Important Notice

This judgment was delivered in private. The judge has given leave for it to be reported on the strict understanding that (irrespective of what is contained in the judgment) in any report no person other than the advocates and any other persons identified by name in the judgment itself may be identified by name and that in particular the anonymity of the children, the adult members of their family, and their location 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.

IN THE FAMILY COURT

21 January 2022

Before

His Honour Judge Philip Harris-Jenkins

- -

Re G: (Finding of Fact Hearing: Resuscitative Shake)

Judgment handed down on 21st January 2022)

- -

Representation

Louise Price (instructed by the Local Authority solicitor) for the Applicant

Paul Storey Q.C. and Alexa Storey-Rea (instructed by Rachel Carter of Wollens solicitors) for the First Respondent Mother

Gillian Irving Q.C. and Neil Murphy (instructed by Makin Dixon Solicitors) for the second Respondent Father

Cennydd Richards (instructed by Bowermans Solicitors) for the third and fourth respondents.

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Judgment

Judge Harris-Jenkins:

1. On the 17th June 2021, the Applicant Local Authority issued care proceedings in respect of IH, a little boy, born on 16 October 2017, now aged 4 years and 3 months and GH a male infant, born on 3 March 2021, now aged 10 months**.** The First Respondent mother is BM, referred to hereafter as 'M'. The Second Respondent father is HG and is referred to hereafter as 'F'.

2. This is a Fact-Finding hearing to determine intercranial injuries, spinal bleeding and ocular injuries to GH. He was admitted to hospital on the 5th May 2021, having suffered a collapse earlier that morning when in the care of F. He was just 9 weeks of age.

3. This was a hybrid hearing undertaken via CVP and with the consent of all parties. All parties are represented by Counsel. The parents are represented by Leading Counsel and Junior Counsel. The evidence was heard over 8 days and written submissions were directed and spoken to. I reserved Judgment on day 10 of the hearing and I have sent out a draft of this Judgment in advance of its formal handing down on the 21st January 2022.

Precipitating Events

4. Prior to the 5th May 2021, the family was unknown to Children's Services or to the police.

5. On the 5th May 2021, GH was presented to Hospital following an unresponsive episode at home. Upon initial assessment, he looked unwell, pale and irritable. He was transferred to the paediatric ward upon stabilisation.

6. During admission, histories of GH's presentation were taken from the parents. F said that on the morning GH had been well. Around 8.15am, M had left the home to take IH to nursery and GH had been on the sofa when F started to dress him. GH started to cry and went red in the face. He suddenly went limp. F tried to stimulate him. He estimated the episode lasted for several minutes. M returned at approximately 8.40am, by which time GH was alert. The family initially called 111 and then 999. Ultimately, they took GH to hospital themselves, where he arrived at 9.05am.

7. It was explained that GH was unsettled from about the age of two weeks and had episodes of unexplained crying. The parents said that GH had a large head from birth. GH was reviewed on the ward at 10.30am on the 5th May 2021. He was very irritable. He had good tone, power and movement of all limbs. Cranial nerves appeared intact. His anterior fontanelle was

bulging. His head circumference was above the 99.6th percentile. CT scan of his head showed bilateral subdural haematomas. He was transferred to the Neurosurgical Team.

8. The Local Authority convened a strategy meeting on the 5th May 2021. At that time, the injuries suffered by GH were being treated as unexplained. A section 47 of the Children Act 1989 was instigated jointly with the local Police force.

9. On the 6th May 2021, a skeletal survey revealed no obvious bony injuries. An MRI scan on the 10th May 2021 confirmed the presence of bilateral subdural collections showing differential signal changes in keeping with subdural collections of presumed different ages. A further MRI scan on the 19th May 2021 confirmed bilateral subdural collections with little change in size. At the time, it was suggested GH had suffered intracranial bleeds at different points in time.

10. Ophthalmologist investigations on the 7th May 2021 revealed multiple bilateral intraretinal haemorrhages, on the right side more than on the left. There was right macular involvement with a foveal haemorrhage and possible macular schisis. Investigations excluded clotting abnormalities.

11. On the 7th May 2021, a further strategy meeting was held. It was reported that the retinal bleed and the head swelling were two separate issues. It was also reported that GH had up to four old bleeds, but without a clear time frame.

12. On the 10th May 2021, the Social Worker visited the family home and spoke with F. He recalled the events of the 5th May 2021 and described how he was left to care for GH whilst M took IH to Nursery. F recalled leaving GH on the sofa whist he went upstairs to get his clothes. As F was getting dressed, GH had become distressed, with a high-pitched scream and then went limp. F recalled giving his son CPR and tried to stimulate him by running his hand under the tap. F then rang 111 for support but changed his mind and called 999. Following M's return, they decided to take GH directly to the hospital as it was near to the family home.

13. A Child Protection Medical of IH was undertaken on the 11th May 2021 revealed no concerns.

14. On the 12th May 2021, a third strategy meeting was held where health professionals stated that GH's injuries were indicative of having been inflicted, there being no explanation. Seven persons had been identified as being in the pool of possible perpetrators, namely M, F, GH's

paternal grandparents, GH's maternal grandmother, GH's maternal step-grandfather and GH's maternal half-sibling MB (born on the 6th August 2002, now aged 18 years).

15. A Medical Report by Dr H (Consultant Paediatrician) and dated the 17th May 2021, concluded that the combination of subdural bleeds of different ages and retinal haemorrhages in a non-mobile child with no clear history of trauma or evidence of clotting disorder was consistent with a non-accidental cause of the injuries seen. Dr H also concluded, "*The presentation of GH with being acutely unwell on clinical assessment is consistent with an acute bleed on the day he presented*", and "*The findings are not consistent with an injury caused at birth given the normal birth history, overall normal neonatal course and the findings of retinal haemorrhages at the age of 9 weeks*".

16. M and F consented to the Children being accommodated by the Local Authority pursuant to section 76 of the Social Services and Well-being (Wales) Act 2014.

17. GH was discharged from hospital on the 20th May 2021.

18. Upon discharge, GH was placed by the Local Authority into the care of his maternal grandfather and maternal step-grandmother, who were already caring for IH and who were the subjects of a positive viability assessment completed on the 17th May 2021.

19. On the 26th May 2021, during a home visit by the Local Authority to the Children and the Maternal Grandparents, it was reported that GH had experienced two further episodes, one in which he had been unresponsive as though he went into a trance briefly and another where he woke in the early hours of the morning for a feed and instantly stopped screaming and fell asleep. GH's health visitor arranged for an urgent consultation.

20. On the 28th May 2021, GH was seen again by Dr H. He advised the Maternal Grandparents to seek immediate medical attention for GH if such episodes reoccurred.

The Proceedings

21. At a Case Management Hearing on the 29th June 2021, I made interim care orders in respect of the Children and approved the Local Authority's interim care plans dated the 16th June 2021 for the Children to remain in the care of the Maternal Grandparents. The case was timetabled to a Final Hearing (with a time estimate of 10 days) commencing on the 6th December 2021. The following experts pursuant were identified as necessary for the resolution of the case:
    1. Paediatric neuroradiologist, Dr Kieron Hogarth;

2. Paediatric neurosurgeon, Dr Pettorini;
3. Haematologist, Dr Russell Keenan;
4. Paediatrician, Dr Patrick Cartlidge;

22. At a Further Case Management Hearing on the 8 July 2021, I granted permission to the parties to jointly instruct a paediatric ophthalmologist, namely Dr Wayne Crewe-Brown.

Legal Principles

23. The relevant legal principles to be considered by the Court when considering findings of fact sought by a party are uncontroversial and I have the applied the same as was helpfully agreed and set out in the document prepared for me in Annex A. I have also considered the authorities referred to by Mr Storey QC and have been included in the supplemental bundle.

Brief Medical History

24. GH was born at home at 39 weeks gestation. Delivery was normal, and no complications reported in pregnancy or post-delivery. His birth weight was 4.40kg (98th 117 centile). His head circumference was 41cms (above 99.6th centile). His Apgar scores were recorded as normal. No obvious history of any clotting disorder in family. No history of any metabolic disorder in the family.

25. Other key points in the medical chronology can be seen in the very helpful Chronology provided by Mr Richards which should be read in conjunction with this Judgment.

Expert Medical Evidence.

26. *Mr Anthony Crewe-Brown* [Reports: 11th August 2021/ 28th August 2021], Consultant Ophthalmic Surgeon. His Report stated in summary that: (a) This was a complex case (b) in the absence of any underlying medical conditions and in combination with intercranial haemorrhages as in this case the cause is most likely traumatic (c) he concurred with the other professionals involved in this case that it was likely that the baby suffered significant traumatic non-accidental injury in keeping with Shaken Baby Syndrome; (d) In his opinion the likely cause of the Ophthalmic injury was non-accidental injury in the form of shaken baby; (e) In his opinion, the likely degree of force was significant.

27. In an addendum report [6th December 2021] which dealt with F's final statement and his new recollection of a resuscitative shake, the expert said the shaking of GH by F on the morning

of his hospital admission as set out in that statement, does explain the clinical presentation of GH as seen on his scans and on examination

28. In his oral evidence, he confirmed his earlier opinion and did not resile from any part under questioning. The haemorrhages in this case are extensive ('too many to count') and at the most numerous end of the scale that he has seen and they are also bi-lateral. He confirmed that the trauma inflicted was 'significant'/ 'excessive'/'violent' – extremely vigorous, repeated shaking of a baby. The baby had no strength to hold its head still and therefore the head would easily go back and fore. They were not birth related because at birth there would only be 3-4 haemorrhages and they would not be as deep or extensive and would not have a yellow dot in the middle. Further, birth haemorrhages would have been expected to have disappeared by the age of GH at the time of his presentation. He was clear that a 'slight' resuscitative shake (nor an application of CPR to his back) would not cause these types of, nor extent of nor the age of these haemorrhages. 'They would not look like that at all'.

29. He accepted that retinal haemorrhages are caused by traction and with that in mind, it is most likely that GH had been held under the armpit and vigorously shaken. Of course, the amount of force used cannot be quantified precisely. There were no retcam images, which would have assisted the expert more. There was no fundus camera in the department and there should have been a referral to another department in those circumstances. However, the drawings provided were sufficient and marked what was necessary.

30. He confirmed there is no evidence of more than one event on the history provided and the eye injuries could be explained by one event. Only in a small number of cases is this type of injury caused by CPR of the chest. Raised intracranial pressure could not have caused the extent of haemorrhages. The cumulative extent of all three methods could cause the injuries and exacerbate matters.

31. The necessary degree of force required to cause such injuries is, as always, unknown but it is fairly said to be outside of normal handling.

32. *Dr Russell Keenan*, Consultant Paediatric Haematologist [28th August 2021]. No abnormality of the blood clotting system has been identified. The bleeding seen in GH should be considered to have occurred in a child with a normal blood clotting system. Dr Keenan's evidence was accepted, and he was not called to give evidence.

33. *Dr Kieran Hogarth*, Consultant Neuroradiologist [12th September 2021]. Confirmed that the CT head scan dated the 13th April 2021 [clarified in evidence to be 5th May 2021] at age 4 months, 2 weeks showed:

• No scalp swelling.
• No skull fracture.
• There are multiple focal high-density subdural bleeds over both cerebral hemispheres
• There is further frank "fresh" subdural blood within the posterior fossa behind the cerebellum
• There are bilateral subdural collections over both cerebral hemispheres, which are slightly higher density than cerebrospinal fluid (therefore haemorrhagic).
• No widening of the subarachnoid cerebrospinal fluid spaces (i.e. no features to suggest BESS).
• No other significant findings.

34. He confirmed that the skull radiographs dated 6th May 2021 showed:

• No skull fracture or scalp swelling/haematoma. Overall, the constellation of findings, which included subdural bleeds, retinal haemorrhages and encephalopathy (abnormal brain function) are highly concerning for inflicted injury, most likely from a shaking mechanism.

- Some motion artefact on some sequences.

• Bilateral haemorrhagic collections over the cerebral hemispheres are again shown, deeper on the left than the right.
• Thrombosed cortical veins over the cerebral vertices; these are often seen in shaking injuries.
• No hypoxic-ischaemic injury.
• No subarachnoid or intraventricular haemorrhage.
• Blood again shown within posterior fossa. Bright on both T1- and T2 weighting and high density on CT fits with an estimated age of 2 days to 2 weeks.
• No evidence of loculation or neomembrane formation (to suggest chronic healing subdural bleeds).
• No features to suggest a neurometabolic disorder.
• Thin intraspinal subdural haematoma ventrally within the thoracic region (slides 11-13).
• No evidence of soft tissue injury within the neck or elsewhere

35. The MR Head scan dated the 17th May 2021 showed:

• Bilateral subdural haemorrhagic collections have matured.
• Blood within the posterior fossa persists.

36. He confirmed that the MR Head scan dated 28th May 2021 showed that:

• Haemorrhagic subdural collections persist.
• Nil else of note.

37. Likewise, the CT Head scan dated 15-Jun-2021 showed:
    - Haemorrhagic subdural collections persist (slide 19) and appear deeper than previous.
    - Nil else of note.

38. As to timing, Dr Hogarth opined that it was likely that bleeding occurred up to around two weeks or so before the MR scan dated the 10th May 2021. The fact that there was a modest increase in the size of the subdural collections between the presentation CT head scan on the 5th May 2021 and the later MR scan suggests an acute event setting off a dynamic process that, in his opinion, is most likely to have occurred in the hours or days before the CT head scan. It is possible that there was more than one episode of bleeding separated by days or possibly weeks.

39. Overall, looking at the clinical scenario, it is most likely that the main injury that provoked the multi-compartmental intracranial and intraspinal bleeding probably occurred at a point between when GH was last seen well and when he collapsed on 5th May 2021.

40. On the basis of what has been disclosed so far, he could not see that the large head size has any bearing on the causation of the extensive intracranial and intraspinal subdural bleeds. For the avoidance of doubt, he opined that there is no widening of the extra-cerebral CSF spaces on the scans.

41. As to mechanism of injury: He opined that the constellation of findings in this case included multi-compartmental subdural bleeding, retinal haemorrhages, and abnormal brain function. In the absence of any disclosed significant accidental mechanism, inflicted injury must be considered. A vigorous backwards and forwards shaking mechanism may produce subdural haemorrhages, which may occur in more than one location (multifocal) and in more than one compartment (i.e. over the cerebral hemispheres, within the posterior fossa and within the spine).

42. In his opinion, the subdural bleeds seen in this case are highly unlikely to be caused by birth.

43. In his addendum report [6th December 2021] looking at F's recent explanation, Dr Hogarth commented that it did not cause him to alter the opinions earlier expressed. The appearances on the scans are in keeping with a shaking injury. He noted from F's latest statement that the intention behind the shake was to revive or resuscitate GH. Quite properly, he left that for

the Court's consideration. From the medical point-of-view, he was able to say that the injuries in this case are in keeping with a shaking mechanism. Issues relating to the state of mind or intention of the perpetrator are outside his professional domain.

44. In his oral evidence Dr Hogarth confirmed he had not altered his original written opinions. He confirmed that the pattern of injury in the case includes extensive subdural bleeding within the intracranial and intraspinal compartments, retinal haemorrhages and abnormal brain function. To his mind, the only explanation for this constellation of injuries in an otherwise healthy infant is trauma. He explained that the CT imaging shows that the injuries occurred within a maximum period 10 days of the scans because of the fresh blood that he identified for the court on both sides of the brain. These are subdural bleeds, which are multi-focal and multi-compartmental. On the MR scan there is, in addition, blood seen in the intraspinal compartment. These findings lead to his development of the window of causation and also the method of causation. Trauma is the most likely cause, as this type of bleeding is abnormal on any scan and is seen in trauma where there had been a major force applied, such as a road traffic accident. Also, it is seen in inflicted injury by shaking-a rigorous backwards and forwards movement often with the infant held around the chest.

45. In his opinion, the intracranial injury/ intraspinal injury is all attributable to a shaking injury. The resuscitation shake described by F is a good fit for what he found in terms of mechanism, but he could not comment on the state of mind; but the mechanism is consistent with the injuries.

46. He was asked about a possible previous traumatic event and the evidence for that. It was a matter of consideration of the presence of any older collections or the existence of healing signs e.g. membrane formation / compartments. On the CT scan of the 5th May 2021, there are ‘intermediate collections’, not very deep collections. Had they been deeper, then his case for a previous incident would be more robustly made out. It would also have helped had he had a CT scan earlier than the presentation. The best he can say is that there is a possibility that there was a longer standing collection- he could not exclude it. It does not alter his opinion at the time of the presentation which was consistent with a trauma from a shake. He estimated that the force needed to produce GH’s presentation was akin to higher level of force injuries such as a child falling from heights or involved in road traffic accidents. In short, the forces necessary to produce the intracranial and interspinal injuries seen here would be significant/ forceful / vigorous and ‘not trivial’ and well outside what a reasonable carer would consider as normal handling.

47. He agreed that everything could be explained by one event, which was recent to the presentation based on the imaging. He agreed that there would have been a change in the presentation of the child- vomiting is common, as is sleepiness, but there is a wide range of responses. F's description of GH 'going red, going limp and dying on F', fits with that type of expected presentation following an incident. The explanation provided by F fits with what is seen on the imaging. It might have been more forceful than intended with adrenaline but the mechanism and collapse all fits together and there is no glaring feature that causes him to be concerned about that narrative. There are no features that suggest older bleeding but that could not excluded.

48. *Dr Benedetta Petteroni,* Consultant Paediatric Neurosurgeon [21st September 2021]. She opined that, considering the association of brain haemorrhages and the presence of retinal haemorrhages, in the absence of an obvious explanation for the injuries, it is likely that GH sustained one or potentially multiple head injuries, with a shaken mechanism. Therefore,the accident description provided by the father doesn't explain the injury. In the absence of a disclosed shaking episode it is possible that this is a non-accidental injury.

49. It was noted that GH's injuries were due to head injury and are traumatic in nature and due to a shaking mechanism. The main features are multiple, focal high-density subdural bleeds over both cerebral hemispheres with evidence of fresh subdural blood in particular within the posterior fossa. There is no evidence of benign enlarged subarachnoid spaces. There are no skull fractures, there is no scalp swelling or haematoma and there is no brain parenchymal injury. There is also an intraspinal subdural haematoma within the thoracic region and no soft tissue injury in the spine. It is not possible to identify if there has been one event or multiple events.

50. It is unlikely that the kind of subdural haemorrhages seen on the CT at presentation are related to birth injury. She ruled out as a potential mechanism his brother falling on GH. She also felt that the large head had nothing to do with his injuries.

51. In an addendum report dated the 7th December 2021, Dr Pettorini confirmed that he had a big head at birth measuring over the 99th centile and her opinion is that this was reflecting his overall swelling after birth. She thought it unlikely that this measurement reflected an intracranial pathology at that time. There is no record of a bulging anterior fontanelle, sun setting and suture diastasis which are common clinical signs of raised intracranial pressure.

She opined that an isolated head circumference measurement at birth not associated to other signs, is unlikely to be significant.

52. The expert indicated that the two differential diagnoses for such a large head circumference at birth are benign macrocrania which is an anatomical variant of no clinical significance and raised intracranial pressure. However, GH did not have raised intracranial pressure at the time of birth.

53. In her oral evidence she confirmed her reports before adding that an incident around the 22nd April 2021 could explain the head circumference potentially. He was puffy at birth and the head circumference does not give an indication of macro crania. The head then went down when measured by the health visitor and then up again when measured by the GP. If something happened earlier as a separate event to the 5th May 2021 it would be between those two dates. She would defer to the radiologist in terms of whether an earlier event could be evidenced in the imaging but if such was found, she would support that on what she had seen in the papers.

54. When taken to the evidence of radiology that there was no evidence of an earlier episode, she was content to defer to that position. She had looked at the scans but found nothing to contradict Dr Hogarth's opinion on this point.

55. She was in total agreement that everything could be described by one event on the 5th May 2021 and the explanation given by F could have caused all injuries. The holding of the baby under the arms gives the acceleration and deceleration momentum and also explains bleeding in the fossa and in the spine. She agreed that shaking to resuscitate can cause these types of injuries.

