in contrast whether it is more probable that any injury was consequent upon a panicked reaction to a perceived developing emergency. This has meant that whilst this case commenced with a more generalised investigation in mind it has ended with the consideration of a quite narrow question.
- 37) I accept there is real merit in seeking to ascertain (if possible) the likely circumstances attendant on the episode in question. I agree it has a marked impact on the management of the case hereafter as to whether there remains a risk to be managed or in contrast whether this was simply an unhappy accident which will not be repeated.
- 38) I of course remind myself of the important legal principles set out above and in particular the continuing burden being on the applicant to prove any allegations it seeks to make with there being no responsibility on the father to disprove the same. I equally continue to reflect upon the wise guidance as to ‘story creep’ and as to the fragility of human memory set out in the preceding paragraphs.
- 39) With this in mind the final positions taken by each of the parties is as follows:
- The Applicant contends the Court proceeds from the expert evidence as to the mechanism required. The father has provided a detailed account of what took place, and this falls significantly short of anything that could have caused the trauma. The Court should be cautious in accepting the arguments based on a gap in memory and should be wary of being encouraged to fill the gap with an innocent explanation where it has before it a detailed account which is outwith the expert opinion. The wide canvas is important but sadly cases of this sort often arise within otherwise happy and functioning families.
  - The father (supported by the mother’s belief in the father given her knowledge of him) points to the evidence which supports the notion of the child suffering an ALTE and the likely impact on the father as carer.

The father's counsel submits it is most unlikely the father would have latched onto this argument unless it had foundation in reality. The evidence suggested a panicked parent might have acted in a manner they would not have done when settled and there is potential for the father to have harmed N in the course of a panicked response. Viewed from this perspective there is not so much room between what the experts suggest is required and what the father accepts. In any evaluation of accounts regard should be had to the stresses the father was under and proper allowance should be given for the potential for memory to be blurred notwithstanding the father's best attempts to be of assistance. Any assessment must have proper regard to the wide canvas which is entirely positive.

- The guardian takes a neutral position pointing to many of the points identified elsewhere within the arguments.

40) I turn to analyse these arguments.

#### The wide canvas

41) It is always important for the Court to have proper regard to the surrounding circumstances when assessing likely causation issues. In this case there are number of significant positive factors that deserve consideration. Indeed it is fair to observe that this is a case in which the wide canvas is entirely positive in character. My attention has been drawn to the following matters, all of which are material in my assessment (whilst this section focuses on the father most points are equally applicable to the mother and have been considered as noted above):

- There is strong evidence demonstrating a solid attachment and bond of love between the father and N. I have been shown a range of visual and other evidence which paints the picture of a child cherished by the father. This is important as one would expect such a bond to condition the behaviour of the father to the child. A sense of attachment and affection is likely to moderate the father's mood during challenging moments (which will arise in the care of any child at some point or other)
- The evidence in this regard extends to the positive evidence of the father's active engagement with N. It is clear he is not a hand's off father but has played a caring role for N. This is important as it likely provides him with skills to navigate a challenging moment. With experience likely comes tactical skills and the strategies to cope with moments of stress
- The father is reported to demonstrate gentleness and patience when caring for N. This reinforces the points above.
- It is clear that N was a wanted baby and the parents have put real effort into making his early life comfortable and supported. I consider this commitment relegates the prospect of the father acting out of a sense of anger at the child.
- One can find a range of positive references for the father within the available evidence. From the support of his employer - which I agree presents the picture of the father as a gentle, kind and calm man who

absolutely adores his wife and new baby – the maternal grandparents – who as Ms Bazley QC comments have an *‘intimate knowledge of the Father and the dynamics in the household is therefore a very valuable source of information for the court, particularly in the context of their well-earned trusted and respected role in these proceedings as assessed and approved interim carers for N’* and speak in warm and positive terms of the father as an individual, partner to their daughter and father to their grandson – and the early professionals such as the health visitor – who noted a warm bond and supporting role being performed by the father. These are all important positives assessments and must have purchase when assessing the father’s likely behaviour patterns. None of these individuals have found the father to be aggressive, angry or uncontained.

