Important Notice
This decision was delivered in private to the parties and their lawyers. They may not show or otherwise communicate this decision or its contents to any other person. Any party or their lawyers wishing to show or inform any other person about the decision or any other person wishing to see the decision must first come back to court and obtain the permission of His Honour Judge Richard Clarke.

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

Neutral citation number: [2022] EWFC 106
Case No: WD21C00698

IN THE FAMILY COURT SITTING AT WATFORD

Date: 12/09/2022

Before:

HIS HONOUR JUDGE RICHARD CLARKE

- -

Between:

HERTFORDSHIRE COUNTY COUNCIL	**Applicant**
- and -	
(1) MOTHER	**Respondent**
(2) FATHER	
(3) and (4) OLDER SIBLING and CHILD, children represented by their Guardian, Claire Chambers	

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DECISION

Contents

His Honour Judge Richard Clarke :

INTRODUCTION

1. This is the decision of the Court, following a fact-finding hearing, on an application by Hertfordshire County Council (referred to as the Local Authority) for Care Orders issued on 5 July 2021 in respect of the following child(ren):
   1.1. [Older Sibling] born on XXXX 2018 (the older Sibling); and
   1.2. [Child] born on XX November 2020 (referred to hereafter as the Child).

2. The trial of this matter has taken place over 6 days commencing on 21 March 2022, with evidence being heard from 21 March 2022 to 25 March 2022 and submissions on 28 March 2022. This decision was circulated in draft on 26 April 2022 and formally handed down on 12 September 2022.

REPRESENTATION AND PARTIES

3. The Local Authority was represented by Mr Holmes of counsel.

4. The first respondent is Mother (referred to as Mother), who was represented by Mr Barraclough QC assisted by Miss Baruah of counsel.

5. The second respondent is Father (referred to as Father), who was represented by Miss Stone QC, assisted by Miss Quinn of counsel.

6. The children's guardian is Claire Chambers (referred to as Guardian), who was represented by Miss Homer of counsel.

7. Given the potential for wider distribution of this judgment, I have anonymised the names of the children and family members. I have already provided a schedule of anonymised names so that anyone working with this family can readily identify the people referred to it in the decision.

8. The court has also decided to anonymise any reference to the professionals and majority of experts who provided evidence for the benefit of the Court, with substantive reasons being given in a separate decision.

9. This decision involves discussion of significant injuries sustained by a relatively new-born child. They are not a complete description, have been drawn together in some places with attempts to simplify for ease of understanding and do not seek to stand in the place of the extensive medical reports which have been considered. They also refer to research often conducted abroad and are reproduced using the original, published, spelling of terms such as paediatric.

ESSENTIAL BACKGROUND

10. The family was not previously known to social services and no concerns had ever been raised by professionals (including medical, police or social services) regarding the care provided by either parent. The essential background is therefore limited and can be summarised as follows:
    10.1. The parents are married, having met in 2011 and marrying in XXXX.
    10.2. The Child was born at 37 weeks gestation by emergency Caesarean section, due to concerns about his growth.
    10.3. On the evening of [Day 1], when the Child was 7 weeks old, the parents state they were in the kitchen of the family home. It is their case that while

Father was cuddling the Child he picked up the Older Sibling, who was about to go for a bath and bedtime, at the same time. They say Father then dropped the child, tried to catch the Child, but missed, and the Child tumbled to the floor.

10.4. The kitchen floor is a hard wood floor on a concrete base. The Child clearly sustained injury to his head upon impact. The parents left to take the Child to their local hospital, calling 999 (at 18:24 hours) on the way.

10.5. The Child was presented at the accident and emergency department of his local hospital the same evening with a report of having sustained injury in a fall from Father's arms onto a wooden floor from a height which was estimated, by the hospital staff to whom the initial history was given, to be approximately 5 feet. The Child had a short seizure after arrival at the hospital. Initial assessment took place at 18:30 hours.

10.6. The paediatric sign-in sheet, completed at 19:00 hours on [Day 1], recorded a "fall/dropped from height of approximately 2 feet". Subsequent trauma team notes by the Emergency Department Consultant recorded "fall onto floor from father's hands about 3-4 feet high". Record of the discussion between the general paediatric consultant and Father recorded the Child "arched his back fell over dad's arm (approx. 5ft)"

10.7. A neurosurgical on-call referral was made to Great Ormond Street Hospital (GOSH) that evening, by which time the history was that the fall had occurred at 19:00 hours and was from a height of 4 to 5 feet onto a carpeted floor. There is a letter to GOSH, from the local hospital, from the same day stating it was a drop from 4 feet onto wooden flooring. There is also a record of a call to an anaesthetist at GOSH, from the local hospital, noting a drop onto a wooden floor at 19:00 hours.

10.8. The Child was transferred to GOSH in the early hours of the next morning, with ongoing intermittent seizures. There was a further concern as Father had previously presented the elder Sibling at hospital a few years previously, having stated he had fallen down the stairs with her and was concerned she may have hit her head, but no significant injuries had been noted to the Sibling. Both of the parents' children were made subject to Police Protection Orders on [Day 2].

10.9. The Child was found to have sustained bilateral (both sides) parietal skull fractures (the right-sided fracture being complex, with the fracture edges separated and multiple fracture fragments) each with associated areas of scalp swelling, traumatic subdural effusion (escape of fluid), traumatic subarachnoid haemorrhage (bleeding) and a large area of haemorrhagic contusional change which has led to permanent structural brain damage.

10.10. On [Day 2] the Child's grandfather is recorded as reporting Father tried to pick up the Sibling and (the Child) fell out of his arms, but there is nothing to indicate the grandfather was present at the time (the court has not heard from the grandfather, no party requiring either grandparent to give evidence). A nurse also reported that Mother had been upstairs and Father downstairs, and Father tired to pick up the Sibling and the Child fell out of his arms, but the source of the information is not provided. The same day there is a note in the GOSH records questioning the consistency of the parents' account on the basis of the record the Child had fallen onto a carpeted floor.

10.11. Mother is recorded as providing a history to [RG] and [Watford Neurosurgeon] on [Day 3] which was generally consistent with the initial report. The only mention of height is Father himself being about 6 feet tall.

10.12. Father provided a recorded account of events to the police on [Day 4]. The initial view of the medical professionals at GOSH, at a strategy meeting which took place on [Day 4], was that the injuries sustained were compatible with the mechanics of a fall, but it could not be confirmed if this was accidental or non-accidental. [Dr TM] explained it was possible for a single impact to cause bilateral fractures, but she could not rule out a second impact to the left side.