56. In her opinion, the time frame for such injuries always starts after the last feed. F described the child going floppy, red, he thought he had died and there was a cessation of breathing- these the expert described as being typical signs that the injury has happened just before these symptoms. She accepted that children can have funny turns like this absent any traumatic event. She accepted that panic shaking is very well recognised as a mechanism.

57. She was asked if 'scooping' up GH could have caused injuries? If there was a forceful movement with the head not having sufficient support, then these injuries could have occurred or contributed to them. Likewise, if the head was not properly supported as they ran

to the car the same may have occurred. It is a matter of the head being unsupported allowing for acceleration and deceleration.

58. She confirmed that there were no other cerebral injuries which are indicative of a shaking mechanism- no ribs fractures, clavicle fractures, metaphyseal fractures or fingertip bruising. The encephalopathy was quite short term in this case by 10:30 am on that same morning his Glasgow Coma score was normal.

59. However, the expert confirmed that the presence of the spinal blood [as here] is found in only a minority of the cases where there is a panic shake. It may have tracked down from other parts of the brain, but that was not her top option. In her clinical experience she has seen spinal bleed after a shaking event in very severe injuries. It is reported and one of the explanations in the literature is that it can track down in less severe cases. It is more likely that the baby was held under the arms that would cause the spinal bleeding / injury. She was unable to assist with the amount of force.

60. *Dr Cartlidge*, Consultant Paediatrician [22nd September 2021/ 25th November 2021]. He opined that GH sustained a head injury by shaking not long before admission to hospital on the 5th May 2021. Using currently available evidence, he thought that this was most likely an inflicted injury. He also thought that GH had an earlier episode of subdural bleeding that had evolved into a chronic subdural fluid collection by the 28th April 2021. Using currently available information, he thought that this too was an inflicted injury. He stressed 'currently available' information because he was conscious that F's recall of events is blurred. This is an important issue since the differential diagnosis is birth-related subdural bleeding evolving into the chronic subdural fluid collection, and a recent injury caused by a resuscitative shake.

61. In his opinion, it is most likely that the head circumference measurement at birth was wrong. In any event, the head circumference measurement at birth did not reflect the size of the cranial cavity. It follows that the head circumference measurement shortly after birth is not evidence of there being intracranial pathology at birth. It also follows that the baseline head circumference centile is that found on 14/17 March 2021 (98th-99.6th centile). This centile should be used to assess the later growth of the head, regardless of the explanation for the head circumference shortly after birth.

62. Further, he concluded that the subdural fluid collections were the most likely cause of the head being abnormally large by 28 April 2021. In other words, he thought that GH sustained subdural bleeding before the 28th April 2021, which evolved into the subdural fluid collections. This does not exclude him also sustaining acute traumatic effusions shortly before admission to hospital.

63. He ruled out the injuries being caused by IH falling onto his brother on the sofa.

64. The force needed to have caused the head and eye injury would have been obviously excessive to a normally competent and responsible person. The recent head and eye injuries were most likely caused by shaking, with or without impact against a semi-yielding object.

65. His opinion regarding the case as a whole is:

• that GH had a chronic subdural fluid collection causing enlargement of the head, which was already present on 28 April 2021. When considered in isolation, this could be birth-related, or caused by earlier inflicted trauma.

• The subdural bleeding in the posterior fossa and the retinal haemorrhages were caused by GH being shaken shortly before 08.40 hours on the 5th May 2021. This event is also likely to have caused bleeding into the chronic subdural fluid collection.

• He had discussed the possibility of a resuscitative shake causing the injuries on the 5th May 2021, but using currently available information, he thought that to be an unlikely explanation.

• He is trained to seek a unifying root cause for pathology. This is, in essence, applying Occam's razor principle. He thought that if the recent head injury is found to be inflicted, this increases the likelihood of the subdural bleeding that evolved into the chronic subdural collection also being inflicted (rather than being birth-related).

66. There was an Experts Meeting on the 2nd November 2021 and I have considered the transcript of the same. The experts did not demur from earlier reports. I also note that when Dr Cartlidge was asked to take into account further evidence in respect of the size of GH's head at birth and thereafter, he held to his earlier opinion.

67. On the 3rd December 2021, Dr Cartlidge filed a further Report which dealt with the new information provided by F in his second statement of the 1st December 2021. As to the issue of the mechanism described by F of a panicked resuscitative shake, Dr Cartlidge thought that picking up GH under his arms and shaking him is the action typically used when shaking causes subdural bleeding and retinal haemorrhages.

68. The lack of detail meant that Dr Cartlidge was unable to thoroughly assess the likelihood of F's action causing the recent subdural bleeding and the retinal haemorrhages. However, Dr Cartlidge stated that he had been involved in several cases of alleged inflicted head injury in which shaking intended to revive an infant has caused subdural bleeding and retinal haemorrhages.

69. Therefore, he concluded that because the evidence is uncertain, he remained uncertain of its potential to cause the head injury. However, at the same time he stressed that he did not exclude a resuscitative shake being the cause of the acute subdural bleeding and the retinal haemorrhages.

70. In his oral evidence, Dr Cartlidge was questioned in respect of his opinion that there had been an earlier bleed which caused a chronic accumulation in the head by the 28th April 2021. The baseline for measurement of the head was at a 2 week point after birth. When the GP then took the measurement on the 28th April 2021, it is above the 98%-99% and he considered that his head had changed appearance. There was a more rapid increase in head circumference at this point and the only thing that could account for that in his opinion was a choric subdural collection, as was identified by Dr Hogarth. It is a very large head and not a variation of normal. Chronic subdural effusion or a sequela of bleeding that can happen at birth, he could not distinguish between those and both are rare. For there to be two very rare causes he thought is inherently improbable and therefore he looked for one root cause. If the Court found that the latter injury was caused by abuse, then it made it more likely that the earlier was also a consequence of abuse.

71. Dr Cartlidge stated that the mechanism described by F causes shaken baby syndrome. He could not say if the force was sufficient without further evidence of that event and, therefore, he could not comment on the likelihood of the force accepted as being used as being of sufficient degree to it having caused the injuries.

72. He accepted that that an acute lesion would not have happened by 6 am on the 5th May 2021, when he last sucked- that being a sophisticated brain mechanism. The changes in GH's behaviour when M was at nursery evidence that something had then happened in that period. The mechanism and timing fits with the cause of the injuries. He had been involved in a number of cases where parents resuscitative shake and others where parents run with a child and that caused intracranial injuries. One movement with sufficient rigour that causes the

brain to wobble in the skull can be sufficient. If there were a number of movements in panic there can be a potential for a cumulative effect. It depends on the rhythm that is attained. A child of this age has little muscle in the neck and this baby had a heavy head.

73. He is experienced in being involved with a parent responding to a funny turn with a resuscitative shake. He accepted that parents are likely to panic in their response.

74. He dissented from other experts that there was not a chronic lesion earlier- GH had a large head when seen by GP on the 28th April 2021 – the only thing that fits is that there has been a chronic subdural. He did not feel there was a need for a pathologist to deal with that. He was content that the evidence was present.

75. He accepted that other intracranial signs were not present, used to indicate shaking injury. Nor were there rib fractures let alone posterior rib fractures. Their absence may fit with F's description of the child being held under the arm pits. However, rib fractures are quite often absent where he finds shaking to have occurred. It is more a measurement of how hard the grip was, as opposed to whether a shake has occurred. There is also an absence of metaphyseal injuries and / or bruising. It was suggested that had he been shaken twice, then he has avoided those other signs twice, which makes it less likely that there were two incidents.

76. Dr Cartlidge did not exclude the suggestion that in general terms, a birth related bleed could become a chronic subdural collection. However, he stated that he was confident as to his interpretation of the photographs that he has seen in this case. He was challenged about his view that the head was 41 cm, he said that he had thought long and hard about that and it was a frustrating issue but he felt that something had gone wrong with the measurement because his head does not look large in the photograph of the baby just after birth, he would recognise if there was anything anywhere near 41 cm. It was pointed out to him that the head was measured twice by the midwife. Dr Cartlidge said there was not an intracranial injury that caused this head to be so large and then drop so quickly. It could only otherwise have been scalp swelling. It was suggested that it was dangerous to extrapolate too much from a photograph. The expert stated he has been very careful about the interpretation. The head does not look disproportionately large in the photographs and the latter 38.5cm looks more in keeping with the photographs. It was his view that the head did not shrink and that it stayed on the same line. A shrinkage of this much would not be normal and therefore he remained of the view that this was unlikely. Ultimately, it did not matter because it is not a reflection

of what was happening inside the head. He stated that on the 4th April [F54] possibly the head looks larger, by the 3rd May 2021 it was definitely a large head at that point.

77. He accepted that there had been complaints by the parents in respect of the child screaming some two weeks after birth. He agreed that where there is chronic bleeding at birth there can be re-bleeding with little actual force short of abuse. The funny turn on the 22nd April 2021 could be a funny turn linked to birth or it could be reflux. The incident on the 5th May 2021 could also be linked to the same matters. By 10 am on the 5th May 2021, GH was normal on the Glasgow Coma scale, that the brain itself was unlikely to have been injured. He accepted that it is perfectly plausible scenario that the child bled at birth and it died down and then became gently symptomatic causing the head to expand and him to scream and be fractious and then that the child was not shaken at all until 5th May 2021 when F acted as he states.

Wider Canvas Evidence

78. I must consider the wider canvas as part of my determination of the issues and facts in this case. Those which I have found to be most salient are:

(i) Parents' Description of their Baby

79. GH was described as vocal since birth and from 10 days old to 2 weeks he began to scream repeatedly and was extremely difficult to settle. He seemed in discomfort but without an obvious cause. After this, he remained regularly unsettled. There was no real pattern to his screaming and being unsettled other than he would only be content when he was feeding or asleep. M raised concerns with the GP. On one such discussion when GH was about eight weeks old, the GP said 'babies cry at times'. M took videos of GH's distress so that the GP could see what was happening, as she didn't feel like she was being taken seriously. By the 5th May 2021, the GP was beginning to look at whether there may have been a milk allergy and had been trialling different allergy milks. M had also raised potential causes such as acid reflux and colic. He was also considered as potentially having a hernia [8th April 2021], but this was ruled out at the hospital.

80. Due to the medical professionals' lack of concern, the parents say they began to accept that he was 'a grumpy baby'. One of the aspects of this they claim was that GH would hate being dressed and undressed. Even placing a bib on GH was described as a nightmare. He also hated being held with his head against anyone's chest-he would thrash his head about.

(ii) F's Bonding Issues

81. F accepts that he had a difficulty in bonding with GH from birth. In contrast, he had an extremely close relationship with IH. He accepted that he had been googling a website called Quora.com. There were several questions and answers on this forum including "I have no feelings for my baby", "I hate my baby". There was an article that he recalled reading about not being connected to your baby which was perfectly normal and it was suggested that over time things would just click into place. F recalled speaking to a colleague who had reminded him that he had been the same with IH; however, he did not recall being as disconnected with IH.

82. He and M, he claims, had a difficult and awkward conversation about this issue. He opened up and told her how he felt. Both were emotional and he said he felt more relaxed about it all thereafter and began to bond with GH.

(iii) Parental Roles/ Time Alone with GH

83. After his birth and until the 8th March 2021, F took time off work to help care for the baby. Once he returned to work, he would assist when he got home and on days off and that included seeing to GH in the night on occasion. On the 8th April 2021, F had an operation on his foot and that kept him off work thereafter for some weeks and he was still off work on the 5th May 2021 (albeit he had been helping his friend build a patio and was out of the house between 8 am -5/6pm). Whilst off formal work F would share caring tasks for GH.

84. One such occasion was the 22nd April 2021, when the parents went to bed early, but were soon interrupted by GH and F was tasked with seeing to him and giving him a feed, which was indicated as necessary by his scream/ cry. Initially, this noise had been usual and normal for GH. However, a few minutes after F took GH downstairs, M described hearing an 'unusual scream' from GH. M went to investigate and saw F cuddling GH to his chest trying to settle him. F said he had put GH in his ring and went to make him a bottle. He then came back in and started to give GH his bottle but GH was screaming so much, he began having hiccups and at the same time took in a big gulp of milk. F said that after this GH's eyes went wide, like a look of surprise from the milk intake, when his face also went very red and he screamed. M checked him over but could see nothing wrong with him; by this time his red face had gone down. GH was handed back to F and he continued to take his bottle. M went back to bed.

85. F described this same incident differently thus: he took GH downstairs and put him on the nursing pillow on the sofa in the living room, whilst he made a bottle in the kitchen. GH was screaming at the time and hiccupping which was described by F as 'quite normal'. He then fed GH, as he rested on the nursing pillow. As the bottle was placed into his mouth GH hiccupped at the same time and then became quite red in the face and went limp (the limpness was not mentioned by M). F immediately picked him up, walked around with him, rubbed his back, and bounced him. GH's eyes were 'huge', he looked 'terrified'. GH then took a large breath in and began screaming again. On the same night M's brother was walking past the house with his dog. He sent a text message to M at around 10.22pm, saying "just walked past your house, it sounded like GH crying… hard".

86. F went on to describe how he and M had been criticised for not telephoning 999 during this incident. He explained that GH screaming was 'entirely normal for them' and something that they had become used to. Although notwithstanding that, GH had never held his breath like that before. It is of note that F describes the screaming as normal- that was not how M described it, nor it seems M's brother and that was another significant difference in their accounts.

87. In any event, the following day M had an appointment with the GP Dr Rr, about GH's navel and she stated that she also raised about GH having a funny turn in the night. She alleges that the GP asked a few questions but did not pursue the issue further. This account by M is not at all accurate and is likely a lie. She either chose to deliberately omit mentioning the 'funny turn' / the baby going limp, or else the baby did not go limp and that was a detail fabricated on the 5th May 2021, in an attempt orchestrated by F to show that the collapsing event of the 5th May 2021 was not a 'one-off'. Of course, if the latter, then M has since chosen to be complicit in this fabrication.

88. However, M was the primary carer and had most of her time alone with GH. In her statement, M explained that there were very few occasions when F had time on his own with GH.

(iv) <u>Text Messages</u>

89. The following text messages between the parents I found relevant to show the strain that the parents felt in caring for their baby, particularly F:

- M commented 'pass me a shotgun, so that I can shoot myself' to which F replies: 'I can always put him under Matty's patio" with a laughing emoji. M replied 'Put me under

there do me a favour'. This has occurred after GH being fractious. [F to M 21:33 24th March 2021];

- 'He's a nightmare at the moment' [F to M 21:35 24th March 2021]
- 'You'd better bring an oz or 2 up before I kill him' [From M to F 21:39 24th March 2021]
- 'I know you don't like him, and he can be a frigging twat but don't say things like he's having the milk and I hope he chokes on it. Especially to me or in front of me. It's not very nice to hear the father of your children say that about 1 of his own kids. It makes me upset angry at you xx. We know he's testing both our patience, but I'd never say anything like that. It's just not nice xx.' This had been said when GH was screaming in the kitchen. [from M to F 1st April 2021' 9:04]
- 'I never said I hope he chokes on it, I said maybe he will choke on it. And you should know full well I don't mean it you cannot throw away comments like that literally. Fucks sake mun. I know it's not nasty but it's just daft that you think for just one second, I mean anything like that xx'. [F to M, 1st April 2021 9:07]
- 'Whatever you said, pretty much the same thing. It's hard when I can see how negative you are towards him and then you say something nasty comment like that. Xx' [M to F, 1st April 2021 9:09]

(v) <u>F's Internet Search History</u>

90. The following I found relevant in respect of F's strain with parenting GH and also bonding with his son:
    - 12th March 2021: 'I hate my new born son' on google
    - 24th March 2021: 'I have no feelings for my baby".

91. The following was relevant to his mindset post the 5th May 2021:
    - On the 09.05.2021 F searches: "Macrocephaly…Anencephaly…My 9 week old son got rushed into...private neurology Cardiff...getting a second opinion…Shaken baby syndrome…self-hypnosis for anxiety…Intracranial haemorrhages….FBU legal advice…self-hypnosis to forget…Can you use hypnosis to forget P…" (Ti39-42)[It is of note that F was searching shaken baby syndrome, when he was not mentioning a shake had occurred to anyone]

<u>Parents' Initial Accounts</u>

(a) The 999 Call

92. The following portion of the 999 call is relevant to gauge F's first account to a professional:

- F: "…I was dressing my baby this morning on the sofa… he hates it…he's held his breath and then he's gone limp… I've brought him round, but he's crying and screaming now, but I think he'd gone for a minute because he (inaudible)…so obviously massively concerned.
- OPERATOR: So, he's crying at the moment, is he?
- F: He is crying at the moment, yeah, but like I have been with the baby CPR, and then I rubbed his back, and kept him going for ages… and he's slowly, slowly come round, but now he's just screaming uncontrollably now.
- OPERATOR: So, what happened to make him do that?
- F: He held his breath in temper…And then he went completely limp
- OPERATOR: Is he completely alert?
- F: …I would say, yeah, he is, he is alert as in his eyes are open now. Umm, but I say he's screaming uncontrollably. He's not really staring at anything. More like looking through things if you know what I mean.
- OPERATOR: Okay. Okay, is he breathing normally?
- F: It's hard to tell in-between the screaming, but I would say so, yeah…..
- M: He is not right.

(b) At Hospital to Dr A in A&E 8:56am on the 5th May 2021: 'According to GH's father, GH was well on the morning of 05/05/2021. He then started to suddenly cry and went red in the face then became floppy. There was no response to stimulation. GH's Dad turned him over and gave him some chest compressions from the back. There was still no response. To try and stimulate him, GH's Dad put GH's hand in cold water but there was still no response. GH then started to gradually show some response. According to Dad this lasted between 2-10 minutes. The parents then brought GH to A&E where he had another floppy episode. This lasted only for a few seconds where his heart rate dropped to 80-90 beats per minute. There was no history of fever or rashes. GH had been feeding well until that morning. He was opening his bowels and passing urine.'

(c) Dr H note on the 5th May 2021. 'Seen in ED at approximately 9.30am. Very well in the morning. Episode of crying then went red in face. Floppy and lifeless. Dad tried to stimulate the baby at the time. Not responding... '

(d) Further history in hospital records for the 5th May: Dr H in a discussion recorded by Dr A: When dad was dressing him, GH started crying, went red, then limp, dad stimulated, some stimulus, cold water on hand, improved, have a big scream and improved. Mum came in.…On 22/4/21, 22.30 put him on sofa on ring while dad was getting milk ready, had

approx 1oz; has winded him then screamed; breath held, limp few seconds then resolved. [Of note, this was the first mention of GH going limp on the 22nd April 2021]

(e) History provided by F to Dr A for CP medical. 'G was awake. Approx 8am when F was dressing G, G started crying, went red, then limp. F stimulated G, tried poking and put cold water on G, no response. Dad turned G and gave chest compressions from the back. G improved. M arrived. Lasted 2-10 mins (F not sure).'

(f) On the 6th May 2021, Dr H went through the history with both parents present on the ward round. F gave a history that G had been completely well in the morning. M left house with older sibling to drop at nursery. F was starting to dress G at approx 8.30am. G started crying. Dad described that he went red in face. He then went limp. F tried to stimulate him. He turned him over and performed compressions on his back. Put his hands in cold water to stimulate him. F could not say how long the whole episode lasted, however probably a number of minutes. Mum came back to the house at approx 8.40. At the time G had come round. Called 111 then 999….both say G had a similar episode 12 days ago. Unsettled crying and going red. Again, at the time he was very unsettled and crying and going red. He was not limp. He settled after a very brief period of time.

(g) On the 7th May 2021, 9.30am. F provided an account to Dr R: M took the other child to nursery at 8.15am, he was on sofa and had dribbles a lot of saliva, dad was about to change the clothes and he started to scream at about 8.30am and he went red and then M was back at 8.45am. Dad also said that he had hiccups and had an episode where he went completely red during feeding previously as well but he was not floppy or unresponsive then. [Of note, F was confirming that on the 22nd April 2021 that GH did not go limp etc, which was contrary to his and M's earlier case.]

(h) On the 12th May 2021 to Dr A: 'Parents asked about results of MRI. They were informed that they confirmed the findings of the CT scan i.e. multiple bleeds. Dad says 'everyone/ on his Dad's side has been anaemic and needed B12 supplements. Both asked several Qs about what sort of things could cause a bleed e.g. rocking GH to comfort him or putting him down on sofa or bed. They asked whether their toddler falling on GH could have caused the bleed or accidentally headbutting G. M makes ref to placenta being small.'

