Neutral Citation Number: [2019] EWCA Civ 1244

Case No: B4/2019/0877

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM NEWCASTLE-UPON-TYNE
COMBINED COURT CENTRE
HHJ HUDSON
SITTING AS A HIGH COURT JUDGE
NE18C00441

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/07/2019

Before:

LORD JUSTICE UNDERHILL
(VICE-PRESIDENT OF THE COURT OF APPEAL CIVIL DIVISION)

LORD JUSTICE IRWIN
and
LORD JUSTICE MOYLAN

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F (A Child) (Fact-Finding Appeal)

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Mr N Stonor QC & Mr S Ainsley (instructed by **Ward Hadaway Solicitors**) for the **Appellant**
Miss P Howe QC and Mr D Rowlands (instructed by **the Local Authority Solicitor**) for the **1st Respondent**
Miss S Woolrich (instructed by **Richard Reed Solicitors**) for the 2nd **Respondent**
Mr J Gray (instructed by **Gordon Brown Solicitors**) for the 3rd **Respondent**

Hearing dates: 23rd May 2019

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Approved Judgment

LORD JUSTICE MOYLAN:

Introduction:

1. The father appeals from a fact-finding judgment given by Her Honour Judge Hudson on 27th February 2019 in the course of care proceedings. The judge determined that petechial haemorrhages sustained by his child, F, when she was aged 6 months, were inflicted injuries caused by the father.

2. The judge, understandably, found this "a difficult and very troubling case". This was largely because none of the medical witnesses had any experience of petechial haemorrhages and sparing (areas with no haemorrhages) of the nature and in the pattern seen in this case and each, as described by the judge, "was unable to provide an easy 'fit' for a mechanism by which all the petechiae and sparing were caused" and which fitted with "the absence of other injuries".

3. After ruling out a number of "possible explanations", the judge concluded that there were only two options, either an unknown cause or "some form of applied compressive pressure". Based on her evaluation of *all* the evidence, including the parents' evidence, the judge decided that the haemorrhages had been caused by the father. Her conclusion was as follows: "I am satisfied … that … the petechial haemorrhages to F were inflicted non-accidental injuries … It is not possible, nor is it necessary in my judgment, to determine precisely how he did so. I consider it most likely that it involved some form of compression and suffocation or smothering (which resulted in the clearly demarcated areas of sparing)".

4. The judge's conclusion was based on her understanding of the evidence from the treating clinician because the two medical experts instructed for the purposes of the proceedings did *not* support inflicted injury as being the probable cause. The judge's summary of the evidence from the treating clinician was that: "She does not put forward a definite mechanism but now favours a combination of smothering/suffocation and chest compression as the probable cause". As set out below, the father challenges this as being the effect of that evidence.

5. The father advances a number of grounds of appeal which, in my view, can be encapsulated as: (a) that the judge's approach to and conclusions as to the effect of the medical evidence were flawed; and (b) that the judge has insufficiently explained her conclusion that F sustained injuries which were inflicted by the father.

6. The father is represented by Mr Stonor QC (who did not appear below) and Mr Ainsley; the mother is represented by Ms Woolrich; the Local Authority is represented by Ms Howe QC (who did not appear below) and Mr Rowlands; and the child is represented through her Guardian by Mr Gray (who did not appear below).

7. The father's case is that the judgment should be set aside and that this court should take "a robust and pragmatic approach" and determine that there is no realistic prospect of a finding of inflicted injury following any rehearing. This would effectively determine the care proceedings because this was the only finding made by the judge which would support the threshold criteria under section 31 of the Children Act 1989 ("the 1989 Act")

being established by the Local Authority. Mr Stonor submitted that, alternatively, the matter should be remitted for a rehearing.

8. The mother, who is now caring for F in her parents' home, had been prepared to accept the court's finding although she had had no reason to believe that the father had been responsible. As was made clear by Ms Woolrich, the mother's priority has been to seek to ensure that she is able to care for F. However, following the grant of permission to appeal, the mother now invites the court to consider the adequacy of the reasons given by the judge for finding that the father caused the injuries and to conclude that the judge's findings cannot be sustained. She further supports the father's submission that a finding of inflicted injury is not a realistic possibility.

9. The Local Authority opposes the appeal and supports the findings made by the judge. If the appeal is allowed, it is submitted that a rehearing would be required. The Guardian opposes the appeal but also considers that a re-hearing would be necessary if the appeal is allowed.

10. In addition to the grounds of appeal referred to above, the court was also invited to consider giving guidance on the application of section 13 of the Children and Families Act 2014 ("section 13") and Part 25 of the Family Procedure Rules 2010 ("Part 25") when a treating clinician or other treating healthcare professional becomes involved as an expert in care proceedings. In respect of this issue I propose only to make some very general observations as set out below. This is, in part, because the President of the Family Division has set up a Working Group to report on Expert Witnesses and that report might impact on matters of practice which would in turn impact on the practical operation of section 13 and Part 25 and in part because, in any event, the issues involved raise broader questions which would benefit from wider consideration than is practicable in this case.

11. In summary, for the reasons set out below, it is clear to me that this appeal must be allowed and the judgment set aside. The question of whether a rehearing is required is more difficult but ultimately, after probably spending too long analysing the medical evidence, I have concluded that the Local Authority should be permitted to pursue a rehearing if they choose to do so.

12. In coming to that conclusion I acknowledge that, on one view, the medical evidence could be said to present significant obstacles to a finding of inflicted injury. However, it is not clear that this is the only view. To explain these observations, I have set out the medical evidence in far more detail in this judgment that would usually be appropriate in these circumstances. In addition, although I have concluded that the judge's finding must be set aside it was, as is of course essential, based on her evaluation of *all* the evidence. This appeal has focused on the medical evidence and we do not, and cannot, have the broader perspective that a judge who hears all the evidence would have. Whilst that broader perspective cannot justify a finding which is not at least sustainable on the medical evidence, it adds an important dimension which we are not in a position to factor into our assessment of whether a finding of inflicted injury is a possible outcome. An alternative way of expressing this, which is perhaps more apposite to this case, is that, in my view, we are not able to determine that it is *not* a possible outcome.

13. At the outset of the hearing, Mr Stonor applied for a further medical report to be admitted. We read the report but, as Mr Stonor accepted, its contents did not materially assist in the determination of this appeal.

Background

14. F's parents are in their mid-20s. They have been in a relationship since 2013 and have been living together in their own home since 2015. F was born at the end of 2017. The mother took maternity leave and was F's main carer. The father had a short period of paternity leave and then returned to his employment. There were no concerns about F's care in her early months and she was described as thriving.