10.13. On [Day 7] Mother was informed the Child had sustained permanent brain damage and there were concerns of Non-Accidental Injury (NAI). The follow-up strategy discussion from that date recorded Father's explanation as him picking up the older Sibling whilst holding the Child and the Child slipping from his grasp and falling to the floor. The right side of the brain was showing significant injury. No concerns had been noted by ward staff in respect of either parent's interaction with the Child or presentation at GOSH. The neurological team felt the degree of injury to the brain was extreme given the history, the injuries could be the result of 2 separate trauma impacts, there were perceived discrepancies in the accounts provided by the parents and while accidental injury was not impossible it was considered to be unlikely. The complex pattern of fractures from one single event was regarded as highly suspicious. Whilst the view of the Consultant Neurologists appeared to differ, and it was possible the injuries were accidental, on the balance of probabilities, and considering literature and experience, it was felt that the baby had suffered NAI.

10.14. There is a record from GOSH of [Day 10] where Father was noted to be expressing his concern that the medical team had not got the full account of exactly what had happened. Father was recorded as stressing it as not "a simple fall".

10.15. On [Day 12] there was a discussion between Father and [Dr SD], who explained to Father why the incident had been questioned as NAI. Father sent an email to [XE] at GOSH the same day, in response to their request that he set out his concerns, which confirmed:

10.15.1. Father gave his account of what had happened to the doctors and nurses at Watford on [Day 1] and visually demonstrated;

10.15.2. On [Day 4] Father gave his account to the police, which was recorded via video;

10.15.3. It was not until [Day 7] that Father was informed the Child had permanent brain damage;

10.15.4. A meeting took place with the neurologists on [Day 8] where Father expressed concerns his account was not getting through accurately; and

10.15.5. Father still did not believe the medical team as a whole had his accurate account of what happened

10.16. [Dr G], Consultant Paediatric Neurologist at GOSH, provided a report dated [Day 14] at the request of the Local Authority. This and subsequent reports/letters stated [Dr G] believed them to be true and to reflect accurately the opinion of the clinical teams at GOSH. The report went through the various recorded explanations of the incident. It confirms the CT of the brain showed a breakage of the skull on the right side with involvement of multiple skull sutures (joints between the bones of a baby's skull) and an externally displaced fragment. There was a separation of the joint connecting the bones on the side of the head (parietal) and the back of the head (occipital), with associated soft tissue swelling. The brain was seen

protruding through the right fracture at the level of the broken fragment, with significant tissue injury to the right parietal lobe of the brain. There were also 2 breaks (fracture lines) on the upper back area (parietal) of the skull on the left side. There was also suspicion of minimal signal changes to the T2 to T4 vertebrae, with trabecular fractures not being ruled out. The report recorded a consensus neuroradiology opinion that the mechanism of fall described by Father was compatible with the radiological findings, which were suggestive of a single high impact direct traumatic injury. However, [Dr G] also opined "the pattern of injury seen in this child with multiple skull fractures seen on both sides, with associated widening of the sutures, and significant damage to the underlying brain, is highly unusual in the context of the history provided by the parents" and noted "with concern that there are discrepancies in the history provided".

10.17. On [Day 15] [Dr G] responded to questions on the report, confirming it was not possible to date the fractures, referred to the "changing history given by the parents" and stated "I have not seen this degree of injury from a fall of the nature described, although the history given by the parents is not clear".

10.18. A note of a discussion on [Day 15] records Father discussing the fact that the Child would have landed at a different angle than straight down, although he could not speculate what the angle was. The case note, recorded by the police from that date, records [Dr G] stated "he has to go by what the professionals have recorded… although he can completely appreciate that they might not be what father intended to say". It also recorded [Dr G] as stating, "on the balance of probabilities feels that injuries are most likely to be accidental in cause and that he will send a final report stating this". [Dr G]'s view the injury was likely to be accidental was recorded at 3 separate stages of the discussion.

10.19. The Child was discharged on [Day 16], with plans to follow-up treatment.

10.20. A further letter from [Dr G], dated [Day 21], stated "there are discrepancies in the histories recorded as to whether (the Child) slipped while his father was picking up the older sister or whether the father was already standing holding both children when this happened." The letter sought to set out what were viewed as "significant inconsistencies and notable omissions recorded in the histories given by (the) parents from the time of presentation (at the local hospital) to the completion of his admission to GOSH" relating to the:

10.20.1. Height of the fall;
10.20.2. Type of flooring;
10.20.3. Location of the Sibling;
10.20.4. Position and orientation of Father holding the Child in prior to the fall;
10.20.5. Where the parents were standing in the kitchen;
10.20.6. Why Mother's view of the fall was obscured;
10.20.7. Where the Child fell;
10.20.8. The position the Child was in on the floor after he fell; and
10.20.9. The mechanism of the fall.

While [Dr G] maintained the injury sustained could be compatible with the "revised explanation" given on [Day 15], it was stated "based on my experience as a Neurologist with significant knowledge base in Traumatic Head Injuries in children, it is my opinion that the injury sustained is highly

unusual with bilateral broken bones of the skull, with the break not being continuous across the midline and in the absence of a clear and consistent history of having sustained multiple impacts

10.21. The Consultant Paediatrician for Safeguarding at GOSH wrote to the parents on [Day 30], stating this "is a very unusual case in that [Dr G] is unfortunately not able to state whether on the balance of probabilities (the Child)'s injuries are likely to be accidental or non-accidental". The letter also referred to the meeting with the parents on [Day 15] when "[Dr G] indicated to the parents in the presence of the Local Authority Social Worker he was of the view that the injuries were more likely to be accidental than non-accidental."… with a caveat that "[Dr G] also informed those present at the meeting that he would need to consider all of the histories documented again before providing a written report to this effect".

10.22. The parents separated following an incident between them on [Day 37]. Father left the family home following the incident and Mother did not support any further police action.

10.23. Neurosurgery was performed on the Child on [Day 42].

10.24. A strategy discussion took place on 23 February 2021. It recorded the Local Authority s47 investigation as finding "no other risk factors identified beyond highly unusual injury and discrepancy in histories". [Dr W], named doctor for safeguarding at GOSH, "expressed that it was considered that [Dr G] had been put under a degree of pressure when speaking to the parents" (on [Day 15]), and that [Dr W] "held a discussion with [Dr G] in respect to the 'revised history from [Father] provided at the meeting on [Day 15]. It was considered that this it is an elaborated history…". In discussion about the fractures it was stated the Child "has fractures on both sides of his head, which radiate out, and two fractures that radiate from the left side of his head. Those fractures don't join up so if the initial history is that he fell and didn't bounce or tumble on the way down, how is it possible he had fractures on the other side of his head. [Dr W] expressed that if (the Child) had fallen from a great height onto a hard floor it is possible that he would have sustained the fractures. [Dr W] recommended the Local Authority seek an expert second opinion. The Local Authority were recorded as questioning whether this was proportionate given it was not felt that threshold was met for the case to go to court. The police were also recorded as having visited the family home and finding the account given by Father as completely plausible. In considering [Dr G]'s report the police did not regard there as being significant inconsistencies and notable omissions, viewing the minor differences in the accounts given as in line with what each parent saw and how they interpreted it. They also noted how the memory works could explain differences in the details recalled at differing times and the fact the parents had witnessed something traumatic. The police went as far as to state "had both parents arrived at the hospital, given identical accounts and maintained them completely throughout I would be more likely to expect this to be lies".