- An important additional reference comes from the mother. She speaks positively of their relationship and is convinced the father would not have harmed N out of anger. Her evidence as to their warm and mutually supportive relationship is significant. Equally she confirms the father’s support and measured response when they were confronted by a challenge to their relationship arising out of earlier significant ill health on her part. She is clear they share a happy loving family. For the avoidance of doubt I accept this evidence to be genuine and a fair appraisal on her part of their relationship. It is clear from the evidence that of the couple she has the more natural role as parent, but it is also clear the father is open in his communication with her and is willing to seek assistance when required. I agree this testimonial is additionally important given the mother signalled her prioritisation of N’s needs were these to come into conflict with her relationship with the father.
- A developing aspect of the wide canvas has been the father’s acceptance that he was responsible for the mechanism that harmed his child. My assessment of the evidence was that – subject to appropriate enquiry – this was always likely to come into focus. On any basis this could not be easy but there is no equivocation on his part in this respect.
- Finally I am asked to pay regard to the polite, calm and measured manner with which he has conducted himself within these stressful proceedings. This is a fair request and I do acknowledge the manner in which both parents have engaged with the process.

42) The Applicant accepts most if not all of the above points. However they ask me to approach these points having regard to the sad feature that many cases of this type arise in what are otherwise functioning family units. As Mr Goodwin QC noted in closing:

*Ordinary, caring parents can however sometimes cause such injuries during brief losses of control. Such is the context in which the vast majority of ‘shaking’ cases come before the Family Court. This one, we suggest, is no different.*

Plainly such logic does not cause me to ignore the wide canvas. To do so would fail to have regard to all the relevant available evidence. What it reminds me is as to the need to assess all the evidence and apply an appropriate rigour to my assessment. A wholly positive background does not answer the case any more



than does any aspect of the evidence. It is valuable and must be brought into the ultimate analysis with all of the available evidence

The significance of the suggested ALTE

- 43) This is an issue on which the Applicant and father take markedly different approaches. I am asked by the Applicant to view all of N's symptoms as described by the father, through to his collapse/flop as being aspects of the encephalopathy subsequently accepted as existing on presentation to the Hillingdon Hospital. Certainly the medical evidence accepts that the symptoms described by the father are consistent with a continuum of encephalopathic symptoms and Mr Jayamohan noted the need for an intervening action between the suggested ALTE and the accepted encephalopathy were there two to be regarded as separate. On his assessment of the available evidence he could see no such action described. The Applicant also points to the temporal proximity of the suggested ALTE and encephalopathy and suggests this is a coincidence too far. The Applicant states the simple position that all of the symptoms were in fact encephalopathic and derive from an as yet unreported episode which predated the symptoms.
- 44) In contrast those acting for the father point to Dr Cartlidge's acceptance that the symptoms described by the father are also consistent with an ALTE; that one should not overstate the impact the same may have on a frightened parent and that a panicked response to the same cannot be ruled out. They question the weight that can be attached to the temporal association given that were the encephalopathic symptoms the result of a panicked response to an ALTE then they would be bound to be in close temporal proximity to the encephalopathic symptoms. Given the likely recovery time from an ALTE is short any significant gap between the two would rule out panicked response as a cause for resultant encephalopathic symptoms. I am asked to bring into my assessment the improbability of the father in some way latching onto an ALTE account other than by reference to what he actually experienced on the night in question.
- 45) In my assessment this point is perhaps more neutral than either party is willing to accept. I agree with the father that temporal association is not a coincidence too far. For what seemed to me obvious reasons (which is why I asked Dr Cartlidge) encephalopathic symptoms deriving from a panicked response to an ALTE will always sit close in time to each other. However, I am not by necessity persuaded as to the point made by the father as to the inherent unlikelihood of him suggesting symptoms which are subsequently found to fit with an ALTE, as Ms Bazley QC argues:

*It is submitted that it is highly unlikely that the Father would have been able to describe the symptoms of an ALTE arising from choking on milk had he not experienced them and, similarly, highly unlikely that he could have known that they are the same as an encephalopathic collapse. Accordingly, it would be far-fetched to suggest that the Father would have 'made up' a story of [N] stopping breathing in the course of choking in order to explain a shaking in the context of a loss of control. It is significant therefore, and supportive of the truthfulness of Father's account, that he immediately and consistently described the specific symptoms of an ALTE.*

I struggle with this contention for the following reasons; (1) it is agreed the suggested symptoms fit either an ALTE or encephalopathic response; (2) in describing these symptoms the father may correctly record how N presented without telling us anything as to the mechanism which caused the presentation; (3) in reality the father did not at any point define what he experienced as an ALTE, he simply recorded what he observed and that could be an ALTE or encephalopathy; (4) in reality it is the subsequent interpretation linked to the parties' cases which defines the presentation as ALTE/encephalopathy; (5) consequently this tells me very little as to likely causation as I remain entirely uninformed as to whether there was a pre-symptom shake or a post ALTE shake like mechanism. The above points tell me nothing of note and the father's account does not push me in one direction or the other. The resolution is ultimately found in my assessment of the sequencing of events not an interpretation which has subsequently laid over the account. It is said the father would have been unlikely to have been able to describe the characteristics of ALTE unless he experienced the same. But this misses the point as the father may of course be describing the consequence of a shake having shaken N. It may be said why then would the father have introduced this sequencing if there was no interspersed event between ALTE and encephalopathy. But on the facts is this actually a correct analysis. It is equally plausible the father simply described the symptoms suffered by his child to aid the treating team without an eye on ultimate culpability. Of course nowhere within the initial accounts does the father seek to report a shake-like mechanism. His account is of floppiness and dealing with this sudden emergency.