15. In April 2018, when F was five months old, she was seen to have two bruises on her forehead when she was taken to the GP for routine vaccinations. This led to an investigation under section 47 of the 1989 Act. F was seen by a consultant paediatrician. The parents said that the bruises had been sustained when F was in her baby bouncer and, to quote from the judgment, "they surmised they must have been caused by plastic toys hanging from a bar over the chair". Having examined the bruises, the baby bouncer and "the toy", the consultant accepted the parents' explanation. The incident appears to have been recreated on the ward with the consultant noting that "the bruising size, shape and length apart directly correlate to the toy" and that the "appearance and pattern did not suggest any specific alternative mechanism of injury". It appears also to have been noted by a social worker when F was seen at home that "with a very light bounce … the star 'went to hit (F) on the head'".

16. At the beginning of June 2018, when F was aged six months, her parents with the maternal grandparents took her to hospital, arriving at about 4.00pm. This was because she had extensive petechiae over her face and head, together with swelling around her eyes. Petechiae appear as pinpoint spots, similar to a rash, on the skin and are caused by the rupture of small blood vessels.

17. The judgment below summarises the parents' evidence of events leading to their taking F to the hospital. I do not propose to repeat all the detail.

18. Both parents were at home when F woke at about 2.45pm after an afternoon sleep. After about 10 minutes, during which F "continued to murmur and cry" rather than go back to sleep, the father went to get her. F was a bit red in the face, which was normal. The father was upstairs "for only a couple of minutes" before he brought F downstairs. By this time she was crying.

19. The mother then "headed upstairs". As she and the father passed each other, they gave F "a 'sandwich kiss' where they each kiss her on opposite cheeks. They both say she cried when they did this." The father was on his own with F downstairs for what the mother "variously described as three to four or five to ten minutes". During this period the father changed F's nappy. The father noticed "redness and swelling" as he was changing the nappy. He "panicked, believing it to be an allergic reaction and shouted up to (the mother) who replied 'two seconds'". The father then took F upstairs by which time F was "really distressed and crying a lot more". The mother took two photographs and sent them to her sister. She also telephoned her mother who said that the mother was

"panicked and crying". The maternal grandparents arrived at the home very quickly and they all went to the hospital.

20. The mother, the father and the maternal grandmother described the rash developing over the course of about 30 minutes.

21. F was seen at the hospital by a consultant paediatrician, Dr Flowers, who wrote a child protection medical report six days later. She noted widespread petechiae, confined to F's face and head with a few on the neck, that "appeared to be in a somewhat distinct and unusual distribution". The most intense areas were around F's eyes, across her nasal bridge and on her chin extending under her chin on the right hand side. There was another intensive area on the back of F's head which measured approximately 7cms by 7cms. There were scattered (but still numerous) petechiae on F's forehead, on the top of her head and around the intense area of petechiae on the back of her head. There was also "some slight diffuse swelling around" the eyes.

22. On F's face there was "a distinct demarcation between the areas with intensive petechiae (e.g. around her eyes) and the areas that were spared of petechiae (e.g. her cheeks)". As summarised in Dr Flowers first report dated 7th June 2018: "There were demarcations to the distribution of the petechiae: with more concentrated petechial areas around the eyes, chin and the back of the head. Conversely there was sparing (i.e. no petechiae) around the nostrils, cheeks, upper lip and laterally towards the ears. There were no petechiae below the neckline". The clear demarcation remained a feature as they slowly faded over a few days.

23. Dr Flowers was unable to identify a medical case, such as infection, that could account for "such an unusual distribution and demarcation" and having regard to the lack of progression of the rash. She noted that petechiae can be caused by a direct blow, such as a slap, but that this was "an extremely unlikely cause" due to their widespread distribution.

24. Dr Flowers also commented that a "sudden increase in the pressure" in the capillaries can cause then to burst. This increase can be caused by "a number of mechanisms such as forceful and prolonged vomiting, forceful coughing, strangulation and suffocation". She considered coughing and vomiting unlikely, in part because there was no history of these occurring and in part because she would have expected these to have caused more generalised petechiae. She likewise discounted strangulation including, again, because she would have expected this to have caused a more generalised distribution.

25. Dr Flowers also considered that an abnormal bleeding disorder was unlikely but recommended that a paediatric haematologist be consulted. She concluded that: "In the absence of any other plausible explanation, it is my opinion that suffocation is highly likely to be the cause of the petechiae". In her opinion suffocation "can lead to distinct areas of sparing and areas of concentration of petechiae on the face". This was because:

> "The areas of sparing are caused when an area is forcefully compressed … leading to blood being forced from that area into the adjacent skin. The capillaries in the adjacent skin then burst due to the increased pressure resulting in areas of concentrated petechiae in this adjacent skin."

26. She put forward two possible mechanisms. Either the face had been "pressed down into a surface" or the "mouth, nose and cheeks were forcefully occluded by an object". As for the intense area on the back of the head, these could "either be due to the local pressure", as with the face, "or secondary to generalised raised intercapillary pressure within the scalp as a result of forceful pressure being applied".

27. The case was discussed at a "paediatric consultant safeguarding peer review session" at the hospital. As described by Dr Flowers, this "process is not to obtain a full second opinion but acts as a quality assurance mechanism". There were seven Consultant Paediatricians and two Consultant Emergency Department Paediatricians present. None of them could identify a medical cause which was consistent with the distribution and appearance of the petechiae. All of them agreed that "suffocation was highly likely to be the cause".

28. The consultant haematologist reported on 12th June 2018 that all the coagulation testing was within normal limits, ruling out a coagulation or platelet function disorder. Other results were not in keeping with a diagnosis of hereditary angioedema which some members of the mother's family have.

29. When F was discharged from hospital she was placed in foster care under section 20 of the 1989 Act with the agreement of the parents. After two days she was placed with the maternal grandparents where she has remained living.

30. The parents were interviewed by the police but no charges have been made.

Proceedings

31. Care proceedings were commenced on 14th June 2018. At the first hearing permission was given for the instruction of Dr Mecrow, a very experienced consultant paediatrician who, as set out in the judgment, "is a highly experienced expert witness in family and other court proceedings". He provided his report in September 2018 and written answers to further questions in October 2018. Following his report (and recommendation) permission was given for the instruction of Dr Bolton, a Home Office consultant pathologist, who provided a report on 13th January 2019. An experts' meeting took place on 25th January 2019.

32. HHJ Hudson requested the parties to address the status of Dr Flowers for the purposes of a case management hearing in November 2018. The mother and the father referred to a number of, what might be called, concerns if she was to become an expert for the purposes of the proceedings. The order made on 12th November 2018 records that the Local Authority, with the support of the Guardian, intended to seek permission to rely on the opinion evidence of Dr Flowers pursuant to section 13 of the 2014 Act. This issue was then deferred in the order of 20th November.

33. In response to enquiries, Dr Flowers quite rightly made clear that she did not undertake work as an expert witness but that she would be willing to give evidence as a witness with expertise (i.e. a professional, medical, witness). She also referred to it being recommended by the RCPCH (the Royal College of Paediatrics and Child Health) that

paediatricians undertaking work as an expert witness have specific training (such as expert witness training offered by the College) which she had not undertaken.