10.25. On 3 March 2021 Father returned to the family home. The parents have continued to live separately in the same property for some time, although the Father then left the home and the parents have remained separated.

10.26. The Local Authority commissioned a report from [Dr N], Consultant Neuroradiologist, on 18 March 2021. The report is dated 13 May 2021. [Dr N] summarised his view that "the constellation of imaging abnormalities cannot reasonably be explained by a fall from a height such as being held by

an adult. In my view the two main possible explanations for the totality of the abnormalities are that either they are due to a crush injury (as may for example have happened if (the Child) did indeed fall onto the floor but his head was then stepped upon by an adult) or an episode of impact head trauma involving an impact injury involving a much greater degree of force than is likely to have occurred as a result of a fall from carrying height." He described the "parenchymal brain injury, although focal in that only one area of the brain was affected, it was very extensive as it did involve the frontal, parietal and temporal lobes and was also an injury which involved the full thickness of the brain from the surface to the ventricular margin. I cannot recall ever having seen such an injury as a result of an episode of domestic impact trauma."

10.27. A professionals meeting took place on 18 May 2021. The note of the meeting confirmed they had the benefit of the report of [Dr N], who was described as an incredibly experienced radiologist who did the majority of expert witness cases where there is a brain injury and scans require interpreting. There was reference to a revised history from Father, that he had in some way propelled the Child in his flight to the floor, by [Dr W], who said:

10.27.1. "all along GOSH have said that concern is high, because of the nature of the history presented to them cannot say with certainty the intent because history does not convey information to them."

10.27.2. a bit of skull was pushed into his brain, expressing the view it was "incredibly unlikely due to flat surface landed on".

10.27.3. she had reflected on medical notes from Watford Hospital stating Father had initially said "fall from 2 feet, then 3 – 4 feet, then 5 ft, then over 6ft. This account was given over time as it became apparent injuries were more significant."

10.27.4. In respect of the parents challenging this history, that it was "unlikely every practitioner misheard what parents said."

10.27.5. That in [Month 2] Father had changed his account to say there was an active movement and the Child was propelled through the air

10.27.6. The injuries sustained were similar to those if a child had fallen out of a window from the 2nd or 3rd floor; and

10.27.7. "Injuries do not match history given".

10.28. A Child in Need plan was drawn up on 9 June 2021 on the basis that Father's contact with the children would be supervised by an adult at all times.

10.29. The Local Authority application for public law orders, C110a, in respect of both children is dated 6 July 2021.

10.30. Following the issue of proceedings, on 27 July 2021, the court gave permission to the Guardian to obtain a paediatric radiology report from [Professor AM] on a joint basis with the Guardian's solicitor taking the lead.

10.31. Subsequently, on 26 October 2021, the court refused an application by the Local Authority to obtain an addendum assessment from [Dr N] and gave permission to obtain a neuroradiological report from Professor Sellar on a joint basis with the Guardian's solicitor taking the lead.

10.32. [Professor AM] reported on 29 November 2022 and Professor Sellar reported on 6 January 2022.

10.33. At the time that [Professor AM] was instructed the court had not yet determined an application for a report from a bio-mechanical engineer. The

application was later refused. [Professor AM] was asked to provide an addendum report taking this into account and did so on 20 January 2022.

10.34. At a hearing on 17 January 2022 the matter was listed for a fact-finding hearing commencing on 21 March 2022 with a time estimate of 5 days. It was confirmed the witnesses needed for the fact-finding hearing were the parents, [Professor AM] and Professor Sellar. However further witnesses may be required. They would be identified at the next hearing

10.35. The experts were asked to undertake an experts' meeting. The experts' meeting took place on 16 February 2022, between [Professor AM] and Professor Sellar.

10.36. The matter came back before the court for a pre-trial review on 28 February 2022. Various items of evidence remained outstanding, additional witnesses were sought to be called including [Dr TM] from whom a witness statement was sought by those representing the mother. The parties were concerned that 5 days would not be enough. The listing remained, on the basis it would be used to hear the evidence, the advocates would then provide written submissions and judgment would be handed down on 5 April 2022.

10.37. Shortly before the fact-finding hearing, the Local Authority served a letter from [Dr TM] dated 7 March 2022. Included in the letter was the text of a neuroradiology consensus statement which had been shared with the clinical team, which had not appeared in the medical records, which included a discussion between [4 consultant paediatric neuroradiologists] of the GOSH Paediatric Neuroradiology Department. The content of the discussion is as follows:

Based on the current radiological literature on impact head trauma, we think that the mechanism described (i.e., fall of the child from a height of about 5.5ft while being carried by the father) is compatible with the radiological findings.

In fact, a fall from caregiver's arms is more likely to be responsible for complex and more extensive skull fractures and intracranial injuries in comparison to the typical short height accidental fall (uncomplicated fall over a short distance, i.e., maximal 1-1.5 m). These differences are mentioned in the Chapter 2 of the book by Bila et al. on non-accidental fractures in children (see citation below).

Data on falls from caregiver's arms are not extensive but evidence shows that "as a result of such a fall, children may sustain a focal haematoma and even extensive skull fractures and focal contusion of the brain" (Bila et al. 2010). In these cases, the mechanism is more complex than a typical accidental fall from short height and even retinal haemorrhages are possible (Warrington & Wright 2001; Lyons & Oates 1993; Tarantino at al. 1999; Minns 2005).

There is evidence in the scientific literature that "infants reported as having been dropped by caregivers were[. . .] significantly more likely to sustain a major injury (complex fractures and intracranial injury) than other infants who had fallen, or infants injured by any other mechanism" (Settle 2005).

In another article, it was found that "falls were the most common cause of intracranial injury including falls from caregiver's arms" (Crowe 2012).

As in this case, falls from the arms of carers "usually involves a fall of approximately 1. 5 metre.

As a result of such a fall, they may sustain a focal haematoma and even extensive skull fractures and focal contusion of the brain (Bila et al. 2010).

