Neutral Citation Number: [2021] EWFC 22

Case No: CM20C05225

IN THE FAMILY COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/03/2021

Before :

MR JUSTICE NEWTON

- -

Between :

THURROCK COUNCIL

Applicant

- and -

(1) M
(2) D
(3) S
(4) R
(the Third and Fourth Respondents
by their children's guardian,)

Respondents

- -

Peter Horrocks (instructed by **Thurrock Council**) for the **Applicant**
Alexa Storey-Rea (instructed by **Wollens**) for the **First Respondent**
Andrew Bailey (instructed by **BTMK**) for the **Second Respondent**
Tim Parker (instructed by **Gary Jacobs Solrs)** for the Children's Guardian

Hearing dates: 28 January 2021

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

MR JUSTICE NEWTON

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Newton :

1. In the early hours of 5/7/20 P, born 3 August 2019, was found to be unresponsive and was given mouth to mouth resuscitation and CPR. After an initial call to the ambulance service she was taken to Hospital, arriving at 1.10am. She was subsequently transferred to Great Ormond Street Hospital. The parents explained that P had become entwined in a small fleecy blanket which had completely covered her head.

2. Preliminary investigations by Great Ormond Street record the verbal report from the Hospital which suggested following a CT scan "global hypoxic ischaemic changes with diffuse cerebral swelling and notes the presence of a small subdural bleed". GOS also found retinal haemorrhages in both eyes.

3. The preliminary views of Great Ormond Street Hospital were:

   i) P was a previously healthy 11 month old, who was found unconscious and unresponsive with no clear identifiable cause. History of events from her mother alludes to possible suffocation as a cause. However, results of investigations performed so far, do not support this.

   ii) At present, in the absence of a clear explanation given by the parents, together with the constellation of findings thus far, in a previously well, mobile child, the possibility of non- accidental injury cannot be excluded.

   iii) Further investigations are in progress to explore this further.

4. P's sister, S (born October 2016), and P's twin sister R, were placed under police protection on 6/7/20 and were moved to stay with a family friend.

5. P tragically died at 3.02pm on 8/7/20.

6. On 9/7/20 HHJ Roberts granted the Local Authority an Emergency Protection Order until 16/7/20 and listed a further interim care hearing.

7. A post-mortem examination was carried out by Dr Cary on 14/7/20, but he called for further tests to be undertaken and could not provide a full report until those results had been received. Dr Cary did however indicate that there was no evidence of natural disease, and no evidence of injury from assault or restraint. He did not rule out asphyxiation. The skeletal survey was negative and the post-mortem scan was negative.

8. The case came before HHJ Shanks on 16/7/20. Interim care orders were made without active opposition from the parents and with the support of the Guardian. The Local Authority indicated that it would consider carefully whether it might be possible to place the children within the extended family. Very fortunately, the children were able to move to live with their parental grandparents on 24 August 2020. The case that day was allocated to a High Court Judge.

9. Dr Cary's interim report was made available on 22.7.20. An updating report from Great Ormond St Hospital of 10.8.20 could not rule out inflicted injury.

10. Early on S and R were referred for full skeletal screenings by the local hospital, but the local authority correctly took the view that, as these would have required sedation under the care of an anaesthetist and resuscitation nurse, it was not a proportionate step to take.

11. The instruction of a galaxy of experts was approved by the Court on 24 August 2020. Ultimately those experts whose reports were before the Court (including those consulted by Dr Cary) comprised:

    Professor Jacques consultant neuropathologist

    Dr McPartland consultant paediatric ophthalmic pathologist

    Dr Cartlidge consultant paediatrician

    Mr Jayamohan consultant paediatric neurosurgeon

    Dr Keenan consultant paediatric haematologist

    Dr Saggar consultant in clinical genetics

    Professor Luthert, ophthalmic pathologist

12. In his interim report Mr Jayamohan, reviewing the existing medical records (although he claimed no expertise in radiology) said that there was no clear-cut finding of trauma in P. The hypoxic ischaemic injury to the brain was clearly explainable by the prolonged period of cardiorespiratory arrest and resuscitation. The final important issue he concluded would be the pathology results, in particular if there was evidence of extra-axial bleeding or any evidence of traumatic brain injury. It appeared therefore that further opinion would have to await the results from Dr Cary's requested post-mortem tests.