34. At the subsequent hearing on 27th November 2018, a standard direction was given for an experts' meeting but it was also provided that this would be attended Dr Flowers in addition to the experts instructed in the proceedings. She was subsequently provided with additional documents from the proceedings and duly attended the experts' meeting.

35. At the final hearing, the judge, with the agreement of the parties, made an order giving Dr Flowers permission to give expert evidence. This order was made under section 13.

Judgment

36. The judgment contains a detailed direction as to the law which all parties accept is unimpeachable. This included that it "is wrong to infer non-accidental injury merely from the absence of any other understood cause or mechanism" and that a conclusion that an injury is inflicted will only be justified if the evidence "shows that inflicted injury is more likely than not to be the explanation for the medical findings". The judge noted that even where "every possible known cause has been excluded, the cause may still remain unknown".

37. The judge heard evidence from the parents and the medical witnesses. As the judge states, "the doctors have all found this an exceptionally difficult case".

38. The judge questioned aspects of the parents' evidence. She was puzzled by the father's explanation for telling the police twice that he had got up at 3.00pm (having gone to bed when he got home after a night shift) when he had, in fact, got up at about 1.00pm which was consistent with his normal pattern. The father said that he had been pressed by the police to give a time and wasn't good with times so had given a "random guess". The judge did not understand "why he gave a time which was not when he got up – on this day or generally". The judge concluded that the father had not given a truthful account of "his actions" that day.

39. The judge also found the parents' evidence about the manner in which F was crying when she was downstairs with the father "particularly surprising". "Although (they) both now describe F's crying at this time as unusual or very unusual, neither of them mentioned the unusual nature of this during her hospital admission or during their police interview." The account that F had been crying "in a way she had not previously" had been "first given by the mother in her statement in the care proceedings".

40. The judge set out an extensive summary of the medical evidence. She noted, as referred to above, that the doctors had "variously struggled to provide a 'fit' for F's presentation". They all "agreed that the distribution of the spared areas on F's face was highly unusual". Dr Flowers described F's presentation as "something we have never seen". Dr Mecrow described the distribution of the petechiae as "exceptionally unusual". Dr Bolton said that the presentation was "incredibly unusual".

41. The judge went through a number of "potential causes". These included vasculitis/infection; allergic reaction; coughing/vomiting; compressive pressure;

strangulation; smothering/suffocation; chest/thoracic compression; smothering combined with chest compression; and unknown cause.

42. Under the heading of smothering/suffocation, the judge recorded Dr Flowers in her oral evidence as having "revised" her initial opinion that suffocation was "highly likely" to it being "the probable cause". However, in addition, when dealing with the "overall position" of the doctors later in the judgment, the judge states that Dr Flowers "remains" of the opinion that, "in the absence of a medical explanation, the petechiae represent non-accidental injuries", *and* that, again in her oral evidence, Dr Flowers:

> "does not put forward a definite mechanism, but now favours a combination of smothering/suffocation and chest compression as the probable cause".

43. As the judge noted, Dr Flowers had not considered the question of chest compression in her initial report but had done so in response to the views of Dr Mecrow and Dr Bolton. This appears to have further developed in the course of her oral evidence as set out above. However, the relationship between these two elements of her oral evidence is not clear because, on a plain reading, it would seem that Dr Flowers was advancing alternative probable causes.

44. As to the sparing, her opinion was "that something was pressed over the spared areas, which forced the blood elsewhere and resulted in the demarcation between the spared areas and the petechiae". Differences in pressure could account for the different presentation on F's face and the back of her head.

45. Dr Mecrow did not consider that "an abusive mechanism was the cause". He could not exclude smothering as the cause, it "remains a possibility", but he did not consider it "the likely mechanism at a level of the balance of probability". He "urged caution in making a link between the presence of petechiae and smothering". The reasons for this included that he would have expected "to see some other injury such as bruising or trauma to the mouth or nose" and because the research which he had found suggested that petechiae were a "relatively uncommon" feature in smothering.

46. In his opinion, chest/thoracic compression could account for the petechiae but would not account for the sparing. Dr Mecrow was "more open (than Dr Flowers) to the prospect of an unknown cause" which was "not a particularly unusual situation as a treating clinician".

47. Dr Bolton considered the case "seems to leave more questions than answers". In her view suffocation/smothering did not "reach the threshold of being the 'probable' cause" and, more generally, she was "unable to say on the balance of probabilities … that the medical findings represent non-accidental injuries". As with Dr Mecrow, she also said that "she would expect to see some other form of injury such as bruising or trauma to the mouth or nose" if pressure had been applied in this way. Indeed, all the doctors said that "even a young baby would struggle against something obstructing their ability to breathe".

48. The judge accepted Dr Bolton's evidence as to the sparing, namely that "something must have affected the pressure in the blood vessels, most commonly this would be something pressing on the vessels to stop them filling with blood". However, in addition, when

dealing with the issue of smothering/suffocation, Dr Bolton considered that "this mechanism would not account for the absence of sparing on the back of F's head – with pressure effectively applied to her front and back".

49. As to the combination of chest compression and smothering/suffocation, in her oral evidence Dr Bolton said "she could not say with any degree of certainty that this is what happened". The reasons for this included that "it is difficult to (apply) pressure on the right spot" and because, again, she would expect a baby "to wriggle and struggle as a result of which she would expect there to be some sign of injury on her face or in her mouth".

50. The judge considered the wider evidence and the risk factors and protective factors present before setting out her conclusions, as follows:

> "100. … I have weighed the evidence which supports the local authority's contentions against that which does not. In doing so I have taken account of the gaps in the evidence: the absence of any clear explanation for the lack of sparing on the back of F's head; the absence of any other recorded concern (excluding the (earlier) bruising for which the accidental cause was accepted); and the evidence of the doctors, which was unable to provide an easy 'fit' for a mechanism by which all the petechiae and sparing were caused and the absence of other injuries. I have given very careful consideration to the prospect that the cause of these findings is simply unknown.
>
> [The judge next states that she was not satisfied the father had been truthful.]
>
> 102. It is for the local authority to prove its case on the balance of probabilities. Having heard and reviewed the totality of the evidence, I am ultimately satisfied that it has done so. I am satisfied on the balance of probabilities … that, taking the medical evidence together with the evidence of the parents and the maternal grandmother, the petechial haemorrhages to F were inflicted non-accidental injuries which were caused to F while she was in the care of the father which were caused by him. It is not possible, nor is it necessary in my judgment, to determine precisely how he did so. I consider it most likely that it involved some form of compression and suffocation or smothering (which resulted in the clearly demarcated areas of sparing)."