Finally, based on porcine models there are significant differences in how very young skulls react to a direct impact in comparison to adult/older animals: "impacts causing focal brain injuries in adults may yield diffuse injuries in children, due to the more compliant braincase".
Also, in very young animals (equivalent to infant) a single impact can cause multiple fractures relatively distant from the site of impact and closer to the sutures which are still open at that age (Powell 2012). The same study also showed that the number of fractures was higher with "increased levels of impact energy" (Powell 2012 Forensic Sci). Further, "rigid interface generated much diastatic fracturing at this higher impact energy, whereas the compliant interface did not"(Powell 2012 Forensic Sci).
Regarding appearances of brain parenchyma, MRI shows no evidence of diffuse axonal injury in the present patient as parenchymal micro haemorrhages are absent. Diffusion weighted imaging restricted diffusion in the above-mentioned areas outside of the right parietal lobe are in keeping with pre-Wallerian degeneration (Dami 2009).
The left-sided haematoma may be related to rolling after the first impact but can also be related to the fracture.

10.38. An Advocates' Meeting took place on 17 March 2022. Following that meeting the experts were informed, "The local authority has confirmed that it does not assert that the parents gave inconsistent accounts of the circumstances and/or events which they say led to the Child's injuries. In particular it is accepted that the parents did not say that the Child fell onto a carpeted floor, nor did either of them give any estimation of the height of the fall to medical professionals save that the father said he thought the height was more than 5 feet, given his own height. It is accepted that what the parents are describing is an accelerated fall from height, landing at an angle onto a concrete floor."

10.39. The fact-finding hearing commenced on 21 March 2022. Following the evidence of [Dr G], [Dr TM], [Professor AM] and Professor Sellar, on 25 March 2022 the Local Authority accepted they were unable to establish threshold on the evidence. There was disagreement over the way forward, with the Local Authority indicating it wished to seek permission to withdraw the proceedings and the parents and Guardian wishing there to be a full decision exonerating the parents.

10.40. The parents' evidence was heard in the remaining time. The Local Authority then issued an application to withdraw the same day, with written submissions in support. It was agreed the parents and Guardian would file written submissions on the basis judgment may be handed down on 5 April 2022, dependent on whether third parties needed to be placed on notice of any potential adverse findings in the decision. However, the submissions on behalf of the parents ran to roughly 60 pages each (including attachments) and so further time was needed.

ALLEGATIONS

11. This is a single-issue case, namely cause of the injuries sustained by the Child. The injuries were significant and the Child is likely to have significant motor, cognitive, developmental and psychological sequelae from his injuries and only time will tell the extent of those sequelae. The court was being asked to determine that the injuries were caused as a result of a minimum of 2 impacts, that they would not have been caused as a result of a simple fall from 4 to 5 feet, and the injuries were caused as a result of a blunt or crushing injury to the

Child's head. The court was also asked to consider whether the sustained injuries were inflicted by either of the parents, and that the parents had not provided an accurate account of how the injuries were sustained.

THE WITHDRAWAL APPLICATION

12. The Local Authority have issued a formal application for leave to withdraw the proceedings. Under rule 29.4(2) of the Family Procedure Rules 2010, a local authority may only withdraw an application for a care order with the permission of the court.

13. In Lancashire County Council v TP and Others (Permission to Withdraw Care Proceedings) (2019)[1], it was confirmed that there are two distinct approaches to applications for leave to withdraw public law proceedings. If there is a possibility that the threshold criteria might by crossed, the court must undertake a more detailed evaluation of the situation, exercising discretion by referring to the 9 factors set out by McFarlane J in A County Council v DP, RS, BS (by their Children's Guardian) (2005)[2]. The conclusion should then be cross checked having regards to the best interests test.

14. This was followed up by the Court of Appeal in GC v A County Council & Ors [2020][3], when Baker LJ stated:

'[16] … We were only referred to one case in which the provision has been considered by this Court, in the early days of the Act – *London Borough of Southwark v B* [1993] 2 FLR 559 in which at page 573 Waite LJ set out the following approach:
"The paramount consideration for any court dealing with [an application to withdraw care proceedings] is accordingly the question whether the withdrawal of the care proceedings will promote or conflict with the welfare of the child concerned. It is not to be assumed, when determining that question, that every child who is made the subject of care proceedings derives an automatic advantage from having them continued. There is no advantage to any child in being maintained as the subject of proceedings that have become redundant in purpose or ineffective in result. It is a matter of looking at each case to see whether there is some solid advantage to the child to be derived from continuing the proceedings."

This approach is consistent with s.1(5) of the Act, which provides that:
"where a court is considering whether or not to make one or more orders under this Act with respect to a child, it shall not make the order or any of the orders unless it considers that doing so would be better for the child than making no order at all."

'[19] …. In the first, the local authority will be unable to satisfy the threshold criteria for making a care or supervision order under s.31(2) of the Act. In such cases, the application must succeed. But for cases to fall into this first category, the inability to satisfy the criteria must, in the words of Cobb J in *Re J, A, M and X (Children)*, be "obvious".

[1] Lancashire County Council v TP and Others (Permission to Withdraw Care Proceedings) (2019) EWFC 30
[2] A County Council v DP, RS, BS (by their Children's Guardian) (2005) 2 FLR 1031
[3] GC v A County Council & Ors [2020] EWCA Civ 848

[20] …. In the second category, there will be cases where on the evidence it is possible for the local authority to satisfy the threshold criteria. In those circumstances, an application to withdraw the proceedings must be determined by considering (1) whether withdrawal of the care proceedings will promote or conflict with the welfare of the child concerned, and (2) the overriding objective under the Family Procedure Rules. The relevant factors will include those identified by McFarlane J in A County Council v DP which, having regard to the paramountcy of the child's welfare and the overriding objective in the FPR, can be restated in these terms:

(a) the necessity of the investigation and the relevance of the potential result to the future care plans for the child;

(b) the obligation to deal with cases justly;

(c) whether the hearing would be proportionate to the nature, importance and complexity of the issues;

(d) the prospects of a fair trial of the issues and the impact of any fact-finding process on other parties;

(e) the time the investigation would take and the likely cost to public funds.'

15. The Local Authority submit that this is a case where they are unable to satisfy threshold and leave to withdraw must be granted. It is accepted, upon behalf of Mother, that this is a case where the Local Authority is unable to satisfy threshold. However, she asks the court to apply the checklist from A County Council v DP and refuse leave to withdraw. Father does not accept this is simply a case where the Local Authority cannot prove its original case. It is submitted there is a possibility that threshold could be proven on the basis of Professor Sellar's evidence alone and therefore this is not an obvious case where permission to withdraw should be granted. The Guardian seeks a full decision of the court on the basis it is in the children's best interest to have a clear decision based on all of the evidence. The children are entitled to a clear understanding of what happened to the Child and whether his injuries were caused accidentally or non-accidentally.