13. Dr Cartlidge in an email of 2/11/20 advised that there was currently scant evidence of trauma. He advised that an important issue would be the cause of the retinal bleeding, and to a lesser degree the possible bleeding on the surface of the brain.

14. An experts' meeting took place on 14/12/20 (between Dr Cartlidge, Mr Jayamohan, Dr Keenan and Prof. Luthert). A note of the meeting, approved by the experts, was received by the parties on 16/12/20. In essence it indicated that:

    i) The experts had not reached any clear conclusion as to the cause of death of P. Prof. Luthert said that inflicted trauma had to be a consideration, as it clearly had been for the clinicians at Great Ormond Street.

    ii) In particular there was continuing lack of clarity as to whether there was any bleeding or sign of trauma in the vertex.

    iii) There were queries as to whether the retinal haemorrhages, which are not very marked and not seen until 38 hours after P was admitted to hospital, and which

could have developed after coming into hospital as a result of hypoxic injury or might have been caused by a combination of hypoxic injury and DIC (disseminated intravascular coagulation).

iv) Prof Luthert raised whether the retinal haemorrhages might have occurred when P's head got trapped between mattress and skirting board and she was struggling and/or pressure being generated.

v) All experts appeared to agree that the retinal haemorrhages might well become the key issue.

vi) There appeared to be a consensus that a consultant ophthalmologist should be instructed in the proceedings and that it was necessary to wait for further views to be expressed until the neuropathology report of Prof. Jacques was received.

15. Since the experts' meeting further reports have been received.

16. The report of Prof. Jaques (neuropathologist) concludes:

> "There is evidence of hypoxic/ischaemic damage to the brain and spinal cord. This indicates that there has been a significant interruption of the oxygen (hypoxic) and blood (ischaemic) supply. This is demonstrated by the presence of red neurons and a vascular pattern of axonal injury.
>
> ….
>
> I have specifically considered the possibility of traumatic brain injury. While hypoxia/ischaemia may be one of the consequences of brain trauma, it is not specific, and I have not found specific evidence in the brain to indicate trauma. There are features (notably the cerebral haemorrhage and the axonal injury in the cervical spinal cord) where I have considered the possibility of trauma, but in my opinion, these are more likely to be the complications of hypoxia/ischaemia, based on their morphological pattern."

17. Dr McPartland (consultant paediatric ophthalmic pathologist) reported that:

> "In fatal cases of non-accidental/abusive head trauma, the typical constellation of features includes intracranial subdural haemorrhage and encephalopathy, with retinal haemorrhages present in a proportion of cases. While it is true that bilateral, extensive, multi-layered retinal haemorrhages extending to the peripheral retina are considered quite specific for abusive head trauma, in P's case, intracranial subdural haemorrhage was not seen at autopsy examination or on neuropathological examination, and I found no significant optic nerve sheath haemorrhage. Professor Jacques did not find specific evidence in the brain to indicate trauma, and in his opinion, the cerebral haemorrhage and axonal injury in the cervical spinal cord are

> more likely to be complications of hypoxia/ischaemia. Therefore, the overall features in this case are not in keeping with severe head trauma.
>
> ….
>
> Although I await Dr Cary's full autopsy report, from the history given, from information provided this appears to be a case of a complex positional asphyxia, with P prone, with head below the body, under the radiator and between the mattress and the wall….
>
> ….
>
> …. this is a highly unusual case of bilateral, extensive, multi-layered retinal haemorrhages extending to the peripheral retina, with accompanying brain swelling and hypoxic-ischaemia, but without other features of abusive head trauma such as intracranial subdural haemorrhage or optic nerve sheath haemorrhage. It may be that a number of contributory factors acted together in this case to cause unusually extensive retinal bleeding, where each alone would not typically be considered a plausible sole cause."