51. In response to a request for clarification, the judge said that she had preferred the evidence of Dr Bolton on the issue of "sparing/demarcation". This was, as set out in the judgment, that there was no anatomical reason for the sparing and that "something must have affected the pressure in the blood vessels, most commonly this would be something pressing on the vessels to stop them filling with blood".

The Medical Evidence

52. Given the importance of the medical evidence, I propose to set out a more detailed summary of this evidence, and how it developed, in addition to the above summary of Dr Flowers' written report. I also do this to demonstrate the various and at times diffuse strands of this evidence.

53. The medical evidence comprised the following. Dr Flowers' safeguarding report; Dr Mecrow's written report and written responses to questions asked by the Local Authority following receipt of his report; Dr Bolton's written report. All three doctors attended the experts' meeting and gave oral evidence.

54. As often occurs in child care proceedings, the doctors gave evidence at the outset of the hearing. This was, in part, because the Local Authority's case rested on this evidence and, I would assume, for the practical convenience of case management in respect of their evidence.

55. The doctors all ultimately agreed that F had petechial haemorrhages and that these would have been caused by an increase in pressure within the affected blood vessels. However, they appeared in a pattern (in terms of intensity, extensiveness and demarcation) which none of the doctors had ever seen before and which made this is a very difficult and challenging case. They also agreed that they could not identify a clear medical cause.

56. Dr Mecrow remarked on the "degree of severity" of the petechiae and the fact that they were confined to the head and neck. In over 30 years of clinical experience as a paediatrician, he could not recall ever have seen a child of F's age with this pattern. Apart from the sparing, which Dr Mecrow did not consider of particular relevance, it was the type of pattern which might be seen in new-born babies when compression of the thorax during delivery raises venous pressure in the head and neck causing a rash.

57. He considered the history and noted that there was no evidence of neglect or delayed development. As for the bruising sustained by F in April 2018, Dr Mecrow said that, in his clinical experience of many hundreds of babies, "bruising is exceptionally uncommon in infants this age" and that the research "points heavily towards accidental bruising in non-mobile babies being uncommon". He also described the proposed mechanism as being "relatively unusual". However, "given that the bruises are small and of a size that is commonly seen as a result of accidental mechanisms and as they involve the bony prominence of the forehead which is one of the areas commonly bruised by accident" he would "accept that the bruising … had been the result of the mechanism described". This opinion would be "strengthened" if, as recorded, the dimensions of the bruising correlated with the edges of the object suspended above the chair.

58. Dr Mecrow considered possible causes of a petechial rash. He noted that F did not appear to be unwell when seen at the hospital and that "there was no evidence of a fever or other symptoms such as a cough or vomiting which are known to be potential causes of a petechial rash in this distribution". Infections can cause vasculitis but this "would very rarely give the distribution of rash seen in" F's case. In considering this, Dr Mecrow agreed with Dr Flowers that it was unlikely that the initial rash was associated with "the fever and rash that appeared on the 5th/6th June". This would be "an unusual sequence of events" although "this possibility cannot be excluded with absolute confidence".

59. Forceful coughing and/or vomiting are relatively common causes of a petechial rash. However the absence of any history of these from the parents made this unlikely. If one or other of these symptoms had been described by the parents, Dr Mecrow considered that "the rash would have been attributed to this without concern or difficulty".

60. Dr Mecrow agreed with Dr Flowers' conclusion that there was no "easily identifiable medical condition to account for this distribution of rash". He then added: "However, I would have to express very grave concerns about then postulating that the absence of any medical explanation indicates at a level of the balance of probability that this had been the result of an inflicted process such as smothering".

61. After acknowledging that his "own understanding had been that petechial haemorrhage was relatively commonly seen after episodes of smothering or suffocation", Dr Mecrow then said: "However, further research into this in seeking to confirm this view has now led me to be cautious about expressing this to the Court". He provided two "important papers which have influenced my thinking". What Dr Mecrow drew from these papers was that "facial and conjunctival petechiae are distinctly uncommon in smothering and suffocation". He concluded that, whilst smothering or suffocation could not be excluded as a possible cause, it was not "the likely mechanism at a level of the balance of probability".

62. Dr Mecrow was then asked some further questions on behalf of the Local Authority. In response he emphasised that he found this "an exceptionally difficult case". F had a rash "in a distribution that is rarely seen in clinical practice". He repeated that he had never seen a child of F's age "with this degree or severity of petechiae involving only the face and neck". He agreed that F's presentation was consistent with suffocation save that "it is hard to imagine that she would not have been notably upset and distressed following this". This was because, if this was the cause, he believed that F "would have to have been suffocated close to the point of respiratory arrest". It was, therefore, "difficult to imagine that she could have made a complete and full recovery from this spontaneously within a few minutes".

63. Additionally, because clinicians "very rarely indeed" see "children who have been recognised to have been smothered but survived … there is little experience on which to base an opinion".

64. However, Dr Mecrow was able to draw on other direct experience. He had experience, clinically and as a member of a Child Death Overview Panel, of a number of babies and infants who had died as a result of co-sleeping. None of them "displayed facial petechiae of the degree seen in" F. Also, as an expert in family proceedings, he had "considered two children to have been a victim of suffocation". Neither had facial petechiae. "Both presented with acute and very severe respiratory distress which remained unexplained after full investigation. There were also other injuries suggestive of physical abuse."

65. From his literature research, Dr Mecrow found that "much of the published literature" about facial petechiae had investigated traumatic asphyxiation from chest compression. This provided a mechanism which "has the potential to have caused petechiae in the distribution that was seen" and which the court would need to consider as a possibility – "i.e. of a carer pressing on the chest forcibly".

66. When asked to list the possible causes, Dr Mecrow gave three. An unwitnessed episode of coughing or vomiting or straining; asphyxiation or smothering which could be accidental or inflicted; and a medical cause that is "poorly understood" and has not been identified. He considered trying to choose between these "to amount to guesswork and to be as likely to mislead as to assist".

67. In her written report, Dr Bolton explained that petechiae are produced by small blood vessels rupturing. They rupture because of "an acute rise in venous pressure of thin-walled peripheral blood vessels". This may "result from mechanical obstruction of venous return to the heart or attempts to breathe against an obstructed or blocked airway" or when "pressure is applied to tissue such as beneath a tourniquet applied to the arm". There is "no evidence that hypoxia plays a role".

68. Petechiae can be seen "for a variety of causes including as part of natural diseases, as a natural occurring phenomenon such as following coughing or sneezing … as well as from traumatic causes, both accidental and inflicted". Compression can lead to petechiae beneath the compressed area (e.g. with a tourniquet) and "there may also be sparing in association with pressure whereby the pressure prevents blood distending and rupturing the small venules".

69. Typically, whatever the cause, "there is not a clear, distinct demarcation between affected and non-affected areas" which is "remarkably striking" in F's case. The number and density of the haemorrhages were also "most striking features". Another unusual feature was that they were still evident "some 24 hours later".