16. Lancashire County Council v TP and Others (Permission to Withdraw Care Proceedings) (2019) was a High Court decision made on an application for leave to withdraw prior to trial. GC v A County Council & Ors [2020] was an appeal against a decision to grant leave to withdraw made at a case management hearing. Both cases related to applications made at a stage where the evidence had not been tested and evaluated.

17. It is rare for such an application to be pursued at the end of the hearing. No party suggests these proceedings should continue. It is a question of the manner in which they are finalised.

18. The application is based on the assessment of the evidence by the Local Authority. While it would appear that all parties are agreed on the determination of facts, that does not mean the determination is "obvious". For the case to fall in the first category of GC v A County Council & Ors [2020] it would be necessary for the court to agree with the Local Authority assessment. It is difficult to see how that can be done without deciding the evidence first. This is clearly a case where threshold might be crossed, given the significant and life-changing injuries

sustained by the Child. Accordingly, it is the decision of this court that this case falls into the second category.

19. Even if the court determines this is a "second-category" case the Local Authority say on *'an objective and dispassionate check … the local authority should be entitled to disengage from proceedings.'* Due to the fact-finding hearing having concluded, save for final decision, the following seem most relevant from the above criteria to be considered in a second-category case.

20. Necessity and relevance: The court is reminded that both children are living with Mother and having supervised contact with Father. Should the court not determine the issues there would remain the possibility of a lingering suspicion over the parents if anything was later to cause concern for either child. Having faced the accusations, the parents say they are entitled to full exoneration.

21. Dealing with cases justly: The parents argue their Article 6 and 8 Human Rights are engaged, whereby they have the right to have their names fully cleared and fully to understand the court's reasons and analysis for so doing. Further the judgment will be available for the children in their future lives should the matter be raised with them.

22. Concluding the court's decision-making process on the allegations will not cause further delay and would not appear disproportionate to the nature, importance and complexity of the issues. Leave to withdraw is unlikely to save expense and will not impact significantly on the share of court's resources required for the case.

23. Whether the hearing would be proportionate to the nature, importance and complexity of the issues: All evidence has been heard by the court. The parents seek to pursue issues regarding the conduct of certain medical experts and professionals in this case, outside of the court arena.

24. Impact of any fact-finding on any other parties: The parents have made it clear to the court they seek to criticise the medical professionals involved in this case. In particular, they seek permission to disclose any decision of the court to the General Medical Council. They require a full decision to do so.

25. Having considered all of the above, there appear to be substantial reasons for the court to refuse leave to withdraw which outweigh any benefits in allowing leave to withdraw. Whatever happens, the court will need to set out the evidence and explain its reasoning. The court is required to cross-check that conclusion based upon the straight best interest test under s1(1) of the Children Act 1989. Withdrawal at this stage would appear to leave many open questions, including conduct of medical professionals and a lack of a clear decision in the interests of the children. It would leave the parents open to questions about the cause of the juries in future. Overall, having considered all of the above, the court is satisfied it is not appropriate to grant leave to withdraw and the application is accordingly dismissed.

THE LAW AND LEGAL PRINCIPLES

26. The law is well known in this field, uncontroversial and need not be recited at length but the Court needs to remind itself of it both personally and so the

parties are aware of the context of the decision it makes. It can be summarised as follows:

26.1. There is only one standard of proof in these proceedings, namely the simple balance of probabilities.[4] Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts.

26.2. If a fact is to be proved the law operates a binary system in which the only values are 0 and 1 therefore it is open to the Court to make the following findings on the balance of probabilities:

26.2.1. that the allegation is true

26.2.2. that the allegation is false

and once an allegation has been proven on the balance of probabilities it will be treated as a fact and all future decisions will be based on that finding. Equally if a party fails to prove an allegation the Court will disregard the allegation completely.

26.3. It is the local authority that brings these proceeding and identifies the findings they invite the Court to make. Therefore, the burden of proving the allegations that they make rests with them.[5] Those against whom allegations are made do not themselves have to provide an explanation or context for any disputed allegation or to prove that any allegation is false.[6] The burden of disproving a reasonable explanation put forward by the parents falls on the local authority.[7] The fact that (if in fact it be the case) a party fails to prove on a balance of probabilities an affirmative case that party has chosen to set up by way of defence does not of itself establish the local authority's case, there is no obligation on that party to prove the truth of their alternative case.[8]

26.4. The inherent probability or improbability of an event remains a matter to be considered when weighing the probabilities and deciding whether, on balance, the event occurred. "Common sense, not law, requires that in deciding whether the fact in issue is more probable than not regard should be had to whatever extent appropriate to inherent probabilities[9]" The fact an event is common or frequent does not lower the standard of probability to which it must be proved, nor does the fact it is very uncommon or infrequent raise the standard of proof.

26.5. Where the evidence stands only as hearsay, the Court weighing up that evidence has to take into account the fact that it was not subject to cross examination.[10] When assessing the weight to be placed on hearsay evidence the Court may have regard to the matters set out in section 4 of the Civil Evidence Act 1995 even in cases (such as this one) where the Civil Evidence Act does not strictly apply.

26.6. There has been a significant passage of time since the events in question. As Jackson J (as he then was) stated[11]: To these matters I would only add that in cases where repeated accounts are given of events

[4] Re B [2008] UKHL 35
[5] Re A (Care Proceedings: Learning Disabled Parent) [2014] 2 FLR 591
[6] Lancashire County Council v D and E [2010] 2 FLR 196 at paras [36] and [37]; Re C and D (Photographs of Injuries) [2011] 1 FLR 990, at para [203].
[7] Re S (Children) [2014] EWCA Civ 1447 at [10]
[8] See for example Re X No3 [2015] EWHC 3651 & Re Y No3 [2016]EWHC 503
[9] Lord Hoffmann in Re B at para 15
[10] Re W [2010] UKSC 12
[11] Lancashire County Council v C, M and F [2014] EWHC 3 (Fam)

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 or relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith."

26.7. Findings of fact must be based on evidence (including inferences that can properly be drawn from the evidence) and not on suspicion or speculation.[12] If the local authority case is challenged on some factual point they must adduce proper evidence to establish what it seeks to prove. There is also the need to link the fact relied upon by the local authority with its case on threshold, the need to demonstrate why, as the local authority asserts, facts A + B + C justify the conclusion that the child or children has/have suffered, or is/are at risk of suffering, significant harm of types X, Y or Z.[13] The Court's findings must identify what significant harm the Court found the child(ren) to have suffered and/or the type of significant harm the child(ren) was/were likely to suffer.