(i) Parents Account to OW 5th May 2021

93. M gives account of G being more challenging than IH and that he had a tendency to scream etc. Parents made ref to previous limp episode on 23rd April (sic 22nd April) and they had spoken to GP about it at the time (E269). M was worried something medically wrong with G due to him being born with large head and issues with feeding. Sensitive and could get

agitated when touched.' Parents said they had been through everything in their heads trying to work out what could have happened (E269).

94. F explained that M had taken IH to nursery and when she was out G had episode where he stopped breathing. F said he laid G on his front to stimulate him by pressing his back. When this didn't work, he splashed water on his face with brought him around. Both M and F appeared to be in shock (E270)

(j) F's Video Interview 20th May 2021.

95. F's account can be summarised as:

96. "And then decided to take his…..baby grow… off, I took his vest off. Umm, obviously he is screaming and – because G doesn't cry during these periods. G screams as if he's in pain…… Umm, so I've taken his clothes off, try to settle him down as best I can, and then he's still on the ring, just in a nappy. I've gone back upstairs to get clean clothes for him. Umm, come down. Again, trying to keep him calm, and then put the baby grow on him, and he's instantly, umm, screaming again. Put his trousers on, and then put his pyjama top on head first, and then left hand, and then right hand, and when I put his right hand on, he's gone up a level again, held his breath, gone red in the face, gone completely stiff, and then gone limp on me. Umm, so I picked him up. Umm, trying my best to put him on my chest, rub his back."

97. "[repeated his son's name], umm, holding his hand, his hands are completely non, umm, non-responsive to me. Umm, so adrenalin, panic, is kicking in, but then so is my training to be it must have ……Because I then laid him on my left hand, and his chest, and started doing my best CPR for an infant, which I've never done before."

98. "Umm, done all this. I've turned him back over. I've given him – he is still upright. I know he should have been on the floor at this point, but he's still upright in my hand, and I've given him breaths over his nose and mouth

99. "Umm, whether he's actually completely non-responsive, and not breathing, I really couldn't tell you because he's dressed, I couldn't see his rise and fall of his chest properly…So I've walked into the kitchen and put him on the kitchen table. Umm, because it's a decent height. Umm….. And I've tried rubbing his chest and pushing his chest gently. Umm, because I know you are supposed to give compressions to an infant on his back. Umm, so I am doing all this again. Rubbing his hands, rubbing his hands, and he seems to be getting slightly more,

umm, responsive…..and then I have run water over his right hand because that's holding him, and then water in, in and around his lips, just a wet finger, you know what I mean? And then rocking, and rubbing him, and whatever, and then he started to come around, and then all of a sudden, he starts screaming and crying, and I've never been so happy to hear a scream in my entire life. Umm, I'm holding him in close and then M has basically walked round 5 our kitchen, the kitchen is at the front of the house.

100. "I could see M walking past the window. She has come in. Seen my face and gone, "Oh, he's being a nightmare, is he?" And I've just started, umm, crying, telling her, as quickly as I could, what was, what had gone on, and she said, "Right, you, you ring 111 now then. I will 11 have him." So, I've tried ringing, umm, 111, but then its dial for Welsh… Like that and it's just instantly stopped. So, I rung – she said, "Ring 999 now."

101. He explained that this had happened twice recently where he had stopped breathing, but not like this. He often cries a lot, but not so that it goes over the top. [It is of note, no second time has been mentioned elsewhere in advance of the 5th May 2021]

102. He raised the size of his head at birth and that it was always large. They had raised it with the doctors. Nobody seems to have listened about the size of his head and something was wrong. His head had a circumference of 41cm at birth. They researched itself and macrocephaly kept coming up and that was made for him. Also, bleeds on the brain came up. The doctors did not want to know. The parents kept saying to medical professionals he screams, and they can't dress him and his headaches all the time. They kept suggesting that it may be down to milk allergy.

(c) M's Video Interview

103. M described after returning from taking IH to nursery:

104. "Umm, I walked to the door. He stood in the kitchen with the baby in his arms, and I said, "Oh, been hard work, been hard work, has he?" And he just looked at me, he shook his head, and he said, "He just died on me." I said, "What do you mean?" And he said, "I was dressing him." He said, "And he just stopped breathing. I picked him up. He was screaming. I picked him up. He just went all limp and he stopped breathing." He said, "I've had to" F couldn't get a lot of words out because he did seem obviously shocked, scared ….I don't know what you would want to call it when you've had to see that. And I said, "Okay," I said, "Right", the baby was in his arms, making a noise, breathing, I said, "Right, okay," I said,

"We need to phone somebody" and I said to him, "Ring 111." I said, "You give me the baby. You ring 111 because you can tell them what happened, you were here."……So he, umm, he handed me the baby in the kitchen, and as he went to walk out the kitchen, he sort of bent over, collapsed, as in to take a breath, umm, I think the adrenalin had sort of left his body by that point… And then he went into the living room to call 111…

F's 1st December 2021 statement.

105. F clarified the events of the 5th May 2021 in his second statement 1st December 2021.He stated that he was now '99% certain' that after GH's collapse he picked him under his arms and shook him in a moment of panic in order to revive him. He cannot recall how he did it, or for how long, but believes he picked up GH under his arms.

Additional Oral Evidence

(i) Health Visitor

106. KB-R, Specialist Community Public Health Nurse-Health Visitor. There was nothing to indicate that the parents were acting other than appropriately in their care of GH. There was nothing to indicate that there were problems in the house. GH's head circumference remains above the 99th centile and it has grown consistently above the 99th centile since birth and has been measured every fortnight. That is unusual in her experience.

107. She confirmed that M was happy and enjoying GH and she raised with her numerous times that GH was screaming a lot prior to the 28th April 2021. She did all that was expected in the circumstances.

108. M did not mention to her that GH experienced a 'funny turn' on the 21st /22nd April 2021. Had it been raised she would have recorded it. She would have advised them to seek medical attention. The parents discussed the events of the 5th May 2021 with her and she made a record of everything said by F and her note was accurate.

(ii) GP Evidence

109. Dr Rr. There was a telephone consultation on the 23rd April 2021 with M. She usually typed key things said by a patient as she was talking and then afterwards, she writes it out thoroughly. She had no independent recollection of this discussion. She confirmed that GH's head circumference was unusual. In her statement, the witness had said that M had told her that some symptoms had got worse that day –in her notes M had said 'something worse had

happened yesterday'. She did not recall the extent of what was said beyond the recording but she did not recall M telling her that GH had gone red, but could not discount it. There was no mention of a funny turn that night from her recollection. Nor did she recognise anything raised by the parents in their evidence for that night which would have raised alarm bells and she would have asked more questions, particularly about the baby being unresponsive. This event would have warranted a physical examination of the child and she would have raised it with her colleague and the notes reflect that she did not. I prefer the evidence of this witness to that of M on the point of the discussion around the preceding night or the lack thereof. This was a deliberate omission by M.

(ii) Hospital Evidence

110. Dr H, Consultant Paediatrician. The head circumference issue is not accelerating at this stage and no other neurosurgical intervention is required. He has been discharged by ophthalmology and neurosurgery even though his head continues to grow and above the upper centile; however, it remains on the same line. Hydrocephalus had been considered and his head growth will continue to be monitored through Dr H's clinic. At present, there is no need to re-scan GH, but it is one reason why GH is kept open to his clinic.

111. Following his admission, Dr H saw GH around 10:30 am on the 5th May 2021 for the first time. Dr A [Paediatric Registrar] had first seen him in A&E and had treated him and taken the first account from the parents and then handed GH over to Dr H in the Paediatric Assessment Unit where he remained until he was discharged. He confirmed that he discussed the further history with the parents. It was suggested that there was a similarity in the account recorded of the history between Dr A and this witness' initial record of the conversation on the 6th May 2021- an account of how GH went red in the face and went limp whilst still on the sofa and before F picked him up.

112. His records at QI 45 show that at 11am on the 5th May 2021- he took his first account from the parents. This was a mix of information from Dr A and the parents. After the scan he spoke to the parents and Dr A took the notes. Of note, F gave a different account of the event of the 22nd April 2021, where he was winding GH when he screamed and held his breath for few seconds.

113. On the 6th May 2021 at 11 am, he spoke to the parents and explained the results and M asked whether there was another explanation other than trauma.

114. On the 7th May 2021, the doctor typed a summary document which contained the discussion that had taken place on the ward round (above). It says that both parents described that he had a similar episode 12 days before and went red but was not limp and he settled after a very short time and the family did not seek medical attention at the time. This came from the parents on either the 5th or the 6th May 2021. He confirmed whether there was any explanation for what had happened on the 5th May 2021, he would not have asked about shaking directly.

115. On the 7th May 2021, F also gave another account to the witness- where it was raised that GH often hiccuped and on an earlier occasion went red during feeding as well but did not go floppy or unresponsive then.

116. After the retinal examination results came to hand, Dr H discussed with M that the injuries were suggestive of non-accidental injury and would be subject to social services investigation.

117. On the 18th May 2021, [QI 253-4] M asked Dr H whether the sibling falling on GH could have caused the injuries? She raised whether he was unsettled because of reflux, and asked whether putting him down harder than normal or rocking a little harder than normal may have been the cause. She then asked 'how could I have missed this if someone had been hurting him; would there be sign? 'Dr H said these were unlikely causes and said that apart from being irritable the signs of bleed would be inside. M denied seeing bruising. M then asked – that social services see as a red flag that F gave CPR rather than call 999. The MGF asked if the time frame was a few hours before GH attending the hospital, which was answered as being possible.

118. Of note, neither parent has ever raised with him that F may have shaken the baby as part of a resuscitation. He confirmed that CPR was only mentioned as having occurred after he went limp and that was patting on his back. No other episode was described where GH was being shaken.

119. Dr A, Paediatric Registrar. He confirmed his written evidence and his notes. He was the initial treating clinician on the 5th May 2021 when GH arrived at the hospital at 8:56am. He took the initial history from the parents who were distressed and worried. He confirmed that his notes on various days on and after the 5th May 2021 were accurate in terms of what the parents said to him or in his presence.

(iii) Social Work Evidence

120. *OW,* Social Worker IAA Team. She recalled that F's description in the hospital was vivid of what had happened. In her notes, she said the parents were very distressed. In her evidence, she stated M was a little bit calmer and F was not 'distraught', he was clear in explaining what happened. She could not recall whether it was F or M that had volunteered to her information about an earlier incident on the 22nd April 2021 and sought medical advice. She did not recall the detail of what had happened on that night in April.

121. *ZM,* IAA/MASH social worker. She was shown F's latest statement and asked about whether it matched what she had been told. She stated that she was not aware from F that he may have shaken GH. Further, on the day the witness had spoken to him outside the hospital and they had spoken about the concerns and she has responded one concern, why he had not rung 999 or 111 and he had said, because he was a firefighter and was used to working in crisis and was calm in those situations, even though it was his son, he effectively went into work mode. There was no mention of his being under a lot of adrenaline as he now claims– he had made out to the witness that he was in control of the situation. She also raised concern about the way the parents had also been jokey in their demeanour with her and she found that 'strange'.

122. Most of the information she received was during her home visits on the 7th ,10th and 13th of May 2021. The quality of her note keeping was heavily criticised (with some justification). She did not keep notes of her discussion on the 7th at all. There was also criticism of the way in which information was put into her statement which was clearly incorrect (events of 5th May 2021 as set out E12).

123. She confirmed that on the 10th May 2021, F had said that he 'could have said he had dropped him, if he had shaken him' [Lii 15]. He was frustrated at that point because of the interventions and said he 'wished he had not taken him to hospital now'. He said it was the wrong way to approach it and then said the words that he could have said he had dropped him had he shaken GH.

124. *FW,* current social worker and author of the Parenting Assessment. She told me that when she saw F's latest statement she was surprised because she had worked well with the parents in what she thought was an open and honest manner, however F had never told her

that he had shaken GH. The events of 5th May 2021 had been discussed previously but shaking was never mentioned.

125. It was suggested by Ms Irving QC that F's first statement 21st July 2021 was discussed in her interview sessions. It was pointed out that there was no reference that F raised in July that he could have shaken him and that was not explored. The witness could not recall whether she had seen F's document, where he says he 'could' have shaken GH.

126. Otherwise, she spoke positively about the parents' attachment and bond to the children. She had no concerns about F's relationship with GH now and he had been honest about the struggles in the early days with his bond.

127. She was taken by Mr Richards to the account that F gave to her which did not mention 'shaking' and holding him under his arms. He has never mentioned those words to her when she asked him about it and she also went over the words with him and these were not corrected. She also stated that he never demonstrated shaking to her. When she stated in her document that he had always admitted that he may have rough handled GH that morning, this was a reference to him scooping him up, she clarified. That is why F's description in his statement came as a surprise. She saw the statement of the 1st December 2021 after she had spoken to him on the 2nd December 2021 and in which meeting, he made no mention of his new statement and its contents.

The Evidence of the Parents

128. (i) *Mother.* Surprisingly, she claimed that she had not read either of F's statements of evidence. Fortunately, GH is fine now and she has not witnessed any funny turns after the 5th May 2021. She explained that GH did not like anything going over his head from very early on. He was resistant to being undressed and dressed. He would start to scream once undressing started and that was every time. She accepted that this was not mentioned to anyone, as they presumed that was just his way. She now believes that was due to the brain bleed / something wrong with his brain. She believes that the 5th May 2021 incident has corrected whatever was causing his behaviour and he no longer screams, and he is now a normal baby: 'Whatever has happened has changed him.'

129. She accepted that whatever F has explained may be the answer to what had happened. She said that they do not have an answer for the first 9 weeks of his behaviour.

130. On the 5th May 2021, she thought F and got up with the children and given the feed at 6:30 am. When she later came downstairs, GH was on his pillow and was quiet. There was no sign of reflux at that stage. She decided to do the nursery run instead of F and she clarified that with F.

131. When she returned, F immediately said 'he died on me' he was holding GH and he was slumped into F's chest. He went to explain that he was trying to get him dressed and he stopped breathing, went red and he had to give him CPR.

132. GH liked to have his head being more relaxed backwards over the arm of the person holding him. He was not like most babies in that way, but that settled him.

133. On the 22nd April 2021, she went downstairs after hearing a strange scream/ 'not heard GH scream like'. She saw F holding GH who was screaming. F said he went to feed him, he started hiccupping, his eyes went huge and he went bright red and 'limp'. However, GH was crying in his hands, but it was his normal crying he was not red or bulging in eyes. This was the first time that this had occurred, and they checked him over and he seemed fine and he took the rest of the bottle and she left F to finish the feed and she went back to bed. She was going to mention it to Dr Rr the next day when she was having a consultation for GH's navel. In her evidence, Dr Rr did not recall this being mentioned. M claims that she said he had a funny turn last night but seems alright now and the doctor did not pursue it beyond that. Whilst accepting that there was no mention of GH going limp or lifeless by her, she would have gone into detail had the doctor asked. Oddly, this is similar to F's later assertion that he had drip fed information to professionals hoping that they would have made further enquiries of him to allow him to say he had shaken the baby. It is a nonsense and shows M's complicity in respect of this earlier episode initially not being raised and/ or thereafter consistently dealt with by the couple. I have already said I prefer Dr Rr's account.

134. Later, she was to add that she waited a few seconds after the scream and then went down to see if she could help. She was concerned, as she had not heard 'that scream' before. F was presenting as 'fine' when she got downstairs. Her statement at F12 made no mention of the child going limp nor that she was told that he went limp. The first instance that GH went limp was mentioned was on the 5th May 2021 [Q i49]. F had provided that account to Dr H and M was present. She confirmed that she did not question F following that news of

her child going limp on the 22nd April 2021, which I find strange, if it was coming for the first time and in those circumstances.

135. However, she spoke about it in her May police interview. She claimed it was her error that she did not mention this in her statement and 'she must have forgotten' about GH going limp. It was pointed out that Dr Rr said she did not mention him going limp to her. She now agreed that she did not mention limp to Dr Rr for the first time. It was suggested that had her child become unresponsive it would have been mentioned. She stated it was for a short period of time that he was unresponsive and as a parent she knew what to raise and she would have provided detail had she been asked. In my judgment, M was caught out in her own lie.

136. She claimed that she had not read the 21st July 2021 statement and had assumed the account F gave her was what he had told his solicitor in that statement. By 1st December 2021, he had said that he was 99% certain he had shaken their child. She was not sure when she heard that for the first time. She recalled that F was in discussion with his solicitor on the telephone and that was the first time that she had heard the word 'shaken'.

137. She confirmed she had not read the medical experts' evidence in advance of the parenting assessment, so that she had not considered anyone shaking her son – not 'violently', she added. F had said to her that if he had injured him when trying to save his life, I would put my hands up. But she repeated that she had never heard the word 'shaken'. She challenged him immediately and he alleged that he had mentioned this to her earlier. It was the only piece of oral evidence where they diverged. I prefer M's account because it was said naturally and volunteered by her. She had nothing to gain from the same.

138. When the CT results came in and she was told that there were bleeds on the brain she was terribly upset. She did not think there must have been an event because GH constantly screamed in pain and she felt that had to be related. The parents had a brief discussion about whether anything had happened.

139. She denied that there was stress in their relationship, but each could become frustrated with the baby's screaming. She confirmed that she has not asked F to go over what happened, as each knows what was said and done by the other. They had spoken about the 'whole situation' over and over, meaning his crying and discomfort from birth. The issue of his shaking was not mentioned at all by either of them.

140. The parents did not have concerns about his head circumference because professionals were not showing concerns. It only became so after the 5th May 2021. She accepted that they still felt that something had happened at birth.

141. She denied shaking GH and maintained she was not present.

142. She stated that she had not read F's statement because she felt that he would have told her everything. She did not feel that she wanted to check it out, as she didn't want to relive it in any event. She assumed what he said was what they had discussed. She trusted him implicitly and cannot countenance the thought that he may not be telling the truth.

143. Mr Richards took M to various text exchanges where M was clearly stressed and tired by GH's behaviour. When taken to the thread of messages where F refers to putting GH under the patio, she accepted that she was alone in the house whilst F was laying his friend's patio and GH was difficult. She was doing most of the caring in the first few weeks.

144. At some point F mentioned that he was struggling to bond with GH. It was around a month before the 5th May 2021. He had done research and spoken to friends about it. She was concerned about it and suggested counselling but F said that it would get better having done his research. She was taken to some of those searches undertaken by F. The first was 'I hate my new born son' [GH was 9 days old]. She spoke to F after these searches came to light and he said he never typed in the word 'hate'. He said it had come from an original link. On the 24th March 2021, F had searched 'I have no feelings for my baby'. She did not speak to him about these, as she claimed they were covered in their discussion about his struggle with bonding.

145. On the 27th March 2021 at 12:03 am, she raised the fact in a text that he had called her a 'Tramp' [Ti 72]. That message was half an hour after he had called her that name and he was still upset. She mentioned that this was a new side of him she had not previously seen before. She had never been called a name before. He called her a Tramp more than once, but she has no idea why he used that name. The explanation was that he had left GH on the floor and she wanted him to pick him up. F had added that he was not nice when he is angry.

146. On the 31st March 2021, she sent another message to F, texting "this fucking baby" with 5 red angry emojis. She was frustrated at not being able to nap and she was tired and frustrated. She sent an image of GH screaming- she felt that God was testing them. She did

not recall where F was that day. F was supportive and suggested help from family members. She turned that down as she was the mother through bad and the good. She accepted that her texts look bad. She denied the suggestion that these messages showed she was not coping.

147. On the 1st April 2021, she text F about F's negative views of the baby and how nasty it was that he had said 'I hope he chokes on his milk'. She stated that they had all been together and GH was screaming in the kitchen and she misinterpreted what F had said over all the noise. At the time she took it as a nasty comment and another example of negativity by F and it had upset her. She said that F was negative with GH because he didn't have the bond. He was not like he was with IH. F was not short with him. They both called GH horrible names, possibly F called him a knob. On the 21st April, F texted 'he was becoming less of a knob now' to a friend. M accepted he may have called him that. She accepted that this negativity was not a one off.