70. The distribution of petechiae to the face and neck "would be in keeping with some form of compressive neck pressure but the lack of injuries to the neck would" militate against this, "as would the sharp demarcation between affected and spared areas across the front of the face".

71. Dr Bolton considered smothering. "Often cases of smothering are associated with very few petechial haemorrhages even when fatalities have occurred". It would also be expected that an infant would struggle against having their airway obstructed leading to them becoming distressed and to sustain some other injury. There had been no damage to the frenula, lips or nose. The episode which caused the petechiae would have been "prolonged". Further, holding or pressing F's face into a surface "could account for 'pressure sparing' of some areas but would not then account for the petechial haemorrhages on the back of the head".

72. It was Dr Bolton's opinion that this case "seems to leave more questions that I have answers for". Whilst the petechial haemorrhages were very worrying, "I cannot be sure of their cause". In her opinion, "suffocation" did not "reach the threshold of being the 'probable' cause".

73. In the experts' meeting Dr Flowers agreed that this "is a highly challenging and difficult case". She reiterated that she could not "think of any medical cause" but, having read the reports and papers provided by Dr Mecrow and Dr Bolton, she amended her conclusion to being that, "in the absence of any other plausible medical explanation, it is my opinion that (the) most likely cause of the petechiae seen is some form of external

mechanical force and/or compression that lead to an increase in the venous pressure leading to the petechiae … and examples of that would include things like suffocation". Her opinion was that other causes of compression, such as of the thorax, were "a less likely explanation than suffocation".

74. A number of other points emerged from the meeting.

75. Dr Bolton described the amount of petechiae as "extraordinary". She also said, early in the meeting, that she could not explain how, if a child had been smothered, you would "suddenly have that area of sparing that is so well demarcated". She did not know of "any cases where a child has been smothered where you would have this distribution".

76. Dr Bolton did not consider that there was any anatomical reason for the sparing. In her view "sparing may be seen from pressure whereby blood can't get in; therefore you can't have petechiae because there isn't blood there". The "most likely explanation is that there has been some form of compression of those areas to stop the blood getting in". However, she then also said that, "you would have to match your compression to the sparing and that's what then becomes difficult …".

77. On the cause of the sparing, Dr Flowers suggested the "possibility of the point of pressure being the area of sparing". She initially seems to have considered that this pressure might have forced "out blood to other areas (with) that causing the increase of venous pressure".

78. Dr Mecrow was unable "to give a satisfactory account or explanation" for the sparing. Because petechiae are caused by an increase in pressure in the blood vessels, it was "hard to explain" why some areas would be spared. He speculated that it might be "due to natural variation in biological tissues".

79. The doctors discussed asphyxiation caused by compression, as referred to by Dr Mecrow (paragraph 65 above). He made clear that he did not have any evidence for saying this was the "main cause" but that it was something the court needed to consider. This led Dr Flowers to refer to a "combination of something causing increased pressure with something else happening at the areas of sparing". Dr Mecrow commented that it was "difficult to postulate" this being done by one person. Dr Bolton responded that she could "think of a possible way", namely F being held "very tightly" around her chest while being pressed against the adult's body and, at the same time, having a hand "around/over her mouth". She didn't know "how easy that would be to do with a baby, without other marks, without F wriggling, without her being upset". From "a technical perspective it is possible" but it would require "you to get a lot of things right and for things to happen in the right way".

80. At the end of the meeting, the doctors were asked to address a number of possible causes.

81. In respect of smothering, the doctors, in summary, concluded as follows. Dr Mecrow considered it "a potential cause" which could not be "excluded". Dr Fellows considered it a potential cause but in response to "our earlier discussions" "plus something else such as compression of the chest". Dr Bolton did not consider that "smothering itself could account for what we are seeing"; "I think it may or could be a part of what is there but again it is very difficult to see".

82. In respect of asphyxiation "via compression of the chest", Dr Mecrow again considered it a potential cause which could not be "excluded". Dr Flowers also did not think it could be excluded although it was "difficult to explain the pattern". Dr Bolton considered it possible but would have expected the petechiae to "come lower down on the neck and perhaps also on to the top of the chest, i.e. to the point of compression and I would have expected them to be more generalised across the face".

83. When asked to add any further comments, Dr Mecrow repeated his concern that just because something cannot be explained doesn't mean that it was non-accidental. There was no research and no clinical experience to "draw on". Dr Bolton said that she "cannot think of a mechanism by which it has occurred in my experience or that of the people around me"; that she "can't see how it fits forensically"; and that she "couldn't say even on balance" that it was inflicted. She could not "think of a mechanism by which it has occurred"; the presentation "just doesn't fit with all of the mechanisms of the way we see petechial haemorrhages being caused in forensic pathology".

84. To complete this summary of the medical evidence, I now turn to the oral evidence given by the doctors which I deal with, broadly, in the sequence in which it was given.

85. In Dr Flowers' evidence, in response to questions on behalf of the Local Authority, she addressed the apparent need for two different actions, namely one which caused the petechiae and one which caused the demarcated areas of sparing, as follows:

> "We have talked a lot in the various reports and in the experts' meeting about how unusual the distribution of the rash is and if – assuming that these petechiae are due to increased venous pressure in the small veins, which is what everyone seems to be in agreement seems to be the cause, then to get that distribution you have to have something, if you like, causing that distribution, so the reason smothering came up was because, to not have the same increased pressure in the veins in this area or the skin in this area, something needs to be stopping the blood in that area causing the increased pressure, so that is why the smothering came up because … of the sparing. Now, having been through the experts' conversations and things like that as well, people were saying, 'Well, if you have increased pressure through compression of the thorax with something covering the face at the same time, could that do it?'. And I think that that is a possibility, but you have still got something kind of accounting for the sparing in this area".

86. Dr Flowers could not completely exclude strangulation as a possible cause of the petechiae but "some signs of it on the neck" would have been expected. Chest compression could have caused the petechiae but they were in "an unusual distribution … because … you might have expected a few more … on the top of the chest". When asked whether the distribution and the sparing might be explained by one hand on the chest and one on the face, Dr Flowers replied that she was "not sure if just one hand on the chest would be enough to cause the increased pressure to cause the wide distribution" seen on F, "unless the whole thorax was somehow compressed together".

87. In response to questions on behalf of the mother, Dr Flowers maintained that "suffocation remains a … possible cause", continuing: "there is something that seems to have happened within 30 minutes to have caused this petechiae in a very unusual manner and the only possibilities that … I can think of are either suffocation, strangulation, chest – thorax compression with something over the face at the same time …".

88. For clarification, the judge asked whether Dr Flowers was saying that "the only thing she could think of was … smothering with some thorax or chest compression". Dr Flowers replied that this was "the only way that I can think of that would account for this highly unusual presentation seen. Now, that may or may not be smothering on its own, it may or may not be smothering with something else, if that makes sense, with chest compression, with strangulation, with something else at the same time, but the only way that I can account for the areas of sparing that are seen are if something was in that area at the same time".