26.8. When carrying out the assessment of evidence, the Court must pay attention to the fact that "Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the Local Authority has been made out to the appropriate standard of proof"[14] First, 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 must survey a wide canvas. Secondly, 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.[15]

26.9. The Court must weigh up all the evidence, whether given by expert or lay witnesses. "…psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved…" and "The process of civil litigation itself subjects the memories of witnesses to powerful biases."[16]

26.10. Whilst of course appropriate attention must be paid to expert evidence, it is important to remember

i) that the roles of the Court and expert are distinct; and

[12] Re A (A Child) (No 2) [2011] EWCA Civ 12 para 26
[13] Re A (A Child) [2015] EWFC 11 paras 9 and 12
[14] Re T [2004] 2 FLR 838 at para 33, affirmed in Devon County Council v EB & Ors (Minors) [2013] EWHC 968 (Fam), paras 56, 59
[15] see Re W and another (Non-accidental injury) [2003] FCR 346
[16] Gestmin SGPS v Credit Suisse (UK) Ltd [2013] EWHC 3560 (Comm) at [17] and [19]hearsay

ii) that it is the Court that is in the position to weigh the expert evidence against the findings of the other evidence[17] ……
"What may be unexplained today may be perfectly well understood tomorrow. Until then, any tendency to dogmatise [sic] should be met with an answering challenge."[18] The judge must always remember that he or she is the person who makes the final decision.[19] The evidence of an expert is not held in any special position and there is no presumption of belief in an expert no matter how distinguished they may be. However, a judge cannot substitute their own view for the views of the experts without some evidence to support what they conclude and must give reasons for disagreeing with an expert's conclusions or recommendations.[20]

26.11. The medical and expert evidence is but one part of the evidence available to the court at the fact-finding stage and must not take undue prominence. As Ryder J observed[21]: 'A factual decision must be based on all available materials, i.e. be judged in context and not just upon medical or scientific materials, no matter how cogent they may in isolation seem to be. Just as best interests are not defined only by medical or scientific best interests…likewise investigations of fact should have regard to the wide context of social, emotional, ethical and moral factors… I venture to suggest that if a court considers the broader context of expert evidence, that is the social, educational and healthcare history, with the rigour described above, there must surely be less likelihood of inappropriate reliance on what may transpire to be insufficiently cogent and sometimes frankly incorrect expert evidence even where it is uncontradicted"

26.12. If it is satisfied that the child sustained injuries, (the court) must first consider whether they were caused non-accidentally. In this context the Court reminds itself of the comments of Ryder LJ about the expression "non-accidental injury"[22]:-
"I make no criticism of its use but it is a 'catch-all' for everything that is not an accident. It is also a tautology: the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from say negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of section 31(2)."

26.13. Section 31 of the Children Act 1989 provides that a court can only make a care order or supervision order if it is satisfied that the child concerned is suffering or is likely to suffer significant harm and the harm, or the likelihood of harm, is attributable to the care given to the child, or likely to be given to (them), if the order were not made, not being what it would be reasonable to expect a parent to give him … (referred to as the threshold test).

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[17] A County Council v K, D and L [2005] 1 FLR 851
[18] R v Cannings [2004] EWCA 1 Crim
[19] Charles J in A County Council v KD and L [2005] 1 FLR 851 para 39 to 44
[20] See Butler Sloss LJ in Re B (Care: Expert Witnesses) [1996] 1 FLR 667
[21] A County Council v A Mother, A Father and X, Y and Z (by their Guardian) [2005] 2 FLR 129
[22] S (A Child) [2014] EWCA Civ 25

26.14. There has to be factored into every case which concerns a disputed aetiology giving rise to significant harm, a consideration as to whether the cause is unknown. 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.[23] The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark.[24]

27. In alleged non-accidental injury cases there is often reference to an analysis from material produced by the NSPCC, the Common Assessment Framework and the Patient UK Guidance for Health Professionals in Re BR (Proof of Facts)[25] which set out the following:

Risk factors and protective factors

"18. On behalf of the Children's Guardian, Mr Clive Baker has assembled the following analysis from material produced by the NSPCC, the Common Assessment Framework and the Patient UK Guidance for Health Professionals.

Risk Factors

Physical or mental disability in children that may increase caregiver burden
Social isolation of families
Parents' lack of understanding of children's needs and child development
Parents' history of domestic abuse
History of physical or sexual abuse (as a child)
Past physical or sexual abuse of a child
Poverty and other socioeconomic disadvantage
Family disorganization dissolution, and violence, including intimate partner violence
Lack of family cohesion
Substance abuse in family
Parental immaturity
Single or non-biological parents
Poor parent-child relationships and negative interactions
Parental thoughts and emotions supporting maltreatment behaviours
Parental stress and distress, including depression or other mental health conditions
Community Violence

Protective Factors

Supportive family environment
Nurturing parenting skills
Stable family relationships
Household rules and monitoring of the child
Adequate parental finances
Adequate housing
Access to health care and social services
Caring adults who can serve as role models or mentors Community support

[23] Re R (Care Proceedings: Causation) [2011] EWHC 1715 (Fam) Hedley J at paragraph [10]
[24] Re U (Serious Injury: Standard of Proof); Re B [2004] EWCA Civ 567, Butler- Sloss P at paragraph [23]
[25] Re BR (Proof of Facts) (2015) EWFC 41

19. In itself, the presence or absence of a particular factor proves nothing. Children can of course be well cared for in disadvantaged homes and abused in otherwise fortunate ones.

As emphasised above, each case turns on its facts. The above analysis may nonetheless provide a helpful framework within which the evidence can be assessed and the facts established."

28. Two further legal issues arise upon which the law should be set out at this stage. The first is findings sought in respect of medical professionals. In the case of Re W (A Child) [2016][26] a judge made findings against professional witnesses which had not been put to the witnesses in the witness box. The approach the court should take is as follows:

"(95) Where during the course of a hearing, it becomes clear to the parties and/or the judge that adverse findings of significance outside the known parameters of the case may be made against a party or a witness consideration should be given to the following:
a) Ensuring that the case in support of such adverse findings is adequately 'put' to the relevant witness(es), if necessary by recalling them to give further evidence;
b) Prior to the case being put in cross examination, providing disclosure of relevant court documents or other material to the witness and allowing sufficient time for the witness to reflect on the material;
c) Investigating the need for, and if there is a need the provision of, adequate legal advice, support in court and/or representation for the witness"

"(101) It is, unfortunately, sometimes the case that a judge in civil or family proceedings may be driven to criticise the professional practice or expertise of an expert witness in the case. Although what I have said with regard to a right to fair process under ECHR, Art 8 or the common law may in principle apply to such an expert witness, it will, I would suggest, be very rare that such a witness' fair trial rights will be in danger of breach to the extent that he or she would be entitled to some form of additional process, such as legal advice or representation during the hearing. That this is so is, I suspect, obvious. The expert witness should normally have had full disclosure of all relevant documents. Their evidence will only have been commissioned, in a family case, if it is 'necessary' for the court to 'resolve the proceedings justly' [Children and Families Act 2014, s 13(6)], as a result their evidence and their involvement in the case are likely to be entirely within the four corners of the case. If criticism is to be made, it is likely that the critical matters will have been fully canvassed by one or more of the parties in cross examination. I have raised the question of expert witnesses at this point as part of the strong caveat that I am attempting to attach to this judgment as to the highly unusual circumstances of this case and absence of any need, as I see it, for the profession and the judges to do anything to alter the approach to witnesses in general, and expert witnesses in particular."