- 46) As noted above this is in my assessment a neutral point. The evidence tells me ALTE and encephalopathy have some shared symptoms. They would be temporally close in time. Either case has plausibility. That the father and Applicant seek to portray sequencing as they do is more a reflection of their cases and less a signal of inherent probative value. The answer to the sequencing lies in the assessment of the detail of the episode. This is in my view a key area and it is the area to which I now turn.

#### The father's account

- 47) In closing Ms Bazley QC summarises the father's position as being:

*The mechanism for N's head and retinal injuries is likely to have been a vigorous backwards a (sic) forwards movement involving extension and flexion of N's head... The Father's descriptions in his videos and to the police do not demonstrate either sufficient movement or sufficient force... the Father accepts what he did must have mimicked the shaking mechanism described by the experts but that the shock and panic of the moment has robbed him of a clear memory of what took place.*

Mr Goodwin QC for the Applicant disagrees:

*The court should resist the temptation to fill the gap with a conclusion that the father's memory is faulty...[T]he father's poor memory is indeed troubling – but only because he sought to evade difficult questions by hiding behind it during his oral evidence, thereby shedding more light on his case than he might have wished. There is, in short, no reasonable basis on which the court may conclude that the father has simply forgotten, in panic, that he had mimicked an abusive shake whilst reacting to an ALTE.*

- 48) The Applicant submits the notion of a ‘blurred’ recollection only developed in the course of the hearing; that whilst it challenges the consistency of the father’s pre-hearing reporting, it does not suggest this was lacking in detail; that the father has resorted to the use of a loss of memory contention as his accounts have been shown to be non-explanative of the trauma. I am asked to have regard to the accounts given to the treating team; police; within statements provided, and; within the illustrative videos. The Applicant contends this is a case which is not lacking in detail and that the simple reality is that this detail does not account for the harm suffered. The Applicant disputes there is room to now introduce an element of uncertainty based on blurred memory.
- 49) In contrast those acting for the father ask the Court to reflect on the evidence of Dr Carlidge as to the impact an ALTE can have on a terrified parent. Such an event is by its very nature unexpected and highly stressful. In such circumstances it is too much to expect a parent to recall the detail of the events and certain aspects may become prominent in recollection whilst others fade from memory. As Ms Bazley QC submitted:

*a baby stopping breathing is such a frightening event that it is reasonably possible that it could cause a carer to forget what happened immediately afterwards with the events and actual collapse itself being the focal point of the memory and the details hazy thereafter with an erratic recall of some details but not others.*

The case law speaks generally of the fragility of the human mind and traumatic circumstances are not a fertile ground for clear memory. A degree of caution must be applied when considering the accounts given by the father. I am asked to accept on each occasion the father was giving an essentially consistent case and that sequencing or other inconsistencies are to be expected.

- 50) I turn to the accounts given by the father:
- The earliest account was that given to the mother. However, this is forensically of limited value given the surrounding stressors; the fact no note was expected to be taken, and; the obvious focus on the most important need to obtain medical assistance. It is not suggested that a lack of detail or absence of certain detail at this point is of particular probative value. I would certainly share that view
  - The position changed at Hospital as naturally a history was taken to assist the treating team. Dr Perumal received a second-hand account via the mother<sup>20</sup> close to admission (approximated at 6am). The account was of:
 

*...baby was well initially & dad was giving baby feed & suddenly baby choked on feed & became red. No blue episodes. However, baby [unclear] breathless & parent got worried about breathing [and brought to] A&E*
  - A separate account was given by the father to Dr Quereshi<sup>21</sup> at 6:10am:

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<sup>20</sup> I1231

<sup>21</sup> I1077

*Previously well baby. Father says he was feeding baby usually gives half the bottle then changes the nappy then gives half. He gave half the bottle and when he lied him down for changing the nappy when he noticed him choking which is quite usual for him but then noticed he stopped breathing so picked him up and started [patting??] him. He then started to have deep breathes so got in car and bought him [to A&E].*