89. When asked directly by Ms Woolrich for the mother whether she was saying that smothering was "potentially a cause of the petechiae", Dr Flowers replied, "Yes, I think it is". Adding:

> "I still think that some form of smothering as part of the mechanism to account for the sparing is the only way I can see to account for the sparing … Whether it is smothering with something else or smothering on its own is difficult to say …"

Ms Woolrich then asked whether Dr Flowers would accept that it was "not fair to say now that it is highly likely to be smothering, rather than it is one of the … scenarios that the court should consider". Dr Flowers replied:

> "I think it is probably fair to say that there … would probably be some element … I think it comes back to the only way I can account for the area of petechiae is if something is covering the area. So smothering appears to apply."

90. Dr Flowers also said, a bit later in her evidence, that compression of the thorax is "potentially less likely … than compression in other areas" because "it is a bit more protected". This was why she had not suggested it "in the first place", adding that it cannot be "completely" excluded.

91. In questioning on behalf of the father, Dr Flowers was asked about her observation in her written report that the petechiae could have been caused by forceful pressure to the adjacent areas which were spared. Dr Flowers appears to have moved away from this and, as referred to above, considered that there had to be something causing the sparing and something else causing the petechiae. For example, when asked about the presence of different patterns of petechiae on F's face and the back of her head, Dr Flowers said: "I suspect there has to be more than one thing at play here … there's got to be something causing the area of sparing and then something causing the areas of petechiae". She then added that "I can see that just suffocation alone may be difficult to explain, but suffocation with something else going on at the back … something's happening to the back of the head with something in front of it, then that could be an explanation for why

there's a slight difference in the front and the back of the head in terms of the distribution of the petechiae".

92. Towards the end of her evidence, Dr Flowers again said that, "It's difficult to think of any other explanation … it's very difficult to think of potential (medical) causes for this kind of picture, including looking at all the features."

93. At start of his oral evidence, Dr Mecrow dealt with matters arising out of Dr Flowers' oral evidence. First, he made clear his understanding that, in cases involving "traumatic mechanisms", the process which leads to pressure rising and the capillaries bursting is "that obstructed venous return from the head and the neck causes the blood vessels in the face to become engorged". Secondly, he agreed that the swelling of the eyes would require a somewhat different mechanism and were "a little difficult to account for" when there was "no definitive description of distress and F crying". Thirdly, Dr Mecrow agreed with Dr Flowers that "when the blood pressure rose in the head, it is likely that the petechiae occurred over the course of a few seconds or a minute or two". Accordingly, if the court accepted the description of the petechiae developing over 20 or 30 minutes, this would "again be difficult to square with an episode of raised pressure due to whatever mechanism we have talked about being the cause".

94. Dr Mecrow explained that, never having seen a petechial rash in this pattern clinically before and being unable to "substantiate a definitive mechanism from the research", he did not follow the approach which had led Dr Flowers to her conclusion. He added that he was very used to applying her "thinking" in unexplained bruising, fractures and head injuries where there is "a wealth of clinical experience and a huge amount of research to back up the position that if fractures and bruises are unexplained, then there have been abusive mechanisms". He found himself "in a different position here because there isn't the clinical experience and there is the research to back up the next step in thinking". As a result he "couldn't advise that non-accidental mechanisms were likely at a level of the balance of probability".

95. After describing as "very unlikely" vasculitis caused by infection or an episode of coughing and/or vomiting or F having moved herself into a position where she could not breathe properly, Dr Mecrow was asked whether that meant there could be no "innocent" explanation. In his view it did not – "things happen which we can't fully explain". Accordingly, "the court needs to be alive to the possibility that something very unusual here has happened but where there is an explanation which none of us can fully account for" – "another mechanism that we do not understand". He described it as "not a particularly unusual position" for children to recover without the cause being fully identified or to "see children ventilated in intensive care with episodes of collapse where we don't fully understand the cause".

96. Dr Mecrow accepted that there is "unquestionably evidence which links facial and head and neck petechiae with the mechanism of smothering and suffocation". However, the "other factors" in this case meant that he did not consider this the probable cause. These factors included the swelling of the periorbital tissues which was difficult to account for with smothering although he could "just see" that, if the smothering involved pressure over the eyes, the swelling could have resulted from that; the absence of distress shown by F; and the manner in which, if they did, the petechiae developed over "at least some time". There was also the absence of bruising or trauma to the mouth and nose "where

you would have expected and predicted the pressure to have been the greatest and then yet say that the swelling around the eyes was caused by the pressure". This was difficult to reconcile because, "if you are going to smother a child, then you need to occlude the mouth and nose with the greatest pressure".

97. As for the sparing, Dr Mecrow considered that this pattern was likely to be due to natural biological variation in tissue, the periorbital areas and the eyelids being soft. He has never seen sparing from compression being "explained in any texts" and had "not been able to logically account for how pressure would allow sparing". He was also "struck" by the point made by the father's counsel that, if the sparing was due to pressure, "why is there marked petechiae at the back of the head?" He could not "come up with an explanation" for this because there would have been pressure at the front and at the back. He again said that this did not "allow me to say that an abusive mechanism was the cause".

98. Dr Mecrow also referred to his opinion that "raised venous blood pressure in the head and neck is the primary cause of petechiae". This would require "forcibly compressing the chest" and a prolonged obstruction (of venous return) "which would have had to be seconds and minutes even".

99. Dr Bolton explained that petechial haemorrhages occur in an "instance" but they may then only be seen "over a period of time" as they become more obvious on the skin's surface. This would typically be dependent on differences in skin thickness and other variations in the structure of the body. She did not agree with Dr Mecrow and considered that "being able to see more of them within that half an hour window is what I would expect and is what we, as pathologists, commonly encounter".

100. Dr Bolton said that her first response, when she sees extensive petechial haemorrhages, is to "think something has happened to this person's neck and airway or chest to stop them breathing and stop the blood draining from their head".

101. In respect of the areas of sparing, Dr Bolton described these as "incredibly unusual" because "you could effectively draw a very definite line between affected skin and non-affected skin". Usually, the density "progressively gets less and less as it sort of fades out". The "most common reason for (sparing) is something pressing on the skin in that area to stop those blood vessels filling with blood". This was "the most simple explanation that I can put forward … that (there) would be some form of pressure in that area, but that is as far as I can go with that". That "could account for sparing if there was a way that you could cause a generalised increase in blood pressure".

102. Dr Bolton was then asked whether, if the blood was being obstructed, that could have caused "the petechiae that were forming the other side of the spared area". She replied, "It can do and that may be why we see, to an element, tramline bruises … but, in general, in F's case whereby we are looking at far more generalised petechiae, I do not think that it would have a significant effect".