[26] Re W (A Child) [2016] EWCA Civ. 1140

29. The next issue is publication and disclosure of the decision of the court. The court is asked to consider allowing publication of the details of the hospital, treating consultants and experts.

30. S97 of the Children Act 1989 prohibits publication of any material which is intended or likely to identify (a) any child as being involved in any proceedings before the Family Court…; or (b) an address or school as being that of a child involved in any such proceedings.

31. While the prohibition does not extend to hospitals, there is a risk that identification of the hospitals will increase the risk of identification of the child. That is particularly the case with rare or unusual circumstances, which may be discussed amongst professionals as part of case studies without the child being identified. In addition, the more information that is made available the greater the risk of jigsaw identification, whereby the identity of the Child or the Sibling may become known by piecing the information together.

32. The leading decision on naming experts is that of Munby LJ in A v Ward [2010] EWHC 16 (Fam) where he states, quoting from British Broadcasting Corporation v Cafcass Legal and others [2007] EWHC 616 (Fam), [2007] 2 FLR 765:

[34] On the one hand there are powerful arguments, founded in the public interest, for denying expert witnesses anonymity. These include the following, though no doubt there are others:

(i) First, there is, it might be thought, a general public interest in knowing the identity of an expert witness. As Watkins LJ memorably observed in R v Felixstowe Justices ex parte Leigh [1987] QB 582 at 595, 'There is … no such person known to the law as the anonymous JP'. Advocates do not have anonymity. In the same way, it might be thought, the courts should be chary (to put it no higher) of admitting the anonymous expert.

(ii) Secondly, there is a particular and powerful public interest in knowing who the experts are whose theories and evidence underpin judicial decisions in relation to children which are increasingly coming under critical and sceptical scrutiny.

(iii) Thirdly, there is the equally important public interest, especially pressing in a jurisdiction where scientific error can have such devastating effects on parents and children, not only of exposing what Sedley LJ (in Re C (Welfare of Child: Immunisation) [2003] EWCA Civ 1148, [2003] 2 FLR 1095, at [36]) once called 'junk science' but also of exposing other less egregious shortcomings or limitations in medical science.

(iv) Fourthly, and leading on from the last two points, there is a powerful public interest in knowing whether or not someone putting himself forward as an expert has been criticised by another judge or other judges in the past. Thus the sorry saga of Dr Paterson can be traced through the successively reported judgments of Cazalet J in Re R (A Minor) (Experts' Evidence) (Note) [1991] 1 FLR 291, of Wall J in Re AB (Child Abuse: Expert Witnesses) [1995] 1 FLR 181 and of Singer J in Re X (Non-Accidental Injury: Expert Evidence) [2001] 2 FLR 90. In each of those cases, it may be noted, Dr Paterson and the other expert witnesses were named in otherwise anonymised judgments. But in contrast the identity of the so-called 'independent social worker' and 'counsellor' Jay Carter criticised in damning

terms in Re JS (Private International Adoption) [2000] 2 FLR 638 and again in Flintshire County Council v K [2001] 2 FLR 476 (the 'internet twins' case), was not known to the public until she was publicly exposed and named in the judgment in Re M (Adoption: International Adoption Trade) [2003] EWHC 219 (Fam), [2003] 1 FLR 1111. As a commentator has observed (Camilla Cavendish, The Times, 29 March 2007), 'In the dark, we cannot see whether patterns of injustice exist'.

[35] On the other hand, there is an important public interest which, it might be said, justifies preserving the anonymity of expert witnesses involved in care proceedings. This work, though very important, is voluntary. The concern is that if expert witnesses in care cases are publicly identified this will be likely to lead to a further drain on the already diminishing pool of doctors and other experts willing to do child protection work. Doctors and experts in other disciplines may be yet further disinclined to do such work if they see that the evidence they give to the court on the understanding that it (and their own identities) will remain confidential may become public knowledge and be the subject of public criticism. The already inadequate number of experts willing to assist the courts in vitally important child protection cases may, it is feared, be even further reduced.

[36] In this context I note that the Family Justice Council in its response in November 2006 to the Government's Consultation Paper, Confidence and confidentiality: Improving transparency and privacy in family courts (CP 11/06) (TSO, 2006) recognised, at para 34, that:

'There is likely to be an increasing reluctance on the part of professional and expert witnesses to participate in court proceedings if they are to be subjected to the scrutiny of the media. This could lead to increasing delay in dealing with some family cases.'

[37] Thus there are important public interests involved here, just as there are the important personal interests of the social workers, the police officer, the treating doctors and the expert witnesses to be borne in mind. And these interests require careful consideration and, where appropriate, proper protection."

At 155 Lord Justice Munby states:

‘*….but my conclusion at the end of the day, taking into account all the evidence and other material which has been put before me and all the various submissions I have had on the point, is that neither the risks of targeting, harassment and vilification (which I accept are made out to a certain extent) nor the consequential risks of a flight of experts from child protection work (which I again accept are made out to a certain, although I think more limited, extent) are such as to demonstrate the ‘pressing need’ which alone could begin to counterbalance what in my judgment are powerful arguments, the very powerful arguments, founded in the public interest, for denying expert witnesses anonymity’*

And at paragraph 157:

> '*When all is said and done, it seems to me to be a very strong thing to say that the identities of the expert witnesses giving evidence in care cases – cases where the consequences for both children and parent are potentially so serious – should be concealed from the public. And quite apart from the most severely pragmatic of reasons for needing to know who are the experts giving evidence in such cases, does not the public in this context have an interest in not merely knowing what is being done in its name but also in knowing who the experts are whose evidence may have led (though of course not in this case) to a child being removed from his parents and placed for adoption.'*

33. **All parties have been given the opportunity to be represented** within these proceedings. They have been able to put their case. Article 6 of the European Convention of Human Rights has been fully engaged.

THE TRIAL

34. The trial timetable sought to include more than the 4 hours each day that the court was available to hear evidence, representatives did not adhere to time estimates and there were issues with connectivity of professionals and experts, who were giving evidence remotely. The professionals and experts were flexible both in their approach and in making time available to ensure their evidence was completed, and for that the court is grateful. The consequence of the issues meant the court was unable to give judgment at the time and, in any event, a written judgment was sought and was agreed to by the court.