- On admission to GOSH a detailed account was sought from the parents by Dr Alison Steele<sup>22</sup> on 9 December 2019 between 4:45pm – 6:15pm. Dr Steele is the Named Doctor for Safeguarding and this note was taken at a meeting following the parents being aware of the concerns surrounding N. The relevant note reads as follows:

*Dad woke to feed him...took him into next room...took 2.5oz, burped, small vomit, and changed him, baby was laughing/smiling, taking remainder of feed when Father became concerned as N made a grunting noise, went red and stopped breathing for 7/8/9 seconds. Baby lying in crook of father's arm. The corridor light was on. He then did some gentle cardiac compressions over central chest...Took some long abnormal breaths, was floppy with eyes shut as if fainted, no abnormal movements. Father took him to bathroom and wet his head, face and neck. Then woke up Mother.*

- In police interview<sup>23</sup> at 00:57am on 12 December 2019 the father was asked to recount the events

*So once it reaches 2.5[oz]...I then put the bottle down, I will burp him, so I will have him up here, his arms are on my shoulders...and then I'll rest him on the changing mat, I will change him...this is exactly what's happened...I've picked him up and I've carried on feeding him...So how I'm feeding him is, his bottom is on my palm, his head is over here with his bib. I pick up the bottle, it's got 2.5 ounces in it, I carry on feeding him...So two to three minutes while I'm feeding him the rest of the two and a half ounces, he starts choking...I'm thinking, "Is this a normal choke that usually happens?". I'll just rest him on top of my shoulders again and I'll rub his back, I'll tap his back, just to make sure he's burping, but when he's on my shoulder, remember, it's in a morning, it's me and him, I can hear everything clearly, he's not breathing. So he's on my shoulder, he's not breathing...So I'm obviously think there's something wrong now. So when he's not breathing, I feel like he wasn't breathing for about, to be precise, about ten seconds in total. One thing, another thing that you haven't asked me, but I'm going to mention it, with N, as babies, they develop their neck muscles...So one thing that my wife can tell you, which I don't know if she's mentioned it or not, but his neck muscles was really good, so we tend not to rely on holding his neck, his head as much, because he can hold it himself. So when, when I realised that he's not breathing, and I'm holding him this way...And I push him forward, I push him forward to see if everything's okay, he's then just dropped on my arms. He just dropped back on my arms, so it's almost like he's fainted. So what I tend, what I done straight away after that is I've put him on my arms here, I'm holding him, and my, the first thing I thought of doing is I gave him CPR with two fingers..That's the first thing I thought, that was my instinct, I just done it. So I've pushed into his chest, not too hard. I pushed in, about three to four times, and then he's, and then he just, he breathed, so when he breathed now, he was wheezing, and his eyes was closed, he was still floppy on my arms, so I'm trying to wake him up, he's not waking him up, he's not waking up. When he's breathing, he'll take a deep breath, it's not even a deep breath, like he'll just breath and then he won't release after like four to five seconds, and then he'll release again, and then after four to five seconds he'll take another, he'll take another breath. So*

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<sup>22</sup> E3-4

<sup>23</sup> G77

*then what I done straight away is I went to the toilet, I put cold water on my hand, I put it around his face, his head, his neck, his chest, I started blowing on him, and I'm bouncing him trying to wake him up. He's still breathing the same. So that's when I decided to go and wake my missus up...<sup>24</sup>*

The father was asked to clarify his evidence as to neck support and responded:

*if I'm burping him, I usually have my palm in between the top of his back and his head...Like that, so his head will be, his head will be like around here, and his neck will be around there, so I'm controlling his neck and his head at the same time...On his, on his shoulders...So imagine his back...So this side would be on his right shoulder....And then this side will be on his left shoulder...so even if he does drop his back, he'll just lie in between...If he puts his head back, this bit over here, it's still kind of protecting him regardless...<sup>25</sup>*

The father was asked to detail the floppy response:

*I'm moving forward for his weight to switch onto my arms....and while my arm is moving a bit back, I'm not seeing his face or his head or anything like that, but if I'm moving him forward and I'm moving my hands forward, then I'm seeing more of a glimpse of him...that's when everything just happened, that's when he just, he just, it seemed like he fainted in my hands...he didn't fall off my hands...he just, his arms dropped, his head dropped back, he had no control over himself...His head, when it dropped back, it kind of bounced to where his head limitation can go to, if that makes sense....So when I put my hand back on his back and his shoulders....In that V shape...Yes, so it went back and then it come, when it come up, that's when I sort of quickly like crawled up and caught his head with like my finger...<sup>26</sup>*