148. On the 8th April 2021, F had his operation and he was at home for 6 weeks. Things were easier with the two of them present. She accepted that the health visitor was not told about the bonding issue as they felt they could deal with it themselves and by the 21st April she said that F was beginning to bond and things were getting better.

149. When asked about the account she gave to the police in interview about what F had told her about GH's collapse on the 5th May, she accepted that she and F had discussed matters again since and GH was crying and then he went limp and was then picked up. She accepted she should have told the police that she was not sure of the order. He had pointed out to her in reading her police interview that she had got the order wrong and that was raised a couple of weeks ago. He said 'you said in the wrong way' i.e. he went limp after he had picked him up. She said she did not realise that she got it wrong in the interview on the 20th May.

150. The first she became aware that F could have shaken the baby was not long before his last statement. She heard something about shaking when F was speaking on the telephone to his solicitor. He had not raised that with her before that point. She said she could not recall whether she raised it with him at the time. She was challenged about that assertion. She then said that he said he had mentioned shaking to her before and she said that he had not. He had not mentioned the word shaking to her personally.

151. He then told her that a new statement was going in and that he was saying that he was 99% sure that he shook GH. She did not ask him why he was only remembering that now. She did not ask him why he was certain now but not then.

152. On the 9th May 2020, F made some internet searches. Shaken baby syndrome was searched, then self-hypnosis to forget and self-hypnosis for anxiety and then can you use hypnosis to forget painful memories. She confirmed she had not seen these. M says that he still says that every time he closes his eyes, he sees GH dead. It was not raised with her until the day of her evidence that these searches were made.

153. *Father* confirmed his statements. He accepted that he had searched on the internet about the fact that he had no feelings for his baby. The period of these searches was between the 12th and 24th March 2021 and in that period he had read many articles and blogs on the subject. He realised he should have spent more time with GH and his wife and not gone to earn extra money.

154. On the 25th March 2021, M text that she was close to breaking down and was going to speak to the health visitor and he responded by supporting her suggestion and saying they are both at their wits end and he was not looking forward to being home for 6 weeks. Nothing worked to comfort GH. He described the 'off switch' for his son being that he was held in both hands with GH's head dangling back over the uppermost hand.

155. On the 22nd he confirmed GH went limp – he flopped, and his arms went limp for a very short period. His eyes were closed but he couldn't say whether he went unconscious. He went limp in the ring and then he picked him up and tapped his back and his eyes opened. He was limp for 2-3 seconds. F denied doing anything to his son to make him go limp and denied shaking him on that night.

156. He was asked how he went from I could have shaken him in July 2021 statement to 99% certain that he had done so in his final statement on the 1st December. He had time to think more and was terrified to use the word shake and he had thought of a shake only in terms of a violent shake. He could have lost everything and that was a pressure on him. He attempted to address the situation in his July statement, and he thought it would be taken up more by others who read that, and he would have been asked more questions about it and he could have answered more naturally. He confirmed that he had not mentioned shaking to M

because he was terrified and did not have the courage to mention that word shake. He did not know if that was the end of everything for them as a family.

157. When he went limp, he was on the ring on the sofa. M's account in her interview was that he picked him up and then he went limp. He still recalls the image of his son going limp and M got the sequence of events wrong. A few weeks ago, they had watched each other's interviews and he said to her she had got it the wrong way around.

158. He described having 'sound but no pictures' initially about this incident, so that he was unable to recall the minutiae of what had happened between him and GH. He maintained he saved his son's life.

159. In cross-examination, he accepted that he had been open and honest to the Local Authority save that he had not mentioned shaking. In his mind he was using the description of resuscitation and saving GH as the explanation for the mechanism used by him. In my judgment, it was another example of F obfuscating.

160. He provided a very similar description of daily life around GH. They had different approach to parenting. He accepted that the difficulty of getting things over GH's head was never mentioned as an issue to professionals, although issues had been raised.

161. By early April 2021, his mental state and bonding issues were getting better having completed his research.

162. What was different about the 22nd April 2021 was that it was a very short incident and completely different from what happened on the 5th May 2021. He went red, limp and picked him up was not the same sequence because on the 22nd April 2021 that happened as he was being fed, whereas the 5th May 2021, he had been fed some time before. On the 22nd April 2021, it was like his feed had 'gone down the wrong hole.'

163. He denied misleading the hospital professionals by omission of a shake and maintained that he had a blank about using that mechanism. He only recalled what he had done in terms of a resuscitative shake around the 8th July 2021, when I had found in the parents' favour in respect of the prevailing contact dispute. F accepted he knew that GH was poorly after doing what he did. He explained his efforts to revive his son that morning which included rescue breaths (placing his mouth over his nose and mouth for breaths to be used), the use of two

finger CPR compressions and the use of water to sprinkle his son. He asserted that he could not have called the emergency services any earlier. He was clear that GH was limp on the ring and not after he picked him up.

164. He agreed that since the 5th May 2021, that GH has been fine, and the past issues have resolved so that he no longer screams or seems in discomfort and is a loving child.

165. The incident on the 5th May 2021, he described as being the most traumatic incident that he has experienced.

166. He demonstrated how he scooped up GH and then called him and shook him to revive him. That mechanism was to bring GH from a low sofa to his chest region quickly (he is 6 foot 4 inches). He also described how he ran with GH to the car and from the car to the hospital- in which he held GH to his chest but without supporting his head and he accepted that his head must have been flopping around or moving from side to side as he ran.

167. F was taken to his police interview and the passage where he was asked: 'did you Google, "Why do I hate my son"? and he answered 'No, I tried – I Googled it like'. That was a lie. F tried to explain that he had forgotten this and thought he was talking about a later time. He excused his behaviour about 'hating' a 9-day old baby, because he always searched the worst-case scenario and that it was not how he actually felt. In my judgment, this is likely an attempt to distance himself from those thoughts and searches.

168. He was taken to the texts around his calling M a 'Tramp' and F raises that he has to keep a lid on his anger, and it is 'not nice when it comes out.' He said he used that phrase as he knew it would get a response. He explained that he was angry because he was trying his hardest with GH and he was deferring to her judgment because she was with him more and when she glared at him, when he was trying his best, it upset him- he felt it made him feel he wasn't good enough. He wanted to make his point by hurting her. He accepted that he was over-sensitive but that was due to the stress they faced with GH. It was pointed out that he reacted badly to Ms M the social worker who was informing him that he needed to attend a CP medical. It was suggested that he spoke incessantly and aggressively and then abruptly ended the call he accepted the latter. He accepted he was frustrated and upset.

169. He was then taken by Mr Richards in cross-examination to a number of inconsistencies in his account, and which I find to be significant:

(i) On the 22nd April 2021, F's account in his witness statement and in evidence was that after he put a bottle in GH's mouth, GH hiccupped at the same time, went red in the face and then went limp. GH screamed after he came around and was being held to F's chest. The account provided to the doctors on the 5th May at hospital was that GH went limp on being winded on the 22nd April 2021. It is a different account to the one provided to the court and in his statements.

(ii) On the 6th May 2021, F provided Dr H with an account of the episode '12 days ago' but informing the doctor that GH 'did not go limp'. F said that he was trying to explain that it was a different type of limp to the 5th May 2021 and he misunderstood that question.

(iii) On the 7th May 2021, he once again told Dr H that GH did not go floppy and unresponsive on the 22nd April. F could not explain why that account was different. He explained that with everything going on he must have got it wrong but really, he could not explain the difference between that and his current narrative.

(iv) On the 10th May 2021, he told Ms M that by the time M came home, GH had revived some 2 minutes earlier. In his evidence, he said it was 30 seconds later. He was asked why he didn't call 999 at that point and answered that it was because he was not in the right mind. He was crying and M said phone 111. He was asked why he told the 999 operator that the CPR was done 'for ages' when he was now saying it was seconds. He explained that it felt like ages. He told the operator that GH was holding his breath in temper as there was no other explanation for it. He denied that he was frustrated with GH and was not himself in a temper.

(v) F made no mention of a resuscitative shake to the doctors in the period he was in hospital between 5th May and 20th May 2021, nor to other professionals when he had the opportunity. He accepted on the 10th May 2021 he even told Ms M that he could have said that he had dropped GH on the floor. It was put to him that he had an explanation on his account- he said he was terrified and shamed and fearful of losing everything. He said he did not have the courage to do so.

(vi) Nor did he mention to it to the police. He averred that he mentioned it to the Guardian on the 14th July 2021 that he may have done so in reviving him. He claimed to hint at it- his trying to get it in there. 'I was drip feeding revive incident to the right people.' The latter is a clear account of his manipulating the evidence and his narrative and shows a degree of the calculation in his approach to the whole process.

(vii) When taken to his July statement he recounts the incident in uncertain terms – 'I <u>could</u> have shaken him.' He said he was still piecing things together and trying to get

over his cowardice at that time. He accepted that he failed to share the information with the neurology department in outpatients visit in the terms he now described holding GH under the arms and shaking him.

(viii) He also accepted that he failed to tell Ms W this account during the lengthy sessions with her during the parenting assessment. He said it was all due to his shame and losing everything. He also accepted M's evidence that he has not mentioned anything to her about a shake but claimed he had said it in terms of if he had hurt him it was during an attempt to resuscitate.

170. He was challenged as to M's account that she immediately raised with him having heard him mention the word shake over the phone to his solicitor and his then claiming that he had said it to her before. He stated that he did not recall that he had said that. Mr Richards suggested that he had used this as a way of gaslighting her by claiming he had mentioned it earlier. It was also suggested he was doing the same by the discussion around their interviews and him telling her that she had the sequencing wrong. In my judgment, Mr Richards' suggestion was correct.

171. He was taken to his 1st December statement where he said he 'believed' he picked him up under the arms and 'believed' he shook him. He claimed that he has no memory of doing it, save for muscle memory where his hands go to a shaking mechanism when he discusses the incident. He claimed it was all still a blur. He denied that he was even now resisting a full account because of what he did was too awful. It was suggested that his narrative was a half-truth.

172. He was taken to 9th May 2021 and his internet search of that day. [Ti40-43] he was looking at 'shaken baby syndrome' and also 'encephalopathy' and self- hypnosis of anxiety and self-hypnosis to forget and can you use hypnosis to forget painful memories. He was asked why he was searching for these- he said he wanted to get the images of GH going limp on the ring out of his head- that was playing through his mind. He accepted that he used these techniques by looking at a video clip numerous times. He did not mention this to M.

Issues to be Determined at this Hearing

173. The issues are as follows:

- What are the injuries? This includes whether GH has suffered a previous bleed.
- How were they caused? In particular, whether GH's injuries were the result of an abusive as opposed to a resuscitative shake on the 5th May 2021.

- If abusive, can a perpetrator be identified?
- What, if any, issues around failure to protect are identified?

174. There is no issue that as at the 5th May 2021, GH had sustained:

- multiple subdural haemorrhages over both cerebral hemispheres;
- a subdural bleed within the posterior fossa;
- bilateral subdural collections over both cerebral hemispheres which, given their slightly higher density than cerebrospinal fluid, are considered to be haemorrhagic;
- thin intraspinal subdural haematoma;
- multiple bilateral intraretinal haemorrhages.

My Analysis of the Medical Evidence

175. The experts agreed that the CT scan taken on the 5th May 2021 showed that GH had suffered multiple bilateral subdural bleeds including bleeding into the posterior fossa. There was also evidence of bleeding into the spine and multiple bilateral retinal haemorrhages.

176. The experts all agreed that the bleeding in the eyes, posterior fossa and the cervical spine, as well as the bright bleed material over both cerebral hemispheres were recent in origin (recent at the time of the CT scan on the 5th May 2021 and the MRI scan on the 10th May 2021.

177. The experts also all agreed that the likely mechanism is one of rotation or backwards and forwards movement, with Dr Cartlidge also accepting that one movement and an arrest would be sufficient for the purposes of causation of these injuries. The experts also agreed that the distribution of blood was in keeping with movement of the brain within the cranium, causing the rupture of bridging veins running between the arachnoid and the dura. Each agreed the position that the best way of timing these radiologically acute injuries, is against the clinical picture. Outside of the clinical picture, neither the acute retinal haemorrhaging, nor the intracranial and spinal acute injuries can be particularly accurately timed.

178. All agreed in their oral evidence that these could be caused by a single event and occurring after the child had last been fed and was seen to be well. GH was well when the mother went to take IH to the nursery but clearly unwell upon her return shortly afterwards. This is best expressed by Miss Pettorini who stated that "..the fresh bleeding on the CT *"very likely happened in the time frame between GH being well and being acutely unwell"*. Dr

Cartlidge also stated that the causal event was likely to have been shortly before M arrived home at 8.40am on the 5th May 2021. That factual matrix was given by both parents and went unchallenged, as was the evidence of the expert clinicians on this point.

179. Further, all the experts agreed that if F used a shaking mechanism after the mother left the home, then all the injuries identified above could be attributed to that single event on the 5th May2021.

180. However, the experts did differ in their opinion in relation to whether a chronic collection was present on the scans- albeit they did not disagree that if there was a chronic collection, it would not be possible to attribute its presence to an episode of inflicted injury weeks earlier. Crucially, none could say that it had not been there since birth nor that it was not a consequence of the birth itself. Indeed, there was no dissent from the general proposition put in cross-examination by Mr Storey QC that if there was a chronic collection, it could well be birth related.

181. I find it unnecessary to determine the issue of the presence of a chronic collection. The evidence is ambiguous in terms of its presence at best. There were only the two features upon which Dr Cartlidge relied upon in support of his dissenting position, namely: (1) photographs of GH taken by his parents and (2) an increasing head circumference between the 17th March 2021 and the 28th April 2021. I accept the submissions made by Leading Counsel for both parents that there is an inherent unreliability in such an approach, even when it stems from an expert of Dr Cartlidge's pedigree and renown.

182. I am driven to prefer the evidence of Dr Hogarth, the Paediatric Neuroradiologist who is the jointly instructed expert with regards to the interpretation of the scans and he remained steadfastly of the view that there were no clear features on the scans to suggest that pre-existing subdural collections were present before the CT scan of the 5th May 2021. In addition to the absence of a discernible presence observable on the scan, it is noted that the following features were also absent: (i) any loculation or membrane formation;(ii) any mid-line shift; (iii) any widening of the sutures.

183. As Dr Hogarth fairly stated, there was nothing radiologically which could support the contention that there was a chronic collection attributable to an incident of shaking or other inflicted head injury on or around the 22nd April 2021, as was advanced by the Local Authority.

184. To conclude, there is no evidence contrary to that provided by the parents as to the events of the 5th May 2021; that is, that GH went from well to unwell in F's sole care on the 5th May 2021 and when his mother was at nursery. Within that window, I find that the injuries that appear on the scanning and ophthalmological investigations must have occurred and consequently, must have been caused by F.

185. That being the case, the kernel issue in the case is whether the shaking which the father admits occurred on the morning of the 5th May 2021 was an abusive reaction to the child annoying him and F becoming frustrated and shaking his son, or whether it was an instinctive reaction to an apparent life threatening event.

186. As to the issue of force, I found three pieces of evidence significant in respect of the degree of force that must have been used by F in shaking his son that morning. The first is that of Dr Crewe-Brown. He described the ocular haemorrhaging in his evidence as being extensive, bilateral and being too numerous to count. When considered against other cases he has reported on, he described them as 'top end of the scale' and that there would have been significant excessive force. He suggested extremely vigorous shaking. When asked by the Local Authority whether a resuscitative shake by way of assistance might result in this haemorrhaging, he answered: "No, in terms of causing haemorrhages, it would not cause the haemorrhages of the type, extent and age of these haemorrhages. It wouldn't look like that at all."

187. Whilst Dr Crewe-Brown accepted in cross-examination by Mr Storey QC, the possibility that retinal haemorrhages might be caused by chest compressions, and raised intracranial pressure, he expressed doubt given their extent.

188. The second significant piece of evidence is in respect of the spinal blood. Dr Hogarth's evidence was that "*the forces required to produce such extensive intracranial and intraspinal bleeding in an otherwise healthy infant would have to be considerable and not trivial.*" He described the need for a vigorous shake, generally considered to be well outside the range of what a reasonable carer would call reasonable handing. In the experts' meeting he was content to attribute some of the spinal blood to tracking from the posterior fossa, albeit that he noted it to be odd that the blood had tracked down and then across the spinal cord to appear at the anterior end **[H302].** The transcript does however go on to record that he felt that a

local bleed or tracking from the posterior fossa were both possible and that he didn't have a preference either way.

189. Dealing with the same issue, the third piece of significant evidence is that of Dr Pettorini who had accepted in the experts meeting the possibility that the spinal blood may be due to blood tracking from the posterior fossa, she indicated that it was not her "*top option"* (H302). In evidence, Dr Pettorini explained that there is a divide in the medical literature about the causation of spinal blood. The split is between the spinal blood being tracked blood from the posterior fossa, and the spinal blood being present locally due to increased severity of shaking mechanism. In her clinical experience, Dr Pettorini has seen spinal bleeds in shaking events in cases of very severe injury. To the extent that tracking from the posterior fossa is identified as one of the options for the presence of spinal blood, Dr Pettorini explained that she does a lot of posterior fossa surgery where there is a lot of blood going around and she does not normally see tracked spinal blood.

190. In my judgment, it is the combined effect of these three pieces of evidence that leads to my finding, on balance, that there was significant force used by F to cause the trauma necessary to account for the degree of retinal haemorrhage and also the presence of spinal blood. It can safely be inferred that the nature and degree of the shake must have been 'vigorous' and 'not trivial', was not one which would have been forgotten by F. However, I also accept, as I have mentioned that this is not a case where GH sustained other injuries associated with greater trauma such as posterior rib and metaphyseal fractures, parenchymal injury and hypoxic ischemic injury. That is also an important factor when considering the intent behind the shake.

Earlier Incident

191. Turning to examine the issue of whether there had been an earlier incident (which if found, would make it far more likely that the incident on the 5th May 2021 was abusive), I found the following points from the evidence the most salient:

192. The evidence to support the concept of an earlier injury came solely from Dr Cartlidge.

193. When answering questions from the Local Authority about the possibility of a previous injury, Dr Hogarth explained that as a neuroradiologist he can only go so far as the scan series that he has available to him.- *"in this case, the best that I can say from the images is that there is a possibility of a longer standing collection, I can't say more than that, I can't*

exclude it as a possibility. I don't require there to be an existing SD to explain what I see on the head scan. That is about as far as it goes".

194. In response to questions by Mr Storey QC about the absence of features such as loculation and membrane formation, Dr Hogarth explained that *"the lack of features does not exclude it entirely. I don't require it to explain the appearances. I must advise and caution the court that there is a possibility of chronic blood there and I am not able to draw features from the scan to demonstrate positively… I have seen cases where there has been draining from the collections and the blood has an older appearance.*"

195. Similarly, when invited by Ms Irving QC to consider that the absence of features such as membranes and loculation adds weight to the opinion that there is no pre-existing collection, Dr Hogarth replied "*I would prefer not to put it as positively as that. Leave the door open as to a possibility. I see no compelling reason to advise the court there was a pre-existing collection. The problem with saying I can't see any locules or membranes and then drawing from that a position where I say it is persuasive to me in being able to exclude pre-existing collections, I am afraid that this is not the case. Evidence of absence may not translate to a positive finding".*

196. However, he accepted that given that there were no extra cranial injuries, that positing a theory that there was more than one traumatic event involving shaking would mean that the child would have to avoid the commonly associated non-intracranial injuries on two occasions. This latter piece of evidence, it seems to me, is an essential factor in determining this issue.

197. Miss Pettorini's evidence was that there was no evidence on the scans of older bleeding. She indicated that there was no evidence of injury at the cranio-cervical junction, no hypoxic ischemic injury and no parenchymal injury. She accepted, as did Dr Cartlidge, that scooping and running could contribute to the radiological picture. She agreed with Mr Crewe-Brown that the picture could be explained by one event.

198. Mr Crewe-Brown's evidence was that the entire picture from his perspective could be explained by one event occurring on the 5th May 2021. There was no earlier ocular bleeding. I agree that it was not helpful to him that there had been no 'ret-cam' images taken and that RCP guidelines in that respect had not been followed. [This is a matter which needs to be raised with the Local Safeguarding Board and particularly because it is not the first time that

I have come across the issue in this DFJ region]. He was content that a resuscitative shake could have caused the ophthalmological picture and accepted that the mechanism described by the father could therefore explain the ophthalmological picture.