103. Dr Bolton agreed with Dr Mecrow that she would expect to see sparing on both sides of F's head if the proposed mechanism was pressure being applied to F's face or the back of her head because "it is effectively pressure through one channel". If pressure was applied to the face she agreed that it could be softer on the back of the head "but I still

would not expect there to be as many petechial haemorrhages on the back of F's head as there appear to be". Differential in pressure "would not explain the extent of the petechiae that we have got at the back. It could account for a lesser amount but I still would not expect the … relatively dense area on the back that appears to be on the opposite side to the area that we would have had to put pressure on her."

104. When being asked about chest compression, Dr Bolton explained that at the experts' meeting she had "tentatively put forward a scenario" in which, if F was held "in such a way that you could put general pressure on her chest whilst having something over her face, then that might account for these changes". This was "very much a case of that would seem to fit the appearances but I cannot say with any degree of certainty that that is what I think happened". She added that: "Whether that is sustainable, how easy it is to do with an active struggling six-month old, I simply do not know".

105. In addition, when asked about the extent of the petechiae, Dr Bolton said that more can be caused if "you cannot maintain that compression or pressure". However, the "problem with that scenario in many ways is that, whilst I would not necessarily expect there to be any signs on her chest from that, I would have expected to see something on her face from her wriggling and moving."

106. At one point Dr Bolton said that she "cannot exclude" what Dr Flowers had said but she was "not sure of" the cause of the petechiae, repeating that suffocation "does not even reach the threshold of probable". However, it was also her evidence that she did not agree that suffocation alone was a possible mechanism. In answer to a question on behalf of the father, she made clear that she did not agree that F having her "face pushed down into a surface" or the reverse was a possible mechanism "absent any other, chest compression, for example".

107. When addressing these two mechanisms Dr Bolton agreed when asked that, in respect of the chest compression, "you would have to have got an awful lot of things right for that to have worked". It required "very forceful" pressure. This would have been at the same time as the postulated something on F's mouth being "very inefficient". This combination showed "how difficult it would be to do … while you are managing to maintain the pressure on F's chest to cause the venous obstruction, you are not managing to stop her breathing long enough for it to cause anything other than those petechial haemorrhages". This process was likely to have "gone on for 15 to 30 seconds" with F being "very upset and distressed by that experience, not presenting as an otherwise well baby".

108. Dr Bolton described how she had experience of "accidental neck pressure", "smotherings", "strangulations" and "chest compression causing what we often refer to a traumatic asphyxia" but she has "not seen what I saw in F".

Submissions

109. I am grateful to counsel for their succinct but comprehensive submissions.

110. At the outset of his submissions, Mr Stonor acknowledged that this appeal is from a fact-finding decision made by a very experienced judge. However, he submitted that the judge's conclusions were not supported by her analysis of the evidence; in particular her

key finding that the petechiae were inflicted injuries which had been caused by the father with the "most likely" mechanism involving "some form of compression and suffocation or smothering". Mr Stonor accepted that there are many cases in which the mechanism for an injury will be sufficiently well-established for the substantive issue to be whether the identity of the perpetrator can be determined. However he submitted that, in the circumstances of this case, the judge needed to engage more substantively with the mechanism by which the petechiae and the sparing might have been caused when this was critical to the issue of causation and when all three of the medical experts, he submitted, had "struggled to come up with a plausible mechanism".

111. Mr Stonor also submitted that the judge misstated and gave undue weight to the evidence of Dr Flowers and gave insufficient weight to the evidence of the experts instructed specifically for the purposes of the proceedings. As to the judge's understanding of Dr Flowers' evidence, Mr Stonor submitted that Dr Flowers did not give evidence, as set out in the judgment, that she "now favours a combination of smothering/suffocation and chest compression as the probable cause" so that the judge's conclusion that "it most likely … involved some form of compression and suffocation and smothering" was not supported by the evidence.

112. Further, he pointed to the approach which appeared to have been taken by Dr Flowers when she based her conclusion on the absence of any medical or any other plausible explanation. He acknowledged in fairness to Dr Flowers that she was not directly asked at the hearing where an unexplained aetiology fitted into her reasoning. However, he relied on what Hedley J said in *Re R (Care Proceedings: Causation)* [2011] 2 FLR 1384, at [19], about it being "dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism", when submitting that Dr Flowers evidence had been given undue weight by the judge.

113. Mr Stonor also questioned the judge's approach to what she called "gaps in the evidence". In his submission they were not gaps but features of the evidence which needed to be taken into account and with which the judge needed to engage to explain because they pointed against the judge's conclusions. In particular, the fact that the doctors were "unable to provide an easy 'fit' for a mechanism by which all the petechiae were caused and the absence of other injuries". Mr Stonor submitted that the judge did not explain how these features were outweighed by the other evidence. Nor, he submitted, did the judge engage with other aspects of the evidence which did not support the conclusion that the "most likely" mechanism involved both compression and suffocation or smothering.

114. Ms Woolrich supported the father's submission that the judgment does not sufficiently explain why the judge found that F's presentation "fitted with an inflicted injury". For example, Ms Woolrich pointed to Dr Bolton's evidence about how difficult it would have been for the father to have held F with sufficient pressure while at the same time smothering her so as to cause the clear sparing on her face. She also referred to the circumstances in which the inflicted injury would have had to have been caused. This was at the same time as the father was changing F's nappy and when he called for the mother within, at most, a few minutes by which time F was not notably distressed.

115. On the issue of expert evidence and section 13, Ms Woolrich submitted that there are many cases in which the only medical evidence will be that given by a treating clinician.

This is not necessarily linked to the difficulty in finding experts willing to act but more typically because no further or other expert evidence is required. She, therefore, cautioned against the courts taking too literal a view of the scope of section 13 and of the need to comply with the requirements of Part 25.

116. Ms Howe on behalf of the Local Authority submitted that the judge made no error in her determination. She submitted that the judge was entitled to prefer the evidence of Dr Flowers and that, based on her assessment of this and the rest of the evidence, she was entitled to make the finding which she did. The judge had in mind the possibility of an unknown medical cause and expressly referred to this as being a potential determination.

117. Ms Howe accepted that the judge had not undertaken a detailed analysis of the means by which F's presentation could have been caused. She also accepted that Dr Flowers did not put forward a combination of smothering/suffocation and chest compression as "the probable cause". However, she submitted that, viewed as a whole, the judgment contains a sufficient analysis of the evidence and explains why the judge reached the conclusion that the petechial haemorrhages were "inflicted".

118. Mr Gray on behalf of the Guardian submitted that the appeal should be dismissed. During the course of his submissions he also accepted that Dr Flowers had not given oral evidence to the effect that the combination of forces referred to above was the probable cause.