The father was asked to detail his response to the floppy presentation. He described moving to give the CPR elsewhere described:

*At that moment I realised of course that something was not right, so that's when I decided to perform CPR because he wasn't also breathing. and I've done it about two to three times, and the reason why I stopped is because he was breathing...he breathed in and then he was breathing out, but before he breathes out it was about three to four seconds....it was definitely longer, it was not normal...So that was my instinct as well, so I went to the toilet, opened the cold water, put my, so I'm holding on my left hand, I put my right hand over the cold water. I didn't wet him but I kind of just cooled him down, so I put my hand over his head, his face, his neck, gently rubbing over his chest. I got him and I'm bouncing him now, and I'm blowing all around him trying to wake him up, trying to make sure, trying to get him to breathe properly, the way he usually does, but he's not, so then that's when I went straight to my wife...and I woke her up.<sup>27</sup>*

The father confirmed through this process he was holding N in the same 'feeding' position in the crib of his left arm and that he moved at a safe speed using 'big steps'

- In his statement evidence the father reported:

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<sup>24</sup> G105-9

<sup>25</sup> G112-3

<sup>26</sup> G121-4

<sup>27</sup> G125-9

*I picked N up after changing his nappy and sat down on the rocking chair with him and continued to feed him. After a few sucks on his bottle N started to choke. It was just like the reflux. I put the bottle down, I think on the food preparation table, and stood up by the window, holding N over my left shoulder trying to wind him. I would usually hear N winding especially when it was quiet at night but on this occasion I didn't hear anything at all. I could feel that N was very hot against my shoulder and neck. I could not hear him breathing. I had been holding my left hand supporting his bottom and I had been rubbing his back with my right hand. I leant him forward to see him and my hand was in a V shape extended across his back. He normally holds his head a good amount of time for my hand to slide up to support him but at this time he could not control himself and was all floppy. I now know this was because of his serious brain injury but I did not know that at the time. My main concern at that time was that he did not seem to be breathing. I brought him forward and his head and his arms fell back, reaching their limit because he was floppy. He felt heavier, weightier and I caught his head. N's complexion was red and he was sweaty. His eyes were closed and he did not seem to be breathing. I supported him across my left arm and applied CPR pressure to his chest with two fingers. I did not think about it; it was complete instinct. I had no idea what was wrong with him but I could see at that moment that he appeared not to be breathing. After I applied this pressure I heard N breathe. His breathing had a different quality than normal. His breaths appeared to be longer and deeper. I could feel that he was sweaty at the back of his neck. I took N to the bathroom and got old water from the sink. I took water in my hand and put it to the back of his neck, his head, face and chest in an effort to cool him.<sup>28</sup>*

- I have also viewed the police interview and the videos filmed by the father. I will return to the visual evidence in my analysis below. The potential for the video to accurately reflect the episode is limited by the rigidity of the teddy bear being used as a proxy for N
- When examined in chief I noted the following responses from the father:

*Then didn't hear him breathe...after that a blur...my mind was seeing the problem as not breathing...after that everything out of control...I have no better recollection...it is impossible...I have tried to remember myself*

and when cross-examined

*I remember him vaguely dropping onto arms...he dropped onto my arms...arm in front of me...I don't remember where he was before he dropped....all of this part has become a blur...I don't remember everything...[When asked what actual memory is retained]...It is almost like pictures of certain moments...I thought it was just another choking episode...I did not panic as a result...when I made the videos of how handled [N]...even then I was trying best...[N]ot introducing 'all a blur' for this hearing...I was answering the questions...but even then...more shocked due the information getting...there would be things remember and things not...possibly not want to remember....I don't remember the ordering...the information I gave must have been in my head but I don't recall it now...almost like my brain does not want to remember...100% he was not breathing, before this he was normal....after this I do not recall the details of the sequence...[When asked did he fall with you catching him]...I don't remember...I can barely remember what happened....I remember losing control but don't recall how it happened...most of this is a blur...details were coming out but probably wrong details...mind all over the place*

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<sup>28</sup> C31-2

51) In considering this point I of course reflect on the points made by Ms Bazley QC as to Dr Carlidge commenting as to him being surprised if a parent could recall the details when in a state of panic and that his being alert to the possibility of the strange things that people do when panicking. I also have regard to the submissions as to the episode in question lasting a short period of time and the errors that can creep into accounts when reflecting back on issues of timing, speed and other detail. Further I bear in mind the potential for the shock of an episode to undermine the accuracy of a recollection.