18. Equipped with these two reports Dr Cartlidge very helpfully supplied an interim report dated 13/1/21. He emphasised that complete assessment of the cause of death should await the full report of Dr Cary. However, he considered a number of possible causes of death, most of which would be death from natural causes, but without finding evidence of their involvement. In relation to smothering or strangulation he deferred to Dr Cary (although Dr Cary has to date not raised evidence of these issues and found no signs of assault or restraint). His concluding assessment of the current situation was that the clinical history was suggestive of asphyxia as the cause for P collapsing. The clinical course is consistent with cardio-respiratory collapse secondary to asphyxia, occurring shortly before P was found at about 1am on 5/7/20. No alternative cause for her collapse was found by treating clinicians. The retinal haemorrhages were most likely secondary to the profound cardio-respiratory collapse. The evidence now available makes it not likely that P sustained an inflicted head injury. He perceived it to be no more likely that P's death was unnatural then in any infant dying suddenly and unexpectedly. He reiterated that he found no inflicted injury.

19. In his initial Report of 17 July 2020 Dr Cary was unable to identify a cause of death pending the receipt of further tests but he did observe:

    i) There was no evidence of underlying disease

    ii) The circumstances of the case raise the likelihood of suffocating and wedging.

    iii) There was no evidence of any injury as a result of restraint, and the skeletal survey was negative for any injury.

20. On 27/1/21 the Local Authority received an email from Dr Cary which read:

> "As you are aware, I am unable to complete my final report due to outstanding results. However, to assist the Court I am able to state the following having considered the external and internal postmortem findings, the neuropathology, the ophthalmic pathology and the interim opinion of Dr Cartlidge.
>
> 1 Essentially, I agree with opinions of Dr Cartlidge concerning the circumstances leading up to death.
>
> 2 There were no external or internal marks of injury and a skeletal survey was negative for fractures.
>
> 3 The principal finding in the brain was one of hypoxia-ischaemia.
>
> 4 The main findings in the eyes were retinal haemorrhages. Importantly there was no evidence of optic nerve sheath haemorrhage commonly seen in cases of head injury.
>
> 5 At this stage the main finding is one of asphyxia, the cause of which is not apparent from the postmortem findings alone.
>
> 6 This is the sort of case where any final conclusions are heavily dependent on the circumstantial evidence.
>
> 7 In this case there is potential evidence of positional asphyxia with an element of wedging, as well as suffocation from bedding. In relation to these possibilities I accept the careful reasoning of Dr McPartland in relation to the origin of the retinal haemorrhages.
>
> 8 Toxicological results are still outstanding so I cannot absolutely exclude some toxicological contribution.
>
> 9 The final exclusion of head injury will await the examination of the neck by Professor Mangham as there can be subtle changes that imply an element of flexion / extension of the kind seen in shaking injury. However even on the basis of the information available shaking seems unlikely in the absence of both thin-film subdural haemorrhages and optic nerve sheath haemorrhages."

21. Essentially, therefore, the outstanding issues still remaining are in relation to toxicology and the examination of the neck. However, having regard to the reports so far, it is fanciful to think that the further reports awaited by Dr Cary on these matters are likely to change the direction of the enquiry.

22. Upon receipt of their Reports, and in particular the opinions of Dr Cartlidge and Dr Cary, the local authority took the decisive, and entirely correct step, to seek the Court's permission to immediately return S and R to their parents' care.

The Legal Principles

23. By Rule 29.4(2) FPR 2010 a local authority may only withdraw an application for a care order with the permission of the Court.