199. Dr Cartlidge accepted that the acute injuries were all capable of being explained by the F's actions, as described by F. However, in a dissenting expert voice, he maintained his view that there was a chronic event going on inside GH's head. Dr Cartlidge's opinion was that the cross-centile increase in GH's head circumference ("HC") between the 17th March and the 28th April 2021, where GH's head circumference increased from 38.5cm to 43cm, is indicative of there being something chronic happening intracranially. Dr Cartlidge did not depart from this view in cross-examination when pushed on the subject. Dr Cartlidge could identify no other reason for the rapid increase between 2 and 8 weeks of age, other than an earlier episode of subdural bleeding that had evolved into a subdural collection by the 28th April 2021. His assessment of the photographs was that GH had a large head at the time, and the only thing that fitted with that presentation is a chronic subdural collection. This would have been caused either by shaking or be sequelae of what happened at birth. Dr Cartlidge considered that two different explanations for 2 different injuries to be unlikely and was of the opinion that the previous bleed amounts to an inflicted injury. However, when further pushed in cross-examination, he accepted the proposition that it was entirely plausible that GH had bled intracranially at birth, and that he would therefore be prone to re-bleeding with normal handling, or slightly exuberant handling, or following the type of incident observed between the children on the sofa.

200. Dr Cartlidge was adamant that the photographs taken by the parents showed an increase in head size, beginning with the photograph taken on the 4th April 2021. However, I must remind myself of the dangers of reliance on the dogmatic expert. That would mean that photograph predated the incident on the 22nd April 2021 by some 18 days. Also, that photograph was taken only four weeks after the birth and therefore well within the usual parameters of being birth related (which in fairness to Dr Cartlidge, he accepted). Nonetheless, Dr Cartlidge held firmly to his original opinion that there was the real possibility that something chronic occurred at an earlier date than the 5th May 2021 and he was happy to hold to his dissenting voice.

201. In my judgment, I did not find Dr Cartlidge's evidence sufficiently persuasive on this aspect of a likely earlier incident and certainly not to a point which overrode the evidence of the other two main experts in respect of the imaging. I must take great care when relying on

his view being reliant on what he observes from amateur photographs, particularly when there is the ongoing evidential issue between him and the midwives as to head measurement at birth where he questioned the accuracy of measurement based on other photographs taken by the parents. I am also satisfied that the child was being seen by other professionals over this period and they were not noting any concerns on the ground.

202. Of course, there is only the one earlier incident, that of the 22nd April 2021, referred to by the parents. There is evidence of the child being alone in the sole care of F downstairs when the child had a 'funny turn', but soon revived and cried hard. The evidence was that by the short time M went downstairs, he was settled again in his F's arms. She also spoke to the GP by telephone the next day but did not inform the Doctor of the serious event of the previous night- more particularly that he had lost consciousness/ gone limp/stopped breathing. This has been a moving goal in terms of F's evidence on this incident and M has followed suit and this incident has been muddied as a result. It shows a degree of working complicity between the two.

203. However, IF an incident occurred on that night, it also does not fit with Dr Cartlidge's interpretation of the photographic evidence that the head circumference started increasing in the photograph of the 4th April 2021 and thereafter. Further, GH was examined on 28th April 2021 in the GP surgery by Dr K and that examination raised no concerns. There was no evidence of scalp swelling, no evidence to suggest a bulging fontanelle, no evidence of bruising to any part of the body. GH was feeding and putting on weight normally at that date.

204. Further, it was also accepted by the experts that for a child to suck, involves a sophisticated neurological intervention by the brain. That he had been able to do so in the intervening period leads me to conclude that there had been no previous episode of head injury as had been alleged by the Local Authority.

205. Of course, IF Dr Cartlidge is right about the image of the 4th April 2021, then it simply cannot be disproved that IF there was also an underlying chronic bleed, that it was not birth related and it was subsequently activated or exacerbated upon normal or exuberant handling. As such and having reflected on all the evidence, it is not evidence upon which the Local Authority has discharged its burden in respect of there being an earlier abusive episode. I am not in a position to say whether, IF it had occurred, that it later contributed in some way to the 'funny turn' either on the 22nd April 2021 and / or on the 5th May 2021. In short, even if it did, there remained the need for force sufficient to cause the degree of retinal

haemorrhaging, spinal and intracranial bleeding on the 5th May 2021, even if Dr Cartlidge is right on this aspect. However, the evidence is not clear as to there being an earlier collection nor its source, if it existed and, in my judgment, I am content that I need not make a particular finding.

206. I remind myself that the medical evidence needs to be considered in the context of all of the other evidence in the case and that includes the various messages that were sent between the parents; the internet searches made by F; and explanations given about GH's presentation by the parents in the context of other events. There is also the key matter of the oral evidence of the parents. I have done so.

207. Needless to say, I have found the expert evidence profoundly helpful in determining the factual issues in this case, and with only the caveat that I have expressed in respect to Dr Cartlidge's view in respect of any earlier critical incident, I accept their evidence entirely.

My Analysis of the Parents

Mother

208. In terms of credibility, I found M to have a been a quiet, careful and reserved witness and someone who often sought eye contact with F when giving her evidence. I did not get the impression that she was entirely truthful with me, as her significant inconsistencies revealed. However, I accept that she was not present on either the 22nd April 2021 incident nor that on the 5th May 2021 and she has largely relied on what F had told her.

209. She was clearly supportive and protective of F and had taken a rather peculiar decision not to read his statements and allowed herself to alter her evidence in respect of the events of the 22nd April 2021 and the 5th May 2021, to fit in with his. I say that because she had looked at his police interview and had discussed the same with him. As I raised with F in his evidence, that was also an odd occurrence on his part because he knew that the interview did not include his actual case that he had shaken GH, and which information was contained within his statements. It makes little sense to me that someone who had fought as hard as M has done to find an underlying cause of her son's screaming in the first 9 weeks of his life, and subsequently made all proper enquiries with the medical team post 5th May 2021, should shy away from reading F's statements. Her explanation that she did not want to relive the event by reading them, did not resonate, given she was within these proceedings.

210. However, I am satisfied that she did not harm her child in any way. The issue with which I remained concerned was whether she was covering for F and /or failing to protect more generally or else was complicit with F in providing incorrect/ misleading / inconsistent accounts.

211. I am content that she was out of the house at the time of the incident and acted properly and reasonably upon her return to the home, where she found F holding GH and received the narrative that he had saved his life. In all likelihood, her discussion with Dr H when she was with her father, is probably the key to her mindset, in that she was afraid that F may have caused the intracranial injuries deliberately and she had missed the signs. I would have expected her to have read the statements and been more challenging of him, knowing as she must have done that whatever had happened occurred in his sole care. Her simple description of a discussion in terms of 'I haven't done anything, have you?', does not cut the mustard in a case of this nature where a 9-week-old baby has suffered this type of injury. It fits of course with the kind of person who would rather hide her head in the sand than want to explore the reality of a difficult subject that may blow apart family life as she knows it and she wished to preserve that at all costs and in simple terms, that is the only way I cannot fathom her decision not to read F's statements in fear of what they may contain.

Father

212. As to F, I found him to be an unreliable witness on many occasions and someone who has gone out of his way to deceive. He found it difficult to explain why he was unable to tell the doctors at the hospital during GH's admission period that he had shaken GH nor did he tell so subsequently when they were treating GH.

213. He has been selective with the truth during the medical investigation and these care proceedings and failed his son which have been identified by Mr Richards in his submissions and which I adopt:

- Up until the Thursday before the hearing commenced on Monday 6th December 2021, the focus of the parents' case has been upon seeking to establish whether there might be some underlying issue with GH that explained why he was such an unsettled baby, his apparent collapse on the 5th May 2021, and the various injuries then identified at the hospital.
- On Thursday the 2nd December 2021, the parties received F's statement dated 1st December containing the information about him now being "99% *certain"* that he shook GH on the 5th May 2021 in order to revive him. F stated that he still unable to

provide any detail about the shake. F's certainty is expressed as a "*belief"* he now has, that this is something that has taken place. The reference to a resuscitative shake is not necessarily new information as it appears in F's July 2021 statement, as something which F says "*could"* have happened. What is significant about the latest December 2021 statement, is that F was identifying with a high degree of certainty a mechanism that might explain GH's injuries. The statement about when this belief has developed, led the reader to the assumption that this must have been a recent development.

- However, in F's evidence he suggested that this is in fact something F has believed for some time. F identified a court hearing in July as being a point in time where uncertainty about the contact arrangements for the children was resolved, and he was able to better consider the events of the 5th May. That he claimed resulted in the insertion of the phrase *'could have shaken him'* in the 21st July statement. F described how this was him trying to get into his account what he was recollecting, "*tiptoeing and drip feeding",* to use his own words, the shake to what he thought was the right people.

In my judgment that shows calculation and manipulation and a determined lack of transparency on his part. It is also of note that the Court hearing F refers to, took place on the 23rd July 2021, 2 days after the date of the statement (C35).

214. Therefore, on any reading he has for some time withheld important information from everyone, including M, about what he *"believes"* he did on the 5th May 2021. From the children's perspective, it is most regrettable that he has done so. Specific consideration of F's account at an earlier stage may have allowed for entirely different interim care arrangements for the boys. F has explained that the late revelation is due to him believing that had he mentioned the word *shake*- he would be 'in handcuffs, charged with GBH, and would lose everything – the job he loves, his relationship with M and the children'.

215. I reject F's explanation that he had ever had a blank for that one essential part of this significant episode, namely his 'vigorous' and 'not trivial' shaking of the baby and that line of excuse is just a way of distancing himself as being seen by others as a perpetrator of abuse. Rather than forget that action, it should have been seared into his memory. It is also of note that in the aftermath, he was soon searching the internet about how to forget events and he accepted he viewed / listened to such guidance as he found. F claimed he did so to remove the lasting and repeating image of his child limp on the ring. I do not believe him. In my judgment, that account was likely merely an attempt to make the Court believe that the child

was limp on the ring- that being the indelible image. That being so, that he was looking to forget events through hypnosis, only heightens concerns about precisely what he was trying to put out of his mind.

216. His full omission lasted until July 2021 and until around the time that the argument over the extent of contact was put to bed. Only then did he start to fly the kite that he *"could"* have shaken GH as part of a resuscitative act. He claimed that it was only after the contact hearing had resolved the issues around contact, allowed him to think more about what had happened and start to have the courage to use the word 'shake' in his statement and the more esoteric offering to the Children's Guardian later in July. I noted however that he stated initially that he had put the word into his first statement hoping that others would question him and draw out his narrative more naturally. This again shows calculation and manipulation and lack of frankness.

217. In my judgment, F has always known full well what he had done to GH, and that was to shake him. He knew that the shake was vigorous. It was a deliberate decision by him to hide that from M and then the medical professionals at the hospital and the social workers. It was a ploy derived by him, to wait until the issue of contact was settled before starting to *"tip-toe"* around the truth. What he did was to raise it in his statement equivocally, *'he may'* have shaken and then ambiguously *'as part of a resuscitation he may have harmed him'* to the Guardian and M. It was not until the week before this hearing commenced that he filed his statement saying he was 99% certain that he shook him- it is of note that he has never reached 100% certainty and has remained dancing around the concept of certainty of his actions even at this hearing, providing no real detail.

218. At the end of the day, a shaking mechanism is a deliberate act. He was also a firefighter and well versed with dangerous/ emotive/ fast moving and stressful incidents. He is trained to deal with those incidents and whilst I accept that this was his child and not a stranger- his training would have taken over, as his own account describes. It does not explain or excuse his refusal to mention with any clarity until the 11th hour that he shook his child and with sufficient force to have caused all the intracranial, spinal and retinal injuries.

219. I have accepted the expert evidence that the description of there being a bare shaking mechanism action by F, can explain the features seen on the scan and the child's presentation. However, I do not accept F's assertion that he cannot remember GH's head moving backwards and forwards unsupported (although he claims he does so involuntarily, he

mimics the motion whenever recalling the incident). It strains all credibility that he is able to clearly recall all the other motions which might explain how the injuries occurred accidentally, he was able to describe scooping him up quickly under his arms from the couch when the child had a funny turn that morning and initially went limp; he was able to describe carrying out chest compressions; he was able to describe running with him into the hospital unsure if the head was supported. Indeed, almost every feature of the various motions referred to in the case law that has been placed before me, as examples of potential alternatives causes or contributors to a deliberate shaking and which, in itself, is quite a coincidence. I accept that each of these actions described by F potentially fits the requisite description of the child's unsupported head and neck experiencing acceleration and de-acceleration type movements with the resulting signs and symptoms seen on the 5th May 2021 when he arrived at Hospital. However, the difference is evidence in respect of the degree of retinal haemorrhages and the presence of spinal blood that I have already referred to. These are the key to my finding to rule out these other motions as the cause of the injuries in this case. I also rely on F's reluctance to mention the shake and I infer that he has done so to deliberately to avoid any finding that he caused these injuries deliberately. The other points of possible cause or contribution are all a likely contrivance in my judgment, to minimise his actions. They are a smoke screen.

220. The level of the deceit and playing on words has been of concern when set against the failure to bond and the text messages about his feelings for his son. I have been careful not to read much into those text messages. I accept at the end of the day that they were not meant to be taken literally and as such, they do not assist me greatly in terms of what happened on the key morning. In any event, there was a gap in time between those texts of concern and that morning and the evidence was that he had worked out the issues.

221. Whilst F is now also able to describe that he almost certainly did shake GH in a blind panic by picking him up under his arms and shaking him, he had only recently recalled this event. However, he alleges that he still doesn't recall for how long and with what vigour he acted and therefore, I have not been provided with any detail by F of the shake itself. Indeed, I accept Dr Cartlidge's vivid evidence that for the shake to cause the injury, the head would need to have gone back and forth *"to an alarming extent".* What is clear in my judgment is that from the outset F decided that he would withhold from M and also the medical and social work professionals and assessors the key information that he shook GH. As a result, GH was denied his right to have his case properly considered by the medical teams and as such he was placed at risk of harm. Further, the children were deprived of their M's care for many months of these proceedings/ greater contact with her.

222. I am satisfied that F was scared by what had happened that morning and of his own actions and knew the implications of mentioning the word 'shaking' in any description of what had happened to his son. Despite raised suspicions, I cannot get away from the fact that the parents had been raising issues with this child from shortly after birth. Something had also happened on the 22nd April 2021, though F has created (assisted by M) confusion of the extent of that incident. I cannot ignore these factors and nor can I ignore the expert evidence that children of this age do have 'funny turns'.

223. It was of note that he chose to correct M on her alleged misreporting of his chronology of when GH went limp within her interview, but he deliberately chose not to share with her that he had changed his narrative in his statement to one where he now accepted shaking the child. It is clear evidence of a man who was placing his own needs and concerns above those of the child and was deliberately Delphic and full of obfuscation with M. He was prepared to throw his partner under the proverbial bus, to preserve himself.

224. In my judgment, he has acted with a lack of transparency and has sought to deceive those involved throughout, even those closest to him. He has sought to place himself as GH's saviour on the 5th May 2021- the father who revived him from death. It is a shame that he was unable to show any heroic quality or even any common decency by placing the needs of his son and family above saving his own skin.

225. I am of the view that M was more than willing to believe his heroic narrative of being the saviour of their child, rather than challenge his version, and she did so by hiding her head in the sand. That is likely reflected in her rhetorical question to Dr H -how she could have missed it if someone was harming her child? That question suggests that her mind had turned having been told that day that this was indicative of NAI and to something abusive as having likely happened and she, knowing that it was not her, must have turned to consider F as being the likely perpetrator, of any abuse. Thereafter, it seems she has avoided the issue of the reading the full medical reports that were filed and /or read his statements and thus been able to challenge his developing narrative. She did so, in all likelihood, because she did not want to contemplate anything deliberately abusive had been done and shielded herself from the gathering evidence. It is a weakness that will need to be addressed in the future, but it is not a bar to her caring for the children.

226. However, I remind myself of the R v Lucas direction when considering whether F's lies and deceit emerged because he had acted abusively towards GH. Of course, there are many reasons why people lie and in a case such as this I have to consider that F likely thought of the impact on his career, his family and also potential for criminal proceedings had he come out with the truth from the outset. These are plausible reasons why he may have deceived from the outset and only recently found his way to what he claims is the truth.

227. The medical evidence which I accept supports his description of events as he now states them to be, that a shake occurred. I found his evidence around scooping up the baby and running to hospital with the baby's head free to roll around utterly unconvincing. I have more time for his description of the attempts to resuscitate the child because it is likely that his training would have kicked in with the child limp and lifeless.

228. The crucial question for me is the sequence of whether the timing of F shaking GH was after GH went limp, rather than before he did so. The key piece of evidence on this is the fact that M was consistent with relaying the account given to her by F on that morning that GH went limp after he picked him up and not whilst on the ring. It was what she told the police in her interview and the one element that F decided to challenge her upon. In her evidence, she accepted that she may have got the sequencing wrong in the interview having been reminded by F.

229. I have considered this aspect at length. In my judgment, it is more likely on balance, that GH went limp/lost consciousness after the shake from his father- after all that was the account that M was happy enough to provide to the police initially. This is the usual presentation for a child after a shake has been administered in these cases and where the injuries we have seen have been caused. M had nothing to gain from giving that account initially and it is more likely than not to have been the version provided to her by F immediately. F has shown himself to have been slippery with the truth and ready to gaslight M, as discussed earlier and therefore, care has to be taken when taking his account at face value.

230. However, the Local Authority have not discharged their burden to meet their allegation that GH was shaken as an act of abuse or frustration. I am satisfied that F found himself in a position of panic with a child showing difficulty in breathing and shook GH with significant force, and likely more than was intended. I have to accept that it would be difficult to weigh to a nicety the kind of force used on that kind of occasion. F is a tall, powerful man and GH

was a tiny baby with little or no strength to support his head. There is no way of precisely measuring the amount of force required to have caused these intracranial injuries. Simply that enough force with enough acceleration and deceleration / rotation is used to make the brain wobble within the cranial cavity but the injury to the eyes was crucial in understanding the degree of force used.

231. I have taken into account the following factors which I found most salient in reaching that conclusion: (i) The parents accepted that GH was fractious, screaming baby and one who did not like his head being touched nor anything being placed over his head and he settled only when held in a slightly unusual position from a cranial point of view, namely flopping over the arm of the holder; (ii) They accept that this situation placed stress on them and their relationship; (iii) F has no antecedent record and is a hard working firefighter; (iv) No issues have arisen in respect of his older child, IH; (v) There has been no earlier involvement with the Local Authority/ police (vi) There is no issue around alcohol or drugs; (vii) There is no evidence of argument or upheaval within the home on the morning of the 5th May 2021 (viii) Of great importance to me is that there are none of the usual factors seen in cases of abusive shaking, for example, fractured ribs (especially to the posterior) nor of any bruising caused by grabbing or squeezing as part of a shake; (ix) It is also of note that GH made a very swift recovery.

232. These aspects tend to point away from (a) a person more of a risk/ commonly seen as deliberately causing this type of injury and (b) a malicious shake or shake out of frustration.

233. On balance, I therefore find that the injuries were caused by F on the morning of the 5th May 2021, when M was at the nursery. It is likely that GH had a 'funny turn' on the sofa and subsequently went limp either as an accidental / unintended result of F shaking him as part of an attempt to resuscitate him and did so with such force to cause the injuries. The shake was a deliberate but instinctive action in a moment of panic and NOT malicious/ abusive. The force applied by F was sufficient to cause all the intracranial, ocular and spinal injuries reflected in the medical evidence.

234. F deliberately lied to the medical professionals and other professionals and to the Court about his shaking GH on the 5th May 2021. It is likely he did so to avoid blame/ suspicion being placed upon him or his being perceived as a perpetrator. He has also not been wholly truthful to the Court and has remained ambiguous about the specific act of shaking and that has been deliberate. In maintaining a calculated and protracted deceit/ vagueness he has not

been wholly open and honest with the court process. As such, and for the above reasons, he has placed his own interests above those of GH and has consequently failed to protect his son.