Section 13 and Part 25

119. I do not consider it necessary to set out these provisions. Nor do I consider it necessary to do more than record that we were referred to a number of authorities including *Oldham Metropolitan Borough Council v GW and PW* [2007] 2 FLR 597; *Oxfordshire County Council v DP, RS & BS* [2008] 2 FLR 1708; *Re H-L (Expert Evidence: Test for Permission)* [2013] 2 FLR 1434; *Re D (Children)* [2015] EWCA Civ 749; and *Re AD & AM (Fact-Finding: Rehearing)* [2016] EWHC 2912 (Fam).

120. We were also provided with copies of the *Guidance on Paediatricians as Expert Witnesses*, August 2018 issued by the Family Justice Council and the Royal College of Paediatrics and Child Health and of the *Guidance for Healthcare Professionals on Acting as an Expert or Professional Witness*, May 2019 issued by the Academy of Medical Royal Colleges.

Determination

121. I first, again, acknowledge that this was a very difficult case. I would also observe, without in any way being critical of any of the medical witnesses, that it is not easy to summarise the effect of the medical evidence. With the benefit of hindsight, the process by which this evidence was obtained could be said to have led to the picture becoming more diffuse rather than clearer. It may be that this was because of the difficulties present in the case but I have a concern that it was at least in part due to the way in which the evidence was obtained from the doctors. When adopted, the process of reports, meeting and oral evidence, will typically be sufficient to obtain the necessary evidence but in this case it might have been helpful for a summary of the effect of the evidence (not necessarily as formal as points agreed and disagreed but something along similar lines)

to have been prepared by the Guardian's solicitor following the meeting for the doctors' consideration and agreement.

122. In any event, for the brief reasons set out below, it is clear to me that the appeal must be allowed. Further, as referred to above, I have decided that this court is not in a position to determine that the Local Authority's case has no sufficient prospect of being established to justify dismissing the proceedings.

123. I acknowledge that this regrettably prolongs the proceedings. This is a single issue case. If the Local Authority does not establish that the petechiae as seen on F were inflicted, the care proceedings would be dismissed because there is no other basis on which the threshold criteria could be established. However, as I have said, although on one view of the medical evidence such a finding would not be sustainable, I am not persuaded that this is determinative both because this may not be the only view and because the court must determine the issue by considering *all* the evidence and this court is not in a position properly to undertake this exercise.

124. I say that this may not be the only view of the medical evidence because there are elements of that evidence which are, on paper, not as clear as they might be. In particular, it is not clear to me whether and, if so, how the evidence would support smothering/suffocation alone as being the cause of the petechiae. Parts of the evidence would seem to support the conclusion that there would have to have been two different mechanisms – a combination of chest compression and smothering/suffocation (as referred to by the judge). Yet, at times in their evidence, each of the doctors, at least, *might* be saying that suffocation/smothering might alone be sufficient or cannot be excluded.

125. In my view, Mr Stonor and Ms Woolrich have demonstrated through their submissions that the judgment must be set aside. I agree that the judge appears to have misstated Dr Flowers' evidence that she "now favours a combination of smothering/suffocation and chest compression as the probable cause". Absent such evidence, the judge's later conclusion that "it most likely involved some form of compression and suffocation or smothering" is unsupported by the evidence.

126. I should make clear, having regard to some of the submissions made in this case, that this is not to say that a judge cannot made a finding based on the evidence of a treating clinician in preference to that of experts instructed in proceedings. As was pointed out by Mr Gray for the Guardian, one of the factors which the court must take into account when deciding whether to give permission is "what other expert evidence is available (whether obtained before or after the start of proceedings)": section 13(7)(d).

127. Further, however, I agree that the judge did not sufficiently engage with the evidence that did not support her conclusion of inflicted injuries. It is not clear from the judgment why she discounted the evidence which pointed against inflicted injuries. These features included the absence of sparing on the back of F's head; the absence of any other injuries; the speed with which F appears to have recovered from what would have been a life threatening event; and, if this was the mechanism, the considerable difficulty of applying pressure to the face at the same time as applying compressive pressure elsewhere. In my view, in this case, the judge needed to explain, as submitted by Mr Stonor, how these features were outweighed by the other evidence.

128. As a result, as set out above, I have concluded that the judgment must be set aside.

129. As mentioned at the outset of this judgment, I am hesitant about giving guidance about the manner in which section 13 and Part 25 should be applied when treating medical witnesses give expert evidence. All counsel agreed that in their experience such witnesses more frequently give expert evidence than they used to and more frequently theirs is the only expert evidence. In part this may be the result of the lack of experts available to give expert evidence for the purposes of proceedings as well as for the reason given by Ms Woolrich, namely that in some cases, particularly those involving more minor injuries, the only expert evidence required for the proper determination of the proceedings is that given by treating doctors or other professionals. Those professionals may be unwilling or unable (because, possibly, of the terms of their employment) to give what might be termed formal expert evidence.

130. In the present case, Dr Flowers made it clear that she was not in a position to act as an expert witness. This did not, of course, mean that she was not able to give expert evidence. In such circumstances there can be good reason for the provisions of section 13(5), (6) and (7) to be applied with a light touch. This is because, although her evidence would seem to come within the scope of "expert evidence (in any form)", section 13(5), she was not, at least initially, engaged for the purposes of the proceedings. However, despite her having made clear that she could not act as an expert witness, her role became blurred by her involvement in the experts' meeting. She was then providing "expert evidence for use in proceedings": rule 25.2(1).

131. In this case, it is not difficult to see why this occurred because it enabled Dr Flowers to engage with the evidence being given by the instructed experts and the questions being asked by the parties without which she would have been considerably disadvantaged when giving oral evidence at the hearing. However, I agree with Mr Stonor's submission that it raises the question of whether the different perspective she brought to the case from that of the instructed experts was not overlooked. For example, there was no expectation that she would undertake the type of research that an instructed expert would be expected to undertake for the purposes of preparing a report for proceedings. Again, this does not mean that her evidence could not be accepted in preference to that of the instructed experts but it was a feature that the judge needed to have in mind when assessing the evidence.

132. It is, of course, important that the court and the parties recognise the difference between treating professionals and those instructed for the purposes of providing expert evidence for the purposes of proceedings. As I have said, a treating professional will self-evidently have a very different focus to an expert witness. However, as Mr Stonor submitted, it would not support the proper and expeditious determination of cases if unnecessary and/or disproportionate obstacles were placed in the way of expert medical evidence being available to the court. In that context, it seems to me that a treating professional who is also an expert will in some cases be able to give expert evidence without all or even any of the requirements of Part 25 being applied. However, again as referred to above, this is a matter which requires broader analysis than can be undertaken in a single decision. Further, Dr Flowers' situation and the manner in which she became involved in these proceedings raise wider issues which would benefit from a broader consideration such as that which can be provided by the President's Working Group.

Lord Justice Irwin:
133. I agree.

Lord Justice Underhill:
134. I also agree.