52) I have reached the following conclusions:

- I gain little insight from the suggested contradictions in account relied on by the Applicant. In my assessment there is a reasonably settled account provided by the father from the point at which he outlined the event to Dr Steele. This involved an initial feed followed by a nappy change and then further feed. During this second session N began to choke, the feed stopped, and he stood to wind the child. N then acted strangely, and the father's account is as to the 'fainting' episode followed by CPR a trip to the toilet and then into the parent's room to wake the mother. I note the issues in sequencing in the earlier accounts and the absence of certain detail but consider this is likely to derive from the timing and the circumstances in which the history was taken. It is unlikely this was a considered interview but was more focused on understanding the key concern on presentation.
- I accept and agree with the expert view as to the detailed reporting not explaining the trauma suffered. I have considered written and visual explanations provided by the father as to the motion N went through when said to have become floppy and it falls far short of the necessary forces that the expert tell me would be required. As with the experts I simply cannot see in the description anything that would approximate a hyperextension-hyperflexion movement.
- I found the father's account to the police clear and easy to understand. Having both read and viewed the interview I do not have the sense of the father being prompted into error by the police, although I accept, he was understandably prompted on occasion. I found his account to be clear, explicit and volunteered. He was quite clear in his description of having N on his shoulder and guarding him against dropping back by the use of a 'v' shaped hand in which the thumb and index finger cradled the upper shoulders and with the gap between the two digits being filled by N's head (albeit not supported as the head was lolled forward onto his own shoulder). Equally he was clear that as he moved N forward off his shoulder, so N was floppy. In this context moving forward meant moving his own cradling arm away from his body/own shoulder region so that the gap between arm and body was sufficient for him to view N more clearly. This process led to the lower arm moving from a vertical axis and closer to a horizontal axis and it was in transition that gravity caused N's head to fall back into the gap between thumb and index. N's head is reported to have gone fully back with a bounce-back. I noted the father in interview talking about catching the head but perhaps more descriptively crawling his fingers up the back of N to support the head.

I have viewed this section of interview and I fully understand what is said. It is the shifting of the in-contact hand further up the torso to the head to give support that is clearly being described. By this mechanism the head was then supported. The father then described a lateral movement under which the same arm which was close to the horizontal was then brought at a similar angle close to the body to produce a cradling effect. Thereafter the father described N remaining in this position during CPR; whilst in the bathroom and when brought into the parents' bedroom.

- I can see how this process led to a hyperextension of the neck (neck fully back with chin as far from torso as possible). However the father does not describe moving his arm in an uncontrolled fashion and as a consequence the forces which caused the hyperextension would have been gravitational and gradual in accumulation (as the arm moved away from the body). This would not have been a sudden motion and I struggle to conclude this was a forceful hyperextension. However, I cannot see an oppositional hyperflexion (chin as far forward as it can go). The father's account is of catching the head with his fingers crawling up. At most he speaks of a bounce-back effect which is presumably muscle tone related. There is no forceful return mechanism. On the father's description I can find no significant change in directional force between the movement back and then forwards, it is a purely natural elastic response if at all. In questioning mention was made of N being 'yanked' up but this is not found in the father's evidence or in the visual presentation to the police. The closest one comes to this is in the video presentation (without a teddy bear) but it is far from clear to me the father is describing anything that might be said to be a yanking manoeuvre. Indeed the evidence is consistent as to N being moved into the cradling position from the point at which he collapsed. I cannot see how this process could have generated either of the necessary forces. Ultimately N was being brought into a protected cradled position against his father's body.
- So plainly I agree with the experts that there has been no account of a process which would meet the test of a shake-like mechanism with the requisite forces.
- But I have also struggled to understand the case for a 'blurred memory' as advanced during the hearing. Whilst I accept the point in theory it does not sit comfortably with the actual facts of the case. In this case I do not think I have "too much detail" but I have an undoubtedly detailed account of what took place. Up to hearing the father had provided clarity as to what happened and in what order. His police interview in particular provides a sequenced walk-through of the events without any suggestion of poor memory or confusion. So the father set out in detail the events leading up to the nappy change during the 5am feed. He was asked by the police whether he was describing things on a typical basis but confirmed he was describing what had actually happened<sup>29</sup>. He then detailed when asked the 'floppy' episode and explained in detail the manner in which he held N; the loss of control and his movements.

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<sup>29</sup> G106A



Bearing in mind this must on any case have been a matter of seconds he gave a clear account. He then proceeded to explain in detail the process of CPR before explaining what happened in the bathroom and afterwards. Each part of the sequence was detailed and there was no suggestion of uncertainty or blurring.