235. In respect of M, her position is more nuanced and is centred around any finding that I make about her failure to protect/ furnish all information within her knowledge and whether she has been complicit in F's obfuscation. Firstly, when I consider her immediate actions on the 5th May 2021, I accept the parents' evidence that as soon as she realised there had been a critical incident, she assisted F call 999 and get their son to hospital. Her history of parenting prior to these proceedings has been faultless and without involvement of the Local Authority / police. She is a loving and caring mother for her three children.

236. The first real issue is whether she has been totally honest with professionals about what ailed GH and particularly around the information passed to the GP on the 23rd April 2021.

237. In my judgment, M is a proven loving, caring, nurturing mother to her three children. I have really struggled with the idea that M deliberately lied by omission to the doctors about GH and his symptoms. However, it is clear that she has either done that to protect F or she has been complicit in supporting F and his lies about the events of the 22nd April 2021 and the collapse and also the matters around GH not being able to cope with things touching his head and in addition, change her version to support his chronology over when GH went limp on the 5th May 2021, again to protect F.

238. Firstly, I have been properly reminded by Mr Storey QC that the issue of failing to protect has recently been the subject of consideration by King LJ in ***Re LW*** [2019] EWCA Civ. 159 in which she warned of the danger of a "*serious finding"* by way of failure to protect being a "*bolt on"*. Ultimately, failure to protect must sit within a framework in which a mother can foresee the real possibility that the child is going to suffer damage at the sort of level that it eventually does prior to it doing so. King LJ had also said in ***Re GLT*** [2019] EWCA Civ. 717, at paragraph 72 that the question of failure to protect needs to be looked at with "*assiduous care"*.

239. My attention has been drawn to the contents of the statements of Dr A at **[E259]** in which on 8 April in a face to face interview M had described GH as being unsettled for the previous three weeks, she had tried different milks and was observed to be sounding frustrated with GH's symptoms and felt that something wasn't right. She had sought

assistance from Dr Rr who records at **[E355]** "*M described GH as screaming, crying when fed on 23 April, of ongoing screaming with feeds and episodes of being unsettled"*. A discussion with the health visitor, Miss B-R had the mother describing the child in particular on the 26th March 2021 through text messages as a screaming baby, that she hoped he would settle, and that she was having a few issues. By the 8th April 2021, she was describing him as being unsettled and screaming. M was also in regular text communication with the health visitor, along with there being telephone and video calls.

240. I therefore accept that this baby was being seen regularly by medical personnel, family members and was regularly photographed. I accept this was largely due to the fact that both parents were worried after two weeks of his birth that something was wrong with their baby.

241. However, it is the absence of accurate reporting of the 22nd April 2021 incident which draws the eye, particularly when observed against the background of appropriate attention being sought out on all other occasions. Mr Storey QC invited me to consider Dr Rr's note of her meeting with M on the 23rd April 2021, in which the doctor recorded "*worse again yesterday"*. Dr Rr gave evidence that she had no independent recollection of the conversation. However, she was equally adamant that had she been told that there had been a collapse the night before she would have noted the same and taken action. I accept her evidence. That does not require independent recollection. Any reasonably proficient doctor told of a baby stopping breathing /collapsing the night before would have recorded the same and investigated further. It is also of note that despite the consultation and discussions that followed the true picture of what occurred on the 22nd April 2021 was not mentioned until after the main critical collapse on the 5th May 2021- and I note what she told Dr Rr above- which also specifically excluded mention of the seriousness of the event on the 22nd April 2021. I am afraid that *"worse again yesterday"* does not cut it, in circumstances where it is M's case that she planned to inform the GP the next day of the occurrence. It is surprising that she did not do so and therefore, I find that it was a deliberate omission on her part because an intelligent caring mother would not have forgotten something so crucial to her son's wellbeing.

242. Further, she also failed to raise the key issue that GH was crying whenever his head was touched. I reject the submission made by Mr Storey QC that "this may be said to be requiring utopian perfection in terms of mothering, as opposed to reasonable parenting". I conceded that the evidence is that this child cried for a number of reasons and on a number of occasions, however the main reason was his head being touched or something being put

over his head. I reject any submission that this was a factor which was inadvertently missed out by M. From all other aspects of their evidence it was the focal point of the parental concern. To have decided (and it must in my judgment have been a deliberate omission) not to have mentioned this important and significant feature of his presentation was either another example of M failing to protect GH by omission or it is not truthful in the first place and M has continued the fabrication. I prefer the former.

243. Thus, whilst it is correct to say that M kept all professionals alerted to the fact that there were problems with GH, as shown in the GP print out, where she stated there was extreme unsettlement and ongoing issues with screaming throughout the period of the 8th April 2021 and 23rd April 2021. What she failed to relay were the two most pertinent facts: (a) the incident on the night of the 22nd April 2021 and (b) that his distress was mostly triggered by contact with his head.

244. Nor was M open and honest about the difficulties that F had encountered with his bonding with GH. The health visitor Ms B-R spoke to M on the 21st April 2021 and recorded that "*She reported that she felt F was enjoying GH and bonding well with him"*. I am not rushing to overly criticise M about this false picture because maybe M was genuinely reluctant to share the difficulties that the couple were having because it was private and she was worried of the impact of such information might draw concern, or it may have been that matters were by then slightly better, as both parents attested. It is also of note that Ms B-R concluded her statement saying that the couple sought advice and support when needed. However, it is another example when looked against the whole evidential backdrop that M was not as open as she might have been about the issues within the home, even to professionals with whom she enjoyed a rapport. It is clear that at the very least both M and F were under a lot more stress than they were prepared to admit at the time.

My Findings

245. The Local Authority has NOT discharged its burden to prove that Threshold is met on its pleaded Threshold document at B30-31. I have referred myself to the Local Authority Threshold document at B30-31 and for the sake of completeness I have set out to my findings in respect of Threshold as pleaded in Annex C.

246. However, I make the following findings regarding the outstanding factual issues and which are based on the evidence at this hearing. I do so that all actual relevant findings are placed in one section of this Judgment:

(a) On the 5th May 2021, GH experienced an apnoeic episode while in the sole care of his father, presenting as limp and lifeless.

(b) Further, on the 5th May 2021, and whilst in the sole care of his father, GH sustained:

- multiple subdural haemorrhages over both cerebral hemispheres;
- a subdural bleed within the posterior fossa;
- bilateral subdural collections over both cerebral hemispheres which, given their slightly higher density than cerebrospinal fluid, are considered to be haemorrhagic;
- thin intraspinal subdural haematoma;
- multiple bilateral intraretinal haemorrhages.

(c) The injuries are traumatic in origin. They are NOT inflicted and are NOT consistent with GH having been deliberately shaken abusively by his father on the morning of the 5th May 2021.

(d) The degree of force necessary was administered in a situation of panic at what seemed like a medical emergency to GH. It was of sufficient force to have caused all the above intracranial, spinal and ocular injuries.

(e) The said shake was likely part of a resuscitation and done in panic but was sufficiently vigorous to have caused GH's head to accelerate and decelerate/ rotate, causing all the said injuries. As such the injuries were likely NOT deliberately inflicted.

(f) GH sustained the above injuries while in the overall care of Father and were caused by Father but as part of a resuscitative event.

(k) Mother was NOT present at the time, and would NOT have known or ought to have known the child was likely to be injured and therefore did NOT fail to protect the child on the morning of the 5th May 2021.

(l) Neither parent had been open and honest with medical professionals, health visitor, social work professionals regarding an earlier incident of concern regarding GH on the night of the 22nd April 2021, when he went limp /lifeless whilst in his father's care and whilst mother was upstairs.

(m) In respect of the above neither parent informed the professionals of the significance of his scream and cry 'like not heard before' nor of his limp/lifeless presentation, despite many occasions to do after the 22nd April 2021. These were deliberate omissions by the parents.

(n) As a result of (l) and (m), GH was placed at risk of harm by his mother and father.

(o) Neither parent had been open and honest with the professionals about the tensions within the home due to GH's fractious presentation post-birth and in particular Father's difficulty to bond with GH and the impact that had on the family. This was important information and was deliberately withheld from the General Practitioner and Health Visitor.

(p) Neither parent had been open and honest with health or other professionals until GH's admission to hospital on the 5th May 2021 regarding the distress caused to GH by any contact with his head, most often seen when being dressed and undressed. This was important information and was deliberately withheld from the General Practitioner and Health Visitor.

(q) The father has deliberately withheld from all professionals, including the treating clinicians at the hospital, social workers and the author of the parenting assessment that he had shaken GH on the morning of the 5th May 2021. He has also hidden the fact that he shook GH from Mother. Father only admitted that he was "99%" certain that he had shaken GH in a statement dated the 1st December 2021. The impact of that has placed GH at risk of significant harm initially during his treatment at the hospital. There has also been significant emotional harm

suffered by IH and GH of being kept apart from their mother for far longer than was necessary because of father's lack of candour.

247. For clarity, paragraphs (l) –(q) above were not pleaded as Threshold issues by the Local Authority. However, they were factual issues that were raised within the fact-finding hearing and required determination and are likely to have had a significant impact on the way that GH was medically managed both pre and post the 5th May 2021 and also on the way in which these proceedings have been proceeded. It should be noted that the Local Authority were provided with an opportunity to amend their Threshold pleading following the conclusion of the evidence and they chose not to do so. As a result, (l) – (q) are not Threshold findings but they are important findings that I have made based on the evidence.

248. I have been asked to specifically consider whether the child did in fact go limp during the previous incident on the 22nd April 2021. As I have stated, there is conflicting evidence around this incident from F. However, I am satisfied that there was an episode that night where GH had a 'funny turn' and I am satisfied that he may have momentarily gone or appeared limp as part of that episode. I am satisfied that this was NOT as a result of an abusive act by F (or anyone) and was likely organic in nature. It is thus the failure to raise the same with the professionals that lends itself to my findings in (l), (m) and (n) above.

Discussion

249. In terms of the route map forward, I have already directed at the conclusion of the evidence and having received the written submissions and prior to reserving my Judgment that M should be returned immediately to a position of living with the children under appropriate supervision.

250. Having now considered matters in the round, I see no reason why there should not be a full re-habilitation in the near future with F being re-united with the family. The risks of this kind of event re-occurring are now far reduced given GH's age and the lack of issues in his presentation currently and the otherwise good parenting that has occurred. I am sure that the family have learnt a valuable lesson from these proceedings. There is a need for some educative work for the parents around the issues that I have flagged within this Judgment, but I do not see that this is something that is necessarily extensively prolonged in nature.

251. I will deal with the issues of the work and other directions outside this Judgment.

252. I wish to thank the advocates for their assistance throughout.

His Honour Judge Philip Harris-Jenkins

Dated: January 2021.

Annex A

AGREED LAW

(Derived from the judgment of Williams J in Re Z (Fact Finding, Fatal Head Injury, Domestic Abuse) [2021] EWFC 92)

The burden and standard of proof

1. In order to make a care or any public law order the Local Authority must prove that the situation justifies the intervention of the State. This means that the Local Authority must establish the statutory threshold set out in s.31(2) Children Act 1989.

> *(2) A court may only make a care order or supervision order if it is satisfied –*
>
> *(a) that the child concerned is suffering, or is likely to suffer, significant harm; and*
>
> *(b) that the harm, or likelihood of harm, is attributable to –*
>
> *(i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or*
>
> *(ii) the child's being beyond parental control.*

2. In respect of the task of determining whether the 'facts' have been proven, the following points must be born in mind, as referred to in the guidance given by Baker J in *Re L and M (Children)* [2013] EWHC 1569 (Fam) confirmed by the President of the Family Division in In the Matter of X (Children) (No 3) [2015] EWHC 3651 at paragraphs 20 - 24. See also the judgment of Lord Justice Aikens in Re J and *Re A (A Child)* (No 2) [2011] EWCA Civ 12, [2011] 1 FCR 141, para 26

3. The burden of proof is on the Local Authority. It is for the Local Authority to satisfy the court, on the balance of probabilities, that it has made out its case in relation to disputed facts. The parents have to prove nothing, and the court must be careful to ensure that it does not reverse the burden of proof. As Mostyn J said in [Lancashire v R 2013] EWHC 3064 (Fam), there is no pseudo-burden upon a parent to come up with alternative explanations [paragraph 8(vi)]. Therefore, there must be real care not to assert that if the court finds that the parents are unable to provide an explanation for any of the injuries that Z has sustained that this therefore results in the conclusion that the explanation must be a malevolent one.

4. The standard to which the Local Authority must satisfy the court is the simple balance of probabilities. The inherent probability or improbability of an event remains a matter to be taken into account when weighing probabilities and deciding whether, on balance, the event occurred [Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35 at paragraph 15]. Within this context, there is no room for a finding by the court that something might have happened. The court may decide that it did or that it did not [Re B at paragraph 2]. If a matter is not proved to have happened, the court must approach the case on the basis that it did not happen.

5. Findings of fact must be based on evidence, and the inferences that can properly be drawn from the evidence, and not on speculation or suspicion. The decision about whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and

should have regard to the wide context of social, emotional, ethical and moral factors [A County Council v A Mother, A Father and X, Y and Z [2005] EWHC 31 (Fam)].

6. The court considers expert evidence alongside all the other evidence. Rather, it must take account of a wide range of matters which include the expert evidence but also include, for example, its assessment of the credibility of the witnesses and the inferences that can properly be drawn from the evidence. The court must take into account 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.

7. The opinions of medical experts need to be considered in the context of all of the other evidence. 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. It is important to remember that the roles of the court and the expert are distinct and it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision. Cases involving allegations of this nature often involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others. When considering the medical evidence in cases where there is a disputed aetiology giving rise to significant harm, the court must bear in mind, to the extent appropriate in each case, the possibility of the unknown cause [R v Henderson and Butler and Others [2010] EWCA Crim 126 and Re R (Care Proceedings: Causation) [2011] EWHC 1715 (Fam)]. Today's medical certainty may be discarded by the next generation of experts. Scientific research may throw a light into corners that are at present dark. “That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."

8. In *BR (Proof of Facts), Re* [2015] EWFC 41 Peter Jackson J (as he then was) stated:

“8. Each piece of evidence must be considered in the context of the whole. The medical evidence is important, and the court must assess it carefully, but it is not the only evidence. The evidence of the parents is of the utmost importance and the court must form a clear view of their reliability and credibility. 9. When assessing alternative possible explanations for a medical finding, the court will consider each possibility on its merits. There is no hierarchy of possibilities to be taken in sequence as part of a process of elimination. If there are three possibilities, possibility C is not proved merely because possibilities A and B are unlikely, nor because C is less unlikely than A and/or B. Possibility C is only proved if, on consideration of all the evidence, it is more likely than not to be the true explanation for the medical findings. So, in a case of this kind, the court will not conclude that an injury has been inflicted merely because known or unknown medical conditions are improbable: that conclusion will only be reached if the entire evidence shows that inflicted injury is more likely than not to be the explanation for the medical findings.”

9. The evidence of the parents and of any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the

fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them [Re W and Another (Non-Accidental Injury) [2003] FCR 346].

10. When seeking to identify the perpetrators of non-accidental injuries, the test of whether a particular person is in the pool of possible perpetrators is the balance of probabilities [Re S-B (Children) [2009] UKSC 17], the first stage being to identify any person who had the opportunity. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interest of the child. The court must not assume that because Person A is more likely to have inflicted the injury than Person B that this establishes on the balance of probability that it was Person A. Where it is impossible for a judge to find on the balance of probabilities, for example that parent A rather than parent B caused the injury, neither can be excluded from the pool and the judge should not strain to do so [Re D (Children) [2009] 2 FLR 668 and Re S-B (Children)]. Where a perpetrator cannot be identified, the court should seek to identify the pool of possible perpetrators on the basis of the real possibility test, namely that if the evidence is not such as to establish responsibility on the balance of probabilities, it should nevertheless be such as to establish whether there is a real possibility that a particular person was involved. When looking at how best to protect child and provide for his future, the judge will have to consider the strength of that possibility as part of the overall circumstances of the case [Re S-B (Children) at paragraph 43]. The need for care to be taken not to reverse the burden of proof when the court considers the pool of perpetrators was considered in *B (Children: Uncertain Perpetrators)* [2019] EWCA Civ 575. [para 48]

"*Centrally, it does not alter the general rule on the burden of proof. Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool': see* Re S-B *at [43]. Approaching matters in that way risks, as Baroness Hale said, reversing the burden of proof.*"

11. Where there are only two possible perpetrators the court must survey the evidence as a whole as it relates to each individual in order to arrive at a conclusion about whether the allegation has been made out in relation to one or other on the balance of probabilities. Evidentially this will involve looking at them separately and together no doubt comparing the probabilities in respect of each of them. The question the court must ask is "*does the evidence establish that this individual probably caused this injury*" and not who is the more likely. [**Re B (a child) 2018 EWCA civ 2127**, set out at paragraph 21.]

12. There is no burden on parents to prove accidental cause. In the Popi M case [1985] 1 WLR 948 Lord Brandon identified the dangers of the court reaching a conclusion by reliance on the exclusion of other possible causes.

"My Lords, the late Sir Arthur Conan Doyle in his book The Sign of Four, describes his hero, Mr. Sherlock Holmes, as saying to the latter's friend, Dr. Watson: "How often have I said to You that, when You have eliminated the impossible, whatever remains, however improbable, must be the truth?" It is, no doubt, on the basis of this well-known but unjudicial dictum that Bingham J. decided to accept the shipowners' submarine theory, even though he regarded it, for seven cogent reasons, as extremely improbable.

In my view there are three reasons why it is inappropriate to apply the dictum of Mr. Sherlock Holmes, to which I have just referred, to the process of fact-finding which a judge of first instance has to perform at the conclusion of a case of the kind here concerned.

The first reason is one which I have already sought to emphasise as being of great importance, namely, that the judge is not bound always to make a finding one way or the other with regard to the facts averred by the parties. He has open to him the third alternative of saying that the party on whom the burden of proof lies in relation to any averment made by him has failed to discharge that burden. No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so. There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take.

The second reason is that the dictum can only apply when all relevant facts are known, so that all possible explanations, except a single extremely improbable one, can properly be eliminated. That state of affairs does not exist in the present case: to take but one example, the ship sank in such deep water that a diver's examination of the nature of the aperture, which might well have thrown light on its cause, could not be carried out.

The third reason is that the legal concept of proof of a case on a balance of probabilities must be applied with common sense. It requires a judge of first instance, before he finds that a particular event occurred, to be satisfied on the evidence that it is more likely to have occurred than not. If such a judge concludes, on a whole series of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense. This is especially so when it is open to the judge to say simply that the evidence leaves him in doubt whether the event occurred or not, and that the party on whom the burden of proving that the event occurred lies has therefore failed to discharge such burden."

13. Drawing on this Lady Justice King in *A (Children)* [2018] EWCA Civ 1718 stated that:

"57. I accept that there may occasionally be cases where, at the conclusion of the evidence and submissions, the court will ultimately say that the local authority has not discharged the burden
of proof to the requisite standard and thus decline to make the findings. That this is the case goes hand in hand with the well-established law that suspicion, or even strong suspicion, is not enough to discharge the burden of proof. The court must look at each possibility, both individually and together, factoring in all the evidence available including the medical evidence before
deciding whether the "fact in issue more probably occurred than not" (Re B: Lord Hoffman).

58. In my judgment what one draws from Popi M and Nulty Deceased is that:

(i) Judges will decide a case on the burden of proof alone only when driven to it and where no other course is open to him given the unsatisfactory state of the evidence.

(ii) Consideration of such a case necessarily involves looking at the whole picture, including what gaps there are in the evidence, whether the individual factors relied upon are in themselves
properly established, what factors may point away from the suggested explanation and what other explanation might fit the circumstances.

(iii) The court arrives at its conclusion by considering whether on an overall assessment of the evidence (i.e. on a preponderance of the evidence) the case for believing that the suggested event happened is more compelling than the case for not reaching that belief (which is not necessarily the same as believing positively that it did not happen) and not by reference to percentage possibilities or probabilities."