24. In *GC (by her Children's Guardian) (Withdrawal of Care Proceedings)* [2020] EWCA Civ 848 summarised the law arising from the three authorities on withdrawal applications. Baker LJ::

> "19.As identified by Hedley J in the Redbridge case, applications to withdraw care proceedings will fall into two categories. In the first, the local authority will be unable to satisfy the threshold criteria for making a care or supervision order under s.31(2) of the Act. In such cases, the application must succeed. But for cases to fall into this first category, the inability to satisfy the criteria must, in the words of Cobb J in Re J, A, M and X (Children), be "obvious"."
>
> 20.In the second category, there will be cases where on the evidence it is possible for the local authority to satisfy the threshold criteria. In those circumstances, an application to withdraw the proceedings must be determined by considering (1) whether withdrawal of the care proceedings will promote or conflict with the welfare of the child concerned, and (2) the overriding objective under the Family Procedure Rules. The relevant factors will include those identified by McFarlane J in A County Council v DP which, having regard to the paramountcy of the child's welfare and the overriding objective in the FPR, can be restated in these terms:
>
> (a) the necessity of the investigation and the relevance of the potential result to the future care plans for the child;
>
> (b) the obligation to deal with cases justly;
>
> (c) whether the hearing would be proportionate to the nature, importance and complexity of the issues;
>
> (d) the prospects of a fair trial of the issues and the impact of any fact-finding process on other parties;
>
> (e) the time the investigation would take and the likely cost to public funds."

Analysis

25. The local authority assert that there is no reasonable prospect that threshold can be proved. The first issue for the court to determine is whether this application falls within the first category of cases – the obvious. As the evidence stands there is no evidence to support a finding of an inflicted head injury. While Dr Cartlidge defers to Dr Cary on asphyxiation, Dr Cary in his response appears not to consider this cause to

remain open. Rather Dr Cary considers that the outstanding information will be relevant to the possibility of a shaking injury which has been excluded by the medical opinions. Whilst Dr Cary leaves the matter open, he associates himself with Dr Cartlidge and does not draw attention to the possibility of an inflicted cause.

26. If the "obvious" test is not satisfied the court will have to assess the application be reference to the five principles summarised in *GC*:

    i) The investigation would be necessary to establish whether P's cause of death was inflicted. If proved, the outcome would have a profound effect upon interim and final care -planning;

    ii) A fact-finding hearing would provide a just process by which to deal with the case;

    iii) Given the severity of the issues at large the fact-finding hearing would be proportionate to the nature, importance and complexity of the issues.

    iv) The trial would be a fair process; the events are recent, a high level of expert opinion has been collected and the interested parties all have representation. Despite this the impact upon the family would be considerable. The parents would no doubt find the process of a fact-finding hearing extremely stressful and distressing, their distress being obvious at every stage of the court process.

    v) The fact-finding hearing is already listed. Given the large measure of agreement between experts and the absence of intervenors, the current time-estimate is likely to be capable of reduction. The cost nevertheless of the fact-finding hearing will be high, albeit proportionate given the severity of the issues to be determined and their impact upon S and R.

Conclusion

27. Given that it is not contended that this case now falls into the second category and, clearly falls into the first, as identified by Baker LJ, and comforted by my assessment so far of all the evidence, including the conduct of the parents, whilst it might still be thought by some necessary to hold a fact finding hearing, no one advocates such a course, and I do not consider that such a course is appropriate given that I also conclude that it clearly falls within the first category of GC.

28. Accordingly (having already endorsed the decision for the family to be reunited), I give the local authority permission to withdraw the proceedings. No findings have therefore been made. I have hesitated (since not all the tests are back) as to whether it is appropriate to exonerate the parents of any wrongdoing or responsibility. Standing back, I have concluded overall that it is. This family were previously unknown to the authorities, it is perfectly obvious that they are a close and decent family, where the children were and are lovingly and attentively cared for, and who have behaved appropriately at all times in unimaginably distressing circumstances. Whilst the local authority could not possibly be criticised for the steps which they have taken, indeed quite the reverse, all the evidence now so clearly points in one direction, that this was a tragic accident, that it is appropriate that I should exonerate the parents, and I do so.