- I therefore struggle to insert into this account an evidential period of ‘blurred memory’. It sits uncomfortably with the case as previously presented and it is far from clear where this should in fact be inserted. I struggle to identify room for this period of confusion. It is not clear it can go before the awareness of floppiness as this period was wholly usual for the father even with the choking. How can it go after the floppy period without abandoning a wholly clear description of a process of CPR (including force used; the sense of N’s bones; the number of compressions and related breathing) or the process in the toilet (which is itself detailed in the video provided). One is left with the very short period between awareness something is wrong and the CPR. But this was a matter of seconds and is fully described in interview.
- For my part I was surprised by the father’s inability to recall these events given the history of reporting including the video presentation. In preparation for the hearing it seemed to me the examination of the father would likely be most helpful as he appeared to have a strong recall with respect to the episode. It was puzzling that his memory seemed to have deteriorated and that at times this uncertainty was being pushed back to a time when he appeared in fact to have good recall. I was left concerned as to why this was the case. I ask myself whether this was a father being evasive and seeking to head off problematic questioning or an overly cautious witness not wanting to overstep the bounds of full recollection.
- Importantly, I do not consider it appropriate on the facts to put to one side the clear history of reporting and largely replace it with an uncertain history. I consider this would be a perverse approach in such circumstances. I have to scrutinise the evidence with real care, but it is not proper for me to fill gaps and particularly so where the evidence questions the existence of gaps altogether.
- So I am left unfortunately with a detailed account of the period during which N suffered trauma which does not explain how he could have suffered the trauma. I am not satisfied there is within this same period a passage of time which remains unclear or ‘blurred’. I am left concluding that I have not been provided with a full account of what took place. In reality it is only the father who could help me fully understand what happened.

#### Additional Features

- 53) I briefly deal with various points raised and comment on their value within my assessment.

#### The events of the weekend

- 54) The Applicant suggests the events of the weekend in question point to some level of acrimony between the parents. I simply cannot reach this finding. The parents both explained why the weekend was managed in the way it was and I found the accounts credible. That the father stayed with his family and did not join the mother is not in my assessment of any forensic value but simply reflects what seems to me wholly understandable time alone from each other. I say no more.

The father's weekend

- 55) I do though agree there are some features to the father's weekend which bear consideration. The evidence indicates the father was tired after a hard week at work. Nonetheless he appears to have stayed up late on the Saturday to watch a sporting event before playing video games with his brothers into the following morning. On the Sunday after the mother returned home, he stayed up for the 2am feed rather than have an earlier night and was of course up for the 5am feed. Whilst I bear in mind the father spent Sunday resting this does raise real concern in my mind as to the likely impact of lack of sleep upon him. I appreciate that he was not working on the Monday and so may have expected to be able to get extra rest by return to work on Tuesday.

Not alerting the mother immediately

- 56) The Applicant points to the father not calling the mother when he became aware N was not breathing and then taking him to the toilet before waking the mother and questions whether this was the father trying to resolve the situation without need to inform the mother. The suggestion being that the father had realised he had misconducted himself and wanted to sort things out without the mother being aware. The father accepts this was the sequencing of events but denies any improper motive arguing that he was acting on instinct.
- 57) In isolation I consider this a difficult point to resolve. On any case the father would have likely been panic-stricken and I have to ask myself as to the predictability of a panicked individual. Whilst the Applicant suggested instinct would kick in, I wonder on what basis this can be presumed. However, at the same time the father's evidence (globally) was of considered thinking around both the application of CPR and travelling to the toilet. It is puzzling indeed that he would not have alerted the mother until after his visit to the toilet. Taken with the findings above I am left to consider whether the Applicant is correct in its suggestions.

The 999 call

- 58) I am asked by the father to consider this call as a pointer against culpability on the basis that it is inconsistent with collusive parents seeking to cover up a culpable episode. In broad terms I agree with that point, but it tells me little about likely reaction where only one parent has been involved in the episode in question. In such circumstances the pace and form of response will be shaped by both parents. A parent who may wish to drag their feet may well find themselves pulled along by the other parent whatever their own interests.

An inadvertent admission

59) I did not find this point helpful. In his statement the father commented

*but at this time he could not control himself and was all floppy. I now know this was because of his serious brain injury but I did not know that at the time.<sup>30</sup>*

The Applicant suggest this is an inadvertent admission. I disagree and agree with Ms Bazley QC that this is no more than the father stating his understanding at the time as to the state of the expert evidence.

Expert experience of ALTE based trauma

60) I use this heading loosely, but the point is that the Applicant points to the experience of Professor Stivaros as having never included a child suffering these injuries in the hands of a panicked parent. The problem I have with this point is that both Mr Jayamohan ('a resuscitative shake') and Dr Cartlidge ('a panicked mother running down the street') have such experience. I accept it is possible for such trauma to arise from a panicked response.