14. In R v P (Children: Similar Fact Evidence)[2020] EWCA Civ1088 the Court of Appeal at paras 24-26 considers when and how the court should rely upon propensity/similar fact evidence:

"24. *This analysis, given in a civil case, applies also to family proceedings. There are two questions that the judge must address in a case where there is a dispute about the admission of evidence of this kind. Firstly, is the evidence relevant, as potentially making the matter requiring proof more or less probable? If so, it will be admissible. Secondly, is it in the interests of justice for the evidence to be admitted? This calls for a balancing of factors of the kind that Lord Bingham identifies at paragraphs 5 and 6 of O'Brien.*

25. Where the similar fact evidence comprises an alleged pattern of behaviour, the assertion is that the core allegation is more likely to be true because of the character of the person accused, as shown by conduct on other occasions. To what extent do the facts relating to the other occasions have to be proved for propensity to be established?...

26. Again, this analysis is applicable to civil and family cases, with appropriate adjustment to the standard of proof. In summary, the court must be satisfied on the basis of proven facts that propensity has been proven, in each case to the civil standard. The proven facts must form a sufficient basis to sustain a finding of propensity, but each individual item of evidence does not have to be proved."

Lies/Withholding Information

17. 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 at all times that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear, and distress. The fact that a witness has lied about some matters does not mean that he or she has lied about everything [R v Lucas [1981] QB 720]. It is important to note that, in line with the principles outlined in R v Lucas, it is essential that the court weighs any lies told by a person against any evidence that points away from them having been responsible for harm to a child [H v City and Council of Swansea and Others [2011] EWCA Civ 195].

18. The Family Court should also take care to ensure that it does not rely upon the conclusion that an individual has lied on a material issue as direct proof of guilt but should rather adopt the

approach of the Criminal Court, namely that a lie is capable of amounting to corroboration if it is (a) deliberate, (b) relates to a material issue, and (c) is motivated by a realisation of guilt and a fear of the truth [Re H-C (Children) [2016] EWCA Civ 136 at paragraphs 97-100]. Lies about one aspect of a case should not lead the court to conclude that there is a lack of honesty about another category of allegations. If parents have been dishonest in various ways, it does not mean they have been dishonest in every respect and it does not mean their evidence can in effect be ignored. The weight rightly to be given to the evidence of parents who are transparently honest and reliable might outweigh medical and other factual evidence leading to a local authority being unable to prove a case on the balance of probabilities. On the other hand, the same medical and other evidence might establish the local authority's case when the parent's evidence can be given little weight because it is transparently dishonest and unreliable. That does not reverse the burden of proof but is simply the outcome of the evaluative exercise of the weight to be given to the various pieces of evidence before the court.

19. There is danger in placing too much weight on inconsistencies which may emerge from the giving of multiple accounts over time. In Lancashire County Council v The Children [2014] EWFC 3 (Fam), Jackson J (as he then was) said:

"*To these matters I would only add that in cases 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 accounts. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one-person hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural - a process that might in elegantly be described as 'story-creep' - may occur without any necessary inference of bad faith*."

21. When assessing and weighing the impression to be formed of parents, Macur LJ in *Re M (Children) [2013] EWCA Civ 1147* observed*:*

> *[12]* Any *judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so.*

22. The need for caution in how one evaluates the credibility of a witness and the reliability of their evidence by reference to demeanour and the need for caution in the weight to be given to demeanour in the evaluation of evidence was also articulated by Leggatt LJ in *Sri Lanka v Secretary of State for the Home Department [2018] EWCA 1391*.

23. In *Re L-W (Children)* [2019] EWCA Civ 159 the Court of Appeal allowed a mother's appeal in respect of a failure to protect finding following a Fact Finding Hearing at which her partner had been found to have inflicted serious non-accidental bruising to her daughter. Lady Justice King said that courts at a fact finding hearing must not fall into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, a finding of failure to protect is almost inevitable - and should be alert to the danger of such a serious finding becoming a "bolt on" to the central issue of perpetration (see para 64). King LJ stated the following:

"62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.

63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm."

24. In *G-L-T (Children)* [2019] EWCA Civ 717 King LJ repeated what she had said in *Re L-W* and further stated that:

"72. I repeat my exhortation for courts and Local Authorities to approach allegations of 'failure to protect' with assiduous care and to keep to the forefront of their collective minds that this is a threshold finding that may have important consequences for subsequent assessments and decisions.

73. Unhappily, the courts will inevitably have before them numerous cases where there has undoubtedly been a failure to protect and there will be, as a consequence, complex welfare issues to consider. There is, however, a danger that significant welfare issues, which need to be teased out and analysed by assessment, are inappropriately elevated to findings of failure to protect capable of satisfying the section 31 criteria.

74. It should not be thought that that the absence of a finding of failure to protect against a non-perpetrating parent creates some sort of a presumption or starting point that the child/children in question can or should be returned to the care of the non-perpetrating parent. At the welfare stage, the court's absolute focus (subject to the

Convention rights of the parents) is in relation to the welfare interests of the child or children."

CHRONOLOGY

27.10.77	Father, born (44yrs)
03.05.85	Mother, (36yrs)
06.08.02	Mn born (19yrs)
2011	F's marriage breakdown (S107 refers)
03.11.15	F GP visit. *Low mood. Turbulent 4yrs. Left wife for new partner, but relationship with partner finished 4 months ago, felt guilty for ending first marriage….would like to start SSRI*. Referred for counselling. 20mg Citalopram prescribed (S7, S107 referral form, N12)
Feb 2016?	Karuna Counselling Closure form. 4 sessions of counselling. Diagnosis of depression. CBT undertaken. F discovered that he had not recovered from his previous marriage breakdown and was allowing this to filter through to new relationships. No recommendation for further treatment but to see GP if situation changes (S105).
Aug 2016	M and F meet via online dating (F4).
16.10.17	IH born (3yrs 9m). M refers to him as a 'perfect, textbook, easy baby' (F5).
03.03.21	**GH born**. 4.4kg/9lb11oz. **HC 41cm** (above 99.6th percentile) (Qi134). M says F took week off (F7). Midwives (x3): MB (E253-4), FW (E255-7), KP (E353-4).
04.03.21	SE attends for Newborn/Infant physical exam. Mark noticed on eyelid (E242-3)
08.03.21	F goes back to work and to do friend's patio (F7)
09.03.21	FW attends the home. G has sticky eye. Heel prick test delivered (E256).
10.03.21	M visits hospital to see consultant about varicose veins. G in F's care (F10). G also seen by practice nurse for a sticky eye (H120 refers, Qi377)

11.03.21 F internet history: *Menshealth – The Trials of New Fatherhood (Ti21) & Pornhub (Police Phone files - Exhibit1 p89).*

12.03.21 G seen by nurse as umbilical cord not healed (H120 refers, Qi376)

F internet history: Google searched *"I hate my newborn son"* (Ti21-22)

12/16th March M reports that I fell on G's head when I jumping on sofa (F10 para 22 M statement; M police interview at Ti186)

16.03.21 10.17hrs. M messages F *"I'm gonna drive this baby down to you in a minute. You can deal with him. By the time he fucking settles long enough for me to nap it'll be no point as I'll have to get showered and ready to get I xx … "He's having more milk then I'm trying one more time then I'm giving up. Getting myself stressed with it as I'm so tired xx"* (Ti119)

17.03.21 HV primary birth contact by phone @10am by KB-R (C246-50, Q65, 76, 95) and Home visit at 2pm by CF (C244-5, Q64, 76, 95). **HC 38.5cm**. 98th centile. Noted to be smaller than at birth. CF HV Flying Start writes that the occiput is rounded, perfect shape but difficult to measure and M mentioned he was swollen at birth where it was reported to be 41cm (Q60-61, Q64, Q44-47, 49-59, H120 refers, Q95)

24.03.21 9.24am. M message to F. *"Don't know why I fucking bother trying to sleep. Got him to sleep eventually in his moses basket and with 10mins of me being in bed just dropping off he just starts grunting and stirring. So we're back up now having milk. I'm so bloody tired xx".* M later jokes about wanting a shotgun so she can shoot herself. F suggests that he can always put him under MXX's patio. F refers to G being a *"nightmare at the moment" (Ti66-7)*

M to F *"You had better bring me an ounce or two up before I kill him" (Ti67, Ti188)*

F internet history: *Pornhub* & Quora *"I recently became a F, but I do…"* Google: *"I have no feelings for my baby"* (Ti24) (Police Ex1. Page 166)

25.03.21 11.03am M message to F. *"I think I might ring the HV today and lay everything on the line with her. I'm close to breaking down. I dread it when he's not sleeping as I know he'll cry most of the time. He been sick a bit again after another bottle. Is that cox we've stopped the Gaviscon or just coincidence xx"* F responds: *"Ring her babes and tell exactly that. You are at your wits end and so am I xx…If I'm being honest the way he is I don't know how you are holding it together as your with him 24/7 I am dreading being at home for 6 weeks. And it shouldn't be like that xx"* (Ti69)

T/C from M to HV RT to asking for advice as G unsettled (C262-3). Several text messages sent from M to HV KB-R (H246-50) up to the 6th April 2021 re feeding, rash and umbilical granuloma. (C246-50, Q69 refers, see Q76-78 for messages, Q94)

27.03.21 22.44hrs. M message to F. *"I really hope you can see you owe me an apology for the nasty unnecessary name calling. Very horrible and hurtful".* F apologises for calling names but says he is *"angry has hell with you but doesn't excuse it".* M: *"I understand and accept you feel the way you do but calling me a tramp not just one either was very uncalled for…Seen a different side to you tonight".* F: *"I'm not nice when I'm angry. I keep a lid on it as much as I can. It's not nice when it comes out" (Ti72-3).*

30.03.21 F suggests that PGPs had sole care for 1.5hrs. Parents went to register the birth (para 29 statement & M's interview at Ti186). M says she attended at 9.30am. MGM took over after 1.5hrs.

F suggests that MGM had sole care for an hour. MSGF in garden (para 30 statement)

31.03.21 9.28hrs. M message to F. *"I am trying to nap honestly but every time I put a sleeping baby down it fucking wakes xx…This fucking baby….I just hate the fact he will sleep for hrs when I can't nap or don't want to but as soon as I need to nap he plays up like fuck. It's like he knows and does it on purpose. He's trying to break me!! Xx….Fuck he is really breaking me this morning. 30mins nap so I managed to shower now he's screaming" (Ti75-8, Ti190 M's police interview)*

01.04.21 9am. M message to F. *"I need you to do something for me. I know you don't like him and he can be a frigging twat but don't say stuff like he's having the milk and I hope he chokes on it. Especially to me or in front of me. It's not very nice thing to hear the father of your children say about 1 of his own kids. Makes me upset and angry towards you xx... we both know he's testing both our patience but I'd never say anything like that. It's just not nice xx… And this isn't a nasty text it's just letting you know how it made me feel".* F responds *"I didn't say I hope he chokes on it, I said maybe he will choke on it. And you should know full well I don't mean it you cannot take throw away comments like that literally. Fucks sake mun xx"* M says *"It's hard when I can see how negative you are towards him and then you say a nasty comment like that…It gets my back up"* (Ti80-82, Ti191 M's police interview)

06.04.21 T/C with Dr A (E258-9) who advised to clean umbilicus with salt water (C258-9, Q69 refers, Qi376)

06.04.21 M goes food shopping. G in F's care (F10 para 22 M statement)

08.04.21 F has a foot operation (F11). Sick leave begins.

T/C with Dr A (E258-9) as G reported to be unsettled after feeds and had a rash around his mouth. M stated that "something was not right" with G (E258-9, Q69 refers, Qi375)

M attends GP appt with G re him being 'extremely unsettled' and screaming. Dr A concerned that he may have a hernia and refers to paediatrics (E258-9).

M and G attend hospital at 12.35pm. G is checked out by Dr Shah (E347-50) and then reviewed by Dr A. It was not felt anything wrong with him. Discharged same day (E347-50, F11 refers, Qi375, Qi128, Qi156-169)

18.46hrs. F messages M: *"So what do we do about the screaming xx"*. M responds *"He said he can't find anything wrong with him xx"* (Ti89)

12.04.21 F internet history: Google *"Extreme colic in babies.."* (Ti35-37)

20.19hrs. F messages "B": *"..don't think I need anything other than a swap of a baby with someone"* (Ti115)

14.04.21 F says PGPs had sole care for 1.5hrs when parents had 2 house viewings (para 29 statement).

19.04.21 T/C with Dr M (E238-43) as G still unsettled and screaming after feeds and the rash still present around his mouth. M convinced something going on but paeds thought normal baby colic. G had been given Aptamil Pepti by M and was reported to be much better, M asked for the milk to be prescribed (C238-43, Q69 refers, Qi375)

20.04.21 10.37hrs. F messages "B". *"Boys are OK cheers butt. I is quality to be honest and G is becoming less of a knob and settling down now"* (Ti114)

21.04.21 HV follow up by phone by KB. G reported to be well and settled and no concerns were reported or identified. M reported that she was well, enjoying G very much and coping well with demands of a new baby and her older child I. M reported she had good support and F was really supportive. F was reported to be bonding with G well and enjoying him very much (Q69 refers, see also Q77, Q93).

21.04.21 F googling *"extreme colic in babies"* (Ti37)

22.04.21 Funny turn incident. F and M tried to go to bed at around 10pm. 10.10/15 G wanted a feed. F took him downstairs and placed him on a nursing pillow on sofa while F made a bottle. G screaming at the time and hiccupping. F fed G on nursing pillow with F sat next to him. As F put bottle in his mouth G hiccupped at same time, went red in face

and then limp. F picked him up, walked around with him, rubbed his back and bounced him. Eyes were huge and he looked terrified. G took a large breath in and began screaming again. When he settled G took his feed (G5 para 24). F gives similar account at G18 para 17. M came down to help because she heard G scream.

10.22pm: M's brother sends a text to M saying *"just walked past your house, it sounded like G crying…hard"* (G6)

M's account of the same incident. F went downstairs with G to feed him. After a few mins M hears an unusual scream for G. M goes downstairs to check everything okay. F is cuddling G to his chest trying to settle him. F gives account to M as outlined in statement. M checked G over but could not see anything wrong with him and his red face had gone down (F12).

23.04.21 T/C with Dr Rr (E355, E236 recording). G still unsettled and screaming. GP advised to continue on prescription milk (Q70 refers, Qi374)

M says she raised about G having a 'funny turn' in the night (F13)

24.04.21 M goes to a friend's home in evening for a few hours for drinks. G in F's care (para 23 M statement)

F internet history: Pornhub and livecam (Exhibit1 p277, 278, 302)

28.04.21 Clinic visit at Surgery. <u>8 week medical</u> and primary immunisations. Seen by Dr K (E260-1). Medical reported to be normal. G receives 1st immunisations for Meningitis B and Rotavirus (C260-1, H121, Q70, Q78 all refer). **HC of 43cm.** Height 63cm. Weight 5.74kg (<u>E260, Q60</u>, Qi374)

29.04.21 8.35am. M texts to F *"Just had 2oz of milk and projectile vomited it all back up"* (Ti97)

30.04.21 F suggests that MGM had sole care for about 2.5hrs (para 32 F statement). M says the same in her police interview at Ti186.

04.05.21 M visits hospital on further occasion to see consultant re varicose veins. G in F's care (para 22 M statement)

05.05.21 **WEDNESDAY. G is 9 weeks old**. Admitted to hospital after an apnoeic episode at home. Initial assessment noted G looked unwell with prolonged capillary refill time.

G treated for sepsis with fluid resuscitation and antibiotics. LP performed. G then transferred to paediatric ward (H121 refers).

2.30am. M feeds G and everything was normal. G was his usual unsettled self and was crying but nothing out of the ordinary. G had been dribbling clear liquid for approx 2 days (F14). M photos of G on the 3th and 4th at F21 and 22.

8.42am 111 call (x2) (Samsung call log)

8.44am 999 call (P1). Recording available. Transcript at Ti125-128. HX given *"I was dressing my baby this morning on the sofa. Umm, he hates it. Umm, he's held his breath and then he's gone limp, umm, I've brought him round, but he's crying and screaming now, but I think he'd gone for a minute to be perfectly honest with you. Ummm, so obviously massively concerned"*. When asked for details F suggests to the operator that G: *"held his breath in temper"* (Ti126).

8.56am Arrive at hospital (Qi170, Qi177)

9.05am Seen in A&E resus bay (Qi177)

9.15am HX to Dr A (E264-7) – paediatric registrar. Written retrospectively. Well this morning. Then cried, went red in face. Floppy. No response to stimulation. Pale then. Dad turned him over, gave him compressions from back. No response. Put his hand to cold water; no response. Gradually started to come back.. Acc to dad lasted between 2-10 mins. Not sure. (E264-7, Qi191)

9.30am HX given. With dad. Recently fed. Lying flat. Went floppy, pale & unresponsive. Dad unable to raise. Started CPR. Started crying. Brought to ED. Further episode in ED. Floppy….responded to stimulation (Qi183)

10.30am Admission to PAU (Qi186). Nursing notes indicate that F said G had been crying and arching back for few weeks (Qi189)

Time? Qi45-47 Dr H note of HX on 5th May. Seen in ED at approx 9.30am. Very well in the morning. Episode of crying then went red in face. Floppy and lifeless. Dad tried to stimulate the baby at the time. Not responding... *(Qi45)*

CT scan. Revealed bilateral subdural collections involving frontal and parietal regions, high attenuation in the region of the falx and overlying the right frontal and parietal lobes, further areas of extra axial high attenuation and also seen in the left frontal and parietal regions, ventricles are symmetrical and not dilated, no obvious intraparenchymal legion or mass affect and no obvious bony abnormality. Conclusion:

bilateral subdural collections with evidence of acute extra axial haemorrhage in both hemispheres (Qi12, H207 refers)

Qi48-50. Further HX in records for 5th May. Dr H discussion recorded by Dr A: When dad was dressing him, G started crying, went red, then limp, dad stimulated, some stimulus, cold water on hand, improved, have a big scream and improved. Mum came in.…On 22/4/21, 22.30 put him on sofa on ring while dad was getting milk ready, had approx 1oz; has winded him then screamed; breath held, limp few seconds then resolved.

Qi60. HX provided by F to Dr A for CP medical. G was awake. Approx 8am when F was dressing G, G started crying, went red, then limp. F stimulated G, tried poking and put cold water on G, no response. Dad turned G and gave chest compressions from the back. G improved. M arrived. Lasted 2-10 mins (F not sure).

1pm Hospital make safeguarding referral to LA. Completed by CNS Safeguarding EJ (Qi124-127)

1st strat meeting. Unexplained injuries. Joint s47 CP investigation with Police (N1-7, HV entry at Q93). *1.15pm? Qi52?*

3pm **HC of 44.2cm** (Qi53)

Parents account to OW: E268-70

M gives account of G being more challenging that I and that he had a tendency to scream etc. Parents made ref to previous limp episode on 23rd April and they had spoken to GP about it at the time (E269). M was worried something medically wrong with G due to him being born with large head and issues with feeding. Sensitive and could get agitated when touched.

Parents said they had been through everything in their heads trying to work out what could have happened (E269)

F explained that M had taken I to nursery and when she was out G had episode where he stopped breathing. F said he laid G on his front to stimulate him by pressing his back. When this didn't work he splashed water on his face with brought him around. Both M and F appeared to be in shock (E270)

M's CA account is at paragraph 29 of her statement dated 21st July 2021 (F13). F already up with the boys. M decided to take I to nursery for a change. M says that her interaction with G was limited and she did not pick him up that morning. M left with I

at approx 8.10/15am and returned at approx 8.40am (away for 25-30m). F was leaning up against kitchen units with G in his arms. M joked about "being hard at work" and F replied "he just died on me". F said he was getting G dressed and he suddenly went limp. He did CPR. M told F to pass G to her and dial 111. F squatted down in shock. G whimpering rather than full cry. F dialled 111 and was going thru the options when G began screaming more than he ever had before. M told F to call 999 straight away and tell them they were on way to hospital (F13).

F14. Later conversation between M and F: F is asked exactly what happened. G had been dribbling. F noticed how wet G was and went to change his clothes. F placed G in his ring and started undressing him. G hates getting dressed and started to scream. G managed to get his vest on and half put G's t-shirt on before G went really red faced. Then F suggested either (i) G went limp and F picked him up or (ii) F picked him up and G went limp. M unable to recall which and F will have to confirm. F tried to wake G up but he was unresponsive and he could not see or hear him breathing. F did CPR chest compressions and tried to get response by calling his name, pinching his ear and putting cold water on the back of his hands. Then, shortly before M arrived, G let out a loud scream and seemed to be taking in breath (F14).