Bruising

61) The key dispute is as to whether there was a bruise on the arm and whether it pre-dated admission to hospital. Second, with respect to chest petechiae whether this arose within hospital or pre-dated admission.

62) I will deal with this in relatively short order and note the following:

- I particularly note the evidence of Dr Cartlidge as to the likely potential for the arm bruise to be consequential on the mechanism which led to the trauma whatever its detailed form. The reality of the child being held and significant forces operating support this view. In many ways it is common sense in just the same way as a bruise of this nature may be caused during the administration of urgent medical care.
- I note the mother in closing accepts the bruise pre-dated medical intervention. She also makes clear it was not present during bath-time on the preceding evening. I consider this is important evidence as the mother was present during the initial medical investigations and is able to time the bruise being noted prior to multiple efforts to place a cannula.
- I accept this was a bruise on the evidence received and I further consider it most likely this bruise arose during the same episode that led to the wider trauma. It does not amount to a separate assault on the child but is part and parcel of the same episode.
- As to petechiae I am less clear. I accept the process at the hospital was fraught and there is the potential for such a mark to arise out of good care. On balance I have been unable to resolve whether this mark pre-dated or post-dated admission. Having considered the evidence were I to have dated the mark pre-admission then I would not have been able to exclude the

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<sup>30</sup> C31

potential for the same to have arisen out of the inexpert resuscitative steps taken by the father.

63) Having considered the evidence I would summarise as follows:

- N suffered the head; eye; neck and spinal trauma alongside the arm bruise during a single event whilst in the care of his father on 9 December 2019
- The mechanism of the trauma was a shake-like mechanism with a forceful acceleration/deceleration component and with hyperextension-hyperflexion of the neck
- I have considered the account given by the father and find it does not explain the necessary mechanism nor account for the trauma suffered
- I reject the notion of a ‘blurred memory’ having regard to the detailed and largely consistent overview presented by the father to the police and hospital (around 12 December 2019) and to the Court (statement February 2020 and videos)
- I accept the Applicant’s case that the pre-‘floppy’ symptoms; the floppiness and the subsequent presentation are all part of an encephalopathic continuum
- I accept the father has given an essentially correct account of these symptoms. However, I do not accept any part of these symptoms are ALTE related
- I am left unclear and can only guess as to the detail of the event that preceded these symptoms. I find it would have involved a shake mechanism and this would have been between the commencement of the 5am feed and the mother being alerted whilst N was in the care of the father
- Whilst only the father can fill the gap in understanding I consider it unlikely this was shake with a malicious motive or with intent to harm N. I consider I remain entitled to reflect on the wide canvas and I consider it most unlikely the father acted with such intention
- I am however unable to determine whether the trauma arose out of a temporary loss of emotional control (through for example frustration) or through some other action known to the father falling short of this (accidental injury in undisclosed circumstances). I accept there are pointers in favour of the former. I have noted the potential impact of tiredness on the father over the weekend and it is possible this affected his behaviour and made him more susceptible to an out of character action, but it could also have led to an error in handling. I also bear in mind my observations as to the puzzling failure to alert the mother, but this point might have purchase on either possibility (to cover embarrassment and guilt or culpability). Finally I note what is said about the unlikelihood of the father failing to be transparent if he simply suffered an accident. I consider this point has additional merit given the father now essentially accepts he was responsible for the trauma. It may be said what would now stop him from disclosing the actual detail? But then to do so would be to admit a lie (not being open) over a significant period, and with the impact it has had on his wife and the wider family. This might deter such a course of action.

- Unfortunately the evidence takes me only so far. I consider it would be dangerous to go further and to do so would amount to speculation. In reality only the father can provide the full answer.

Next steps

- 64) I am sending this judgment out to counsel for their consideration. I will accept any corrections and/or requests for clarification so long as the same are received by 12 noon on Tuesday 3 November 2020.
- 65) I give permission for this judgment to be shared with both lay and professional clients in advance of handing down.
- 66) I will hand the judgment down at an attended (but remote) hearing on 5 November 2020 at 9am (t/e maximum 90 minutes).
- 67) I would be grateful for a draft order in advance of the hearing and proposed directions for the further management of the case (agreed if possible). I would welcome position documents from all parties by 12 noon on 4 November 2020.
- 68) This judgment plainly raises the need for risk to be assessed before there can be consideration of any global family reunification. However, it is not my sense that this case is a closed book so far as rehabilitation is concerned. The future in such regard is now to be considered within a welfare process.

His Honour Judge Willans