F's CA account paragraph 11-22 of his statement dated 21st July (G3). F woke at 6-6.30am. Fed G his bottle and got I ready for nursery. M woke up. F went upstairs to get ready thinking that he was taking I to nursery. M decided she would do it. M left at 8.15 with I. G's clothes wet from dribbling and F went to change them. G had been on nursing pilot on the L part of the sofa. F placed him on changing mat in same location. F took sleep suit off and left him on mat to get clothes from upstairs. F put trousers on G. Attempted to put long sleeve top on him, got both arms in but G screaming and getting worse. G made himself completely stiff. Went red in face and eyes began to bulge. Do not know if he held his breath or had some sort of fit. He went completely limp, red in the face and head stopped moving. Lifeless. F grabbed him, picked him up and walked with him. Tried to wind him, bounced him and called his name. I think I could have shaken him and called his name to try and wake him. I could have shaken him whilst holding both hands under his armpits to wake him. I was walking with him. It is all a bit of a blur to me. Put G in palm of left hand with back towards F. F tried to do some compressions on his back. No movement from G. Took him to kitchen. Placed him on table and performed CPR. Rescue breaths given 6-7. Compressions using 2 fingers – less than 20. Could hear breathing but it was shallow. Tried to pinch ears to make him cry but he did not. Moved to kitchen sink and ran cold water on his right arm to get a reaction. Put a little water on his lips and got a small cry and a little movement of his hand/arm (G4). All of the above was about 2 mins. M then arrives and asks "Has he been hard work?". F says he breaks down in tears and said "I think he just died on me".

06.05.21 **THURSDAY** 10am Dr H explains to parents the CT findings of SD. Would need MRI be would be delayed until tomorrow to make sure G is stable. May have to stay a week. M asked about other causes for bleeds apart from trauma. It was explained that blood tests being done. Dad said that it is quite hard for him to undergo this despite being good parents and was tearful (Qi202).

Dr H went through the history on 6th May with both parents present on the ward round. F gave a history that G had been completely well in the morning. M left house with older sibling to drop at nursery. F was starting to dress G at approx 8.30am. G started crying. Dad described that he went red in face. He then went limp. F tried to stimulate him. He turned him over and performed compressions on his back. Put his hands in cold water to stimulate him. F could not say how long the whole episode lasted, however probably a number of minutes. Mum came back to the house at approx 8.40. At the time G had come round. Called 111 then 999….both say G had a similar episode 12 days ago. Unsettled crying and going red. Again at the time he was very unsettled and crying and going red. He was not limp. He settled after a very brief period of time (Qi205).

Skeletal survey. No injuries (Qi11).

07.05.21 **FRIDAY** 9.30am **HC 44.3** (Qi395 repeated at Qi207). F account to Dr R: *M took the other child to nursery at 8.15am, he was on sofa and had dribbles a lot of saliva, dad was about to change the clothes and he started to scream at about 8.30am and he went red and then M was back at 8.45am. Dad also said that he had hiccups and had an episode where he went completely red during feeding previously as well but he was not floppy or unresponsive then* (Qi395).

10.35am. Ophthalmology investigation by Mr F – paediatric ophthalmologist. Multiple bilateral intraretinal haemorrhages on the right more than the left. Right macular involvement with a voceal haemorrhage and possible macular schisis. Follow up on 8th June (Qi396-7). Later email sent by Mr F to H on 20th May at Qi117

2nd strat meeting. Reported that retinal bleeding and head swelling were two separate issues. G had up to four old bleeds present. LA requested timeline of anyone who had care of G from birth. Ref in the meeting to F having telephoned DC AH and saying that the current situation is having an effect on his MH. F said a similar deterioration happened 7yrs ago (N8-16).

<u>4-6pm</u> Issue with LA as SW indicates that grandparents can no longer supervise as they were in the pool. M upset by this change. M identifies 4 alternative supervisors to assist (Qi215-6).

<u>7.20pm</u> M informs staff that her daughter recalls an incident when G was about 3-4 weeks old "We have a L shaped corner sofa G was laying on the corner and I was at the other end and fell on top of G's head" (Qi217)

09.05.21 **SUNDAY.** F internet history. Searches: *"Macrocephaly…Anencephaly…My 9 week old son got rushed into...private neurology Cardiff...getting a second opinion…Shaken*

baby syndrome…self-hypnosis for anxiety…Intracranial haemorrhages….FBU legal advice…self-hypnosis to forget…Can you use hypnosis to forget P…" (Ti39-42)

10.05.21 **MONDAY.** SW visit. ZM visits F at home. F provides an account of the 5th May (E220, Lii15, N20)

11.15am WR. M present. **HC 44.5cm**. M questioning the bleeds, the age of bleeds and when they happened. M states that her and partner have not shaken baby G but have rocked him when he was crying. M wondering whether rocking may have caused the bleeding and whether they rocked him harder than should have (Qi224)

3.30pm 1st **MRI** of head. Did not show any gross parenchymal abnormality but confirmed the presence of bilateral subdural collections with differential signal changes in keeping with subdural collections of different ages (Qi9, H208 refers).

11.05.21 CP Medical of I reveals no issues (Qii1-3)

12.05.21 9.45am WR. Dr A (E266) **HC 44.6cm**. Parents asked about results of MRI. They were informed that they confirmed the findings of the CT scan i.e. multiple bleeds. Dad says 'everyone/ on his Dad's side has been anaemic and needed B12 supplements. Both asked several Qs about what sort of things could cause a bleed e.g. rocking G to comfort him, or putting him down on sofa or bed. They asked whether their toddler falling on G could have caused the bleed or accidentally headbutting G. M makes ref to placenta being small (C266, Qi231-233).

2pm 3rd strat meeting. Dr A attended. Information shared about what F told ZM on the 10th May re G starting to roll and F's reason for not phoning 999 immediately (N20). F now requesting that new SW replaces ZM. ZM concerned that F did not call 999 when he was trying to resuscitate G. F also said that G was now rolling, but left him on sofa whilst going upstairs to get clothes. F also commented that he wished he had not taken G to hospital because this had led to the involvement of other agencies. F said to ZM that if he had shaken the baby, then he could have dropped him and told staff he had dropped him in order to divert any blame. Medical view is that the injuries inflicted. 7 people ID as being in pool: M, F, PGPs, MGM & MSGF, half-sibling Mn (18yrs). (N17-27, HV notes at Q91, Qi234).

13.05.21 8am **MRI spine.** Showed a high T1 signal in the posterior fossa and in the thoracic spine, suggesting blood products (Qi8, H208 refers, Qi236).

WR. **HC 44.5cm** (Qi236)

15.05.21 WR. **HC 45.2cm** (Qi242)

17.05.21 WR. **HC 44.7cm** (Qi246)

1.35pm 2nd **MRI** of head . Comparison made with 10th May MRI. Bilateral SD collections. Little change in the size of the SD collections. No significant change when compares to previous MRI (Qi7)

Dr H's CP report (E1). Concludes the combination of SDH of different ages and RH in a non-mobile child with no history of trauma or evidence of clotting disorder is consistent with NAI. Dr also of the opinion that G's presentation of being acutely unwell on clinical assessment is consistent with an acute bleed on the day he presented (E1-9).

Positive VA of (MGF and MSGM) (E10-17)

18.05.21 WR. **HC 44.7cm** (Qi249)

12.30. 4th Strat meeting. Dr H confirms G's injuries likely to be NAI. Parents signed s76. S47 enquiries ongoing. Parents have moved out of family home and living with friends and the MGPs have moved in to care for I. Police to interview parents on Thursday (20th) (N28-35, Qi250, HV notes at Q90)

18.15hrs. Dr H and safeguarding nurse meet with parents to explain the situation. Dr H explains that G presented with signs of trauma and that he was an acutely ill child on admission. M asks whether injuries could be caused by putting G down 'harder' than normal or rocking a little harder than normal. Dr H explained no evidence stating how hard a baby needs to be moved before causing trauma. However, it was unlikely to happen that way or with sibling accidentally falling on G. M asking how could she have missed if someone was hurting him. M also questioned about F giving CPR instead of calling 999 (Qi254-55) .

F internet history. Searches: *"Falling apart…I can't do this…How to get your baby or child back"* (Ti47)

19.05.21 Further MRI confirmed SD collections with little change in size.

20.05.21 WR. **HC 45cm** (Qi259)

10am 2nd Skeletal survey (follow up). No issues ID (Qi6, Qi260)

Mr F (Ophthalmologist) replying to an email from Dr H: *The haemorrhages were small and multiple (too numerous to count) and present in all quadrants of both eyes out into the periphery. Many had a white centre. They were all similarly well-defined and prominent as if they had occurred simultaneously and recently. There was no impression that any were in resolution and older. The right macula appeared elevated in the patter of schisis with a central haemorrhage. There was no haemorrhage filling and defining a schitic cavity and I don't have access to portable OCT so I could only say that this was a 'probably' macular schisis. This probably wont be clearer when I review G and will hopefully have been resolving (Qi116)*

G discharged from hospital to the care of MGF and MSGM

F police interview. 11.36am (Ti129-167).

M's police interview (Ti168-194).

23.05.21 Sunday. Early hours of morning after a feed. MGF says G screamed for no reason and instantly fell asleep (Q70 refers)

24.05.21 Monday. Early hours of morning after a feed. MGF says G screamed for no reason and instantly fell asleep (Q70 refers)

25.05.21 Tuesday at 1am. G happy in basket then appeared to be lifeless and staring into space (Q70 refers).

26.05.21 F sees GP. F struggling with event where son had respiratory arrest and F had to perform CPR and has not had the opp to process this as the situation has escalated with LA involvement. Referral to MH services at hospital (S25)

26.05.21 HV contact at home – RT. **HC of 45.5cm** (Q63, Q88). MGF reported the HV the issues with G on the 23rd, 24th and 25th May. G is given his second primary immunisations (Q70 refers). HV made call to Dr H following the visit (Q88).

28.05.21 G seen by Dr H. HC **45.6cms** (99th centile). MGPs advised to seek urgent medical attention for G if episodes occur. Clinic letter from Dr H dated 2nd June 2021 is set out at H122 & Qi383, Qi77.

3rd **MRI** of head carried out due to concerns over HC. Comparison to previous scan of the 17th May. MRI revealed that the bilateral SD collections now show multiple layers of different signal intensity but are of similar volume compared to the previous scan. No other findings (Qi5, H122 refers).

01.06.21 PAU review by Dr H. **HC of 45.9cm** (Qi266)

02.06.21 HV contact at home. **HC of 46.1cm**. Well above 99.6th centile (Q60, 70, Q87)

07.06.21 **HC of 46.4cm** (Q60, Q85)

08.06.21 1st LAC review

Dr H clinic. **HC 46.2cm** (Qi382 & 383)

Follow up ophthalmology by Mr F. Complete resolution of RH (Qi268, Qi398 and Q97 refers)

10.06.21 LA discussion between parents, MGPs, ZM and KL (TM). LA seeking to reduce contact. Parents obviously not in agreement.

11.06.21 Fire Service Occ Health write to GP re F being low in mood, severely anxious & finding situation difficult to deal with. Denies thoughts of self harm or suicide at present, however states that this could change if is children are removed permanently. F has been referred to Fire Services' counselling service for assessment (S81)

14.06.21 **HC of 46.7cm** (Q60, Q84, Q97, Q105, E357 HV statement).

15.06.21 2nd **CT scan**. Comparison made with 5th May CT. Evolution of the previous acute on chronic SD collections. The extra-axial collections have increased in depth which is accounting for the increase in head circumference. No acute intracranial haemorrhage demonstrated. No hydrocephalus at present. Remainder of the cerebral and cerebella parenchyma are unremarkable. Neurosurgical opinion advised (Qi4, Qi271)

Clinical letter by Dr H. Examination of G showed normal cardiovascular, respiratory and abdominal systems. Normal neurology. Cranial nerves and eye movement ok. G has developed some frontal bossing as well as a very prominent and large anterior fontanelle. **HC 46.8cm**. Given the still accelerating HC in excess of centile growth as well as change in head shape, it is important that G be rescanned (H122 refers, Qi381, Qi73)

17.06.21 Proceedings issued

18.06.21 Neurological review by Mr P/Mr L. **HC 47.3cm** (Qi369)

25.06.21 Neurological review by Mr L. **HC 47.3cm** (Qi370)

29.06.21 **HHJ PHJ** (C16-27)

ICOs made. Interim plans approved. Directions to IRH on 29th November and FH on the 6th December. Hogarth, Dr Pettorini, Keenan and Cartlidge approved. Permission for ophthalmologist but adjourned to further hearing.

01.07.21 Dr H. **HC 47cm** (Qi405) (29th June appt? see Qi407)

02.07.21 Statement of AD re contact (E67-69). LA suggesting reduction from 17hrs a week to 9.5hrs week.

08.07.21 **HHJ PHJ** (C29-33)

Permission to instruct Dr Crewe-Brown. Court declined to vary interim contact arrangements in advance of a risk assessment to be prepared by the LA for the 20th July and without the MGPs having been spoken to about the changes.

09.07.21 Case allocated to FW

14.07.21 Guardian meets M and F. Recording at I1-6

15.07.21 **HC 47.2cm** (E358 HV)

20.07.21 Risk assessment by FW (Snr SW). LA now propose following contact regime:

i) Monday daytime – from 1pm until 2.30pm supervised by the Local Authority in the family home, during which time the Maternal Grandparents shall vacate the family home;

ii) Monday evening – from 6.30pm, until 8pm in order that the parents shall participate in the Children's bedtime routine;

iii) Tuesday – no contact;

iv) Wednesday – from 5pm until 8pm;

v) Thursday – no contact;

vi) Friday – from 5pm until 8pm;

vii) Saturday – from 4pm until 8pm; and

viii) Sunday – from 4pm until 8pm.

LA will *on a regular basis* during the above times attend at the home to observe the parents' interactions with the Children during the tea-time routine. Arrangements will be subject to 4 weekly review.

20.07.21 Dr H. **HC 47.7cm** (Qi409)

21.07.21 F's CA statement (G1-14). F's account is as set out at 5th May 2021 entry above. F first indicates *"I think I could have shaken him and called his name to try and wake him. I could have shaken him whilst holding both hands under his armpits trying to wake him. I was walking with him, and this is all a little bit of a blur to me".*

M's CA statement (F3-23).

23.07.21 **HHJ PHJ** (C35-41)

The interim contact arrangements for the children are resolved. M and F confirm that they do not at this stage suggest that any other person should intervene in the proceedings.

04.08.21 **HC 47.9cm** (E358 – HV)

11.08.21 Ophthalmology report No.1 by Mr Wayne Crewe-Brown.

18.08.21 **HC 48.3cm** (E258 HV)

24.08.21 Ophthalmology report No.2 by Mr Wayne Crewe-Brown

26.08.21 Date of RCPCC (Q67 refers)

28.08.21 Haematologist report. Dr Keenan (H114-151). The investigation of the blood clotting system is complete. No abnormality of the clotting system as been ID. No further testing is required (H128).

31.08.21 Dr H. **HC 48.5cm**. 99th centile (Qi407)

02.09.21 **HC 48.5cm** (E358 HV)

12.09.21 Neuroradiologist report. Dr Kieran Hogarth (H152-183)

20.09.21 **HC 49.2cm** (E258 – HV)

21.09.21 Neurosurgeon report Dr Benedetta Lucovica Pettorini (H202-220)

22.09.21 Paediatric report. Dr Cartlidge (H221-255)

06.10.21 **HC 49.6cm** (E358 HV)

25.10.21 **HC 49.7cm** (E358 HV)

02.11.21 Dr H. **HC 49.5cm**. 99.6th centile (Qi408)

02.11.21 Experts' meeting. (E256-270. Amended transcript at E287-310)

09.11.21 LA parenting assessment (E271-300)

HC 49.7cm (E358 HV)

24.11.21 **HC 49.9cm** (E358 HV)

24.11.21 Further Qs to the experts to consider the LA's recent CA statements and the evidence about G's HC.

25.11.21 Dr C's response to Qs/report No.2 (H284-286)

29.11.21 **IRH**

01.12.21 Dr Pettorini's response to Qs/report No.2 (H311-316)

Dr Hogarth's response to Qs/report No.2 (H317-319)

F's 2nd statement (G15-24). *"I am 99% certain that I shook him in order to revive him. I picked him up from the sofa under his arms and I cannot remember the exact details, nor can I recall the video or the picture in my mind. I can hear myself shouting "G, G! No, no, no!" but in a moment of panic, I believe I did shake him in order to revive him. I can't remember how I did it, or for how long, but I believe that I did this by picking G up under his arms"* (G19)

03.12.21 Further Qs to experts requesting consideration of F's 1st December statement.

06.12.21 Listed for FH.

Annex C

IN THE MATTER OF THE CHILDREN ACT 1989

IN THE MATTER OF I AND G H

CASE NUMBER: SA21C50057

REVISED THRESHOLD DOCUMENT

1. The relevant date for consideration as to whether the threshold criteria are satisfied is 12 May 2021, that being the date upon which B Borough Council instigated protective measures and accommodated the children.

2. As at the relevant date:

i. The child, GH, had suffered significant harm attributable to the care given to him by his parents not being what it would be reasonable to expect a parent to give him

Not Proved

And

ii. The children, G and I H, were likely to suffer significant harm and the likelihood was attributable to the care likely to given to them by their mother and father not being what it would be reasonable to expect a parent to give them

Not proved

3. The harm relied upon is physical and emotional harm.

<u>Particulars</u>

(a) On or before 5 May 2021, the child GH suffered at least one if not more injuries

It is proved that he was exposed to one event in which he suffered injuries

(b) On 5 May 2021, G experienced an apnoeic episode while in the care of his father, presenting as limp and lifeless

Proved

(c) G had a chronic subdural fluid collection causing enlargement of the head, already present on 28 April 20213

Not proved

(d) A CT scan on 5 May 2021 revealed multiple focal high density subdural bleeds over both cerebral hemispheres, further frank 'fresh 'subdural blood within the posterior fossa behind the cerebellum and bilateral subdural collections over both cerebral hemispheres, which are slightly higher density than cerebrospinal fluid (therefore haemorrhagic).

Proved

(e) MR Head and Spine scans dated 10 May 2021 again show bilateral haemorrhagic collections over the cerebral hemispheres (deeper on the left than the right), thrombosed cortical veins over the cerebral vertices (often seen in shaking injuries), again blood within the posterior fossa, thin intraspinal subdural haematoma ventrally within the thoracic region.

Proved

(f) G sustained multiple bilateral intraretinal haemorrhages within a few hours to several days prior to admission to hospital on 5 May 20216

Proved

(g) The injuries are traumatic in origin. They are likely to be inflicted and are consistent with G having been shaken on at least one occasion

The injuries are traumatic in origin. They are NOT inflicted and are NOT consistent with GH having been deliberately shaken abusively by his father on the morning of the 5th May 2021.

(h) The degree of force necessary would likely be well outside the bounds of what a reasonable carer would consider to be 'normal handling 'and would have been obviously excessive to a normally competent and responsible person

The degree of force was administered in a situation of panic at what seemed like a medical emergency to GH. It was of sufficient force to have caused all the above intracranial, spinal and ocular injuries.

The said shake was likely part of a resuscitation and done in panic but was sufficiently vigorous to have caused GH's head to accelerate and decelerate/ rotate, causing all the said injuries. As such the injuries were likely NOT deliberately inflicted.

(i)G sustained the above injuries while in the overall care of Mother and/or Father, both of whom fall within the pool of possible perpetrators for the injuries.

GH sustained the above injuries while in the overall care of GH and were caused by Father.

Mother was NOT present at the time, and would NOT have known or ought to have known the child was likely to be injured and therefore did NOT fail to protect the child on the morning of the 5th May 2021.

(j) Insofar as the court is able to do so on the evidence available to it, the court will be asked to identify the perpetrator of those injuries. The local authority asserts that the injuries were caused by Mother and/or Father.

It is proved that the injuries were caused in Father's sole care, but as part of resuscitative act.

(k) Those who did not cause the injury, but were present at the time, knew or ought to have known the child was likely to be injured and failed to protect the child.

Not proved.

(l) By virtue of the injuries G has suffered, I was at risk of suffering harm of a similar nature.

Not proved