35. Throughout the trial the court has sought to ensure the parties' Article 6 rights to a fair hearing have been met. As a result of the issues raised the court has also been required to consider the rights of other parties, as set out later.

THE EVIDENCE AND WITNESSES

36. The Court has read and heard a considerable amount of evidence. The fact that it does not mention something in this decision does not mean that it has not fully considered it. It is impossible to set out in this decision everything that has been heard and read. The decision must be based on proper evidence addressing all the realistic options for the child and containing an analysis of the arguments for and against each option. There must be an adequately reasoned decision which grapples with those factors and which gives a proper and focussed attention to those factors.[27] The basic principle is that the parties need to understand why the Court makes the findings and orders it does.

37. Within its analysis the Court has had the benefit of hearing evidence from the following witnesses:
    37.1. [Dr G], consultant paediatric neurologist;
    37.2. [Dr TM], consultant paediatric neuroradiologist;
    37.3. [Professor AM], consultant paediatric radiologist;
    37.4. Professor Sellar, consultant paediatric neuroradiologist;
    37.5. Mother; and
    37.6. Father.

[27] Re B-S (Children) [2013] EWCA Civ 1146

38. It has also had the benefit of the following written evidence (not an exhaustive list):
    38.1. Report of [Dr N], consultant paediatric radiologist, dated 13 May 2021
    38.2. Statement of [DK] (Social Worker) dated 21 June 2021
    38.3. Statement of the Father with Exhibits dated 9 August 2021
    38.4. Statement of Mother with Exhibits (undated)
    38.5. Report of [Professor AM] dated 29 November 2021
    38.6. Statement of [Watford Consultant Paediatrician], Consultant Paediatrician, dated 14 December 2021
    38.7. Statement of [PD], Senior Social Worker, dated 16 December 2021
    38.8. Statement of [RA], Consultant in Paediatric Neurology, dated 16 December 2021
    38.9. Statement of [RG] dated 16 December 2021
    38.10. Letter from [YSP], GOSH, dated 17 December 2021
    38.11. Statement of [Dr G], Consultant Paediatric Neurology & Neurodisability, dated 20 December 2021, along with signed statements/letters dated [Day 14], [Day 15] and [Day 21]
    38.12. Statement of [NG], Paediatrician, dated 22 December 2021
    38.13. Statement of [PCU Nurse] dated 23 December 2021
    38.14. Statement of [Dr PJ] dated 24 January 2022
    38.15. Statement of [Dr X] dated 25 January 2022
    38.16. Updating Statement from [Dr X] dated 3 February 2022
    38.17. A composite chronology prepared by the Local Authority, along with various responses from the parents
    38.18. The Local Authority threshold document, along with the parents' responses
    38.19. Report of Professor Sellar dated 6 January 2022
    38.20. Addendum report of [Professor AM] dated 20 January 2022
    38.21. Transcript of the experts' meeting of 16 February 2022
    38.22. Statement of [XE], GOSH social worker, dated 4 March 2022
    38.23. Statement of [Dr TM] dated 7 March 2022
    38.24. Statement of XXXXXXXXXXX, maternal grandmother, dated 8 March 2022
    38.25. Statement of [Watford Community paediatrician], Community Paediatrician dated 9 March 2022
    38.26. Police records
    38.27. Various medical literature.

39. It is important that the evidence is considered in context. The parents have had to deal with the grief of the injuries caused to the Child as well as the pressures that a case like this inevitably brings. The behaviours expected from people grieving include:
    39.1. Shock, meaning they are unable to listen to their legal advisor and unable to make decisions
    39.2. Fear and anxiety, meaning they are unable to deal with the legal process
    39.3. Searching, with an inability to accept the reality of the situation
    39.4. Anger
    39.5. Sadness and depression, where they may not answer their legal representative's calls or engage with the proceedings
    39.6. Acceptance, where they are capable of listening to advice and giving constructive instructions
    39.7. Reinvestment and growth

40. The Local Authority instructed [Dr N], consultant paediatric radiologist, to provide a report on 18 March 2021, pre-proceedings, on a single expert basis. The letter of instruction identified "the treating clinicians and any other relevant professional with whom [Dr N] will wish to have contact" as [Dr W], Named Safeguarding Doctor at GOSH. The expert was asked to consider if the Child had suffered a non-accidental injury or not. The documents provided to the expert did not include the medical records, save for the scans, and were:
    40.1. Record of Strategy Discussion dated [Day 4].
    40.2. Record of Follow Up Strategy Discussion dated [Day 7].
    40.3. Statement of [Dr G] dated [Day 14].
    40.4. Statement of [Dr G] dated [Day 15].
    40.5. Addendum Letter of [Dr G] dated [Day 21]
    40.6. Case note of meeting at GOSH with parents, GOSH Social Worker and [Dr G] dated [Day 15].
    40.7. Letter of Dr Alison Steele dated [Day 30].
    40.8. Record of Strategy Discussion dated [Day 62].

41. The background provided to [Dr N] was as follows:
    The parents have reported that on [Day 1] at around 6 pm the family was in the kitchen. The father was cradling the Child in his right arm and was moving him up and down. It is reported that the older child, (the older Sibling) wanted a cuddle from her father. Father tried to pick (the older Sibling) up on his left side on his hip. Mother reported she turned around for a few seconds and when she turned back, she could see the Child arching backwards, flipping over and falling onto the floor. The floor is described as a hardwood floor on top of concrete. There were no obstructions or toys on the floor. Mother was not sure whether the Child fell on his right or left, front or back. The parents reported that the Child did not lose consciousness, no vomiting and no bleeding. Mum reported that one eye was open, and one eye was shut and there was swelling to his head. As the family reside 10-15 minutes away from the hospital, they decided to drive to the hospital. On the way an ambulance was called to make sure they were expected at Watford General Hospital… The professionals involved in the Child's care have not been able to agree on the mechanism of the Child's injury and whether this was an accidental or non-accidental injury. Concern has also been raised as to some discrepancies in the accounts provided by parents.

42. [Dr N]'s report of 13 May 2021 confirmed he knew and had worked with [Dr G] before. It was his opinion that the constellation of imaging abnormalities could not reasonably be explained by a fall from a height such as being held by an adult. The 2 main possible explanations he put forward were a crush injury (such as if an adult had stepped on the Child after the fall to the floor) or an episode of impact head trauma involving an impact injury involving a much greater degree of force that is likely to have occurred as a result of a fall from carrying height. It was his conclusion that the parents' explanation did not account for the totality of the imaging abnormalities.

43. There were discrepancies between the reported chronology in [Dr N]'s report and the background provided in the letter of instruction. Specifically, it stated:
    43.1. Father tried to pick the Sibling up and put her on his lap;
    43.2. the Child arched backwards and fell to the floor (without mention of the flipping);
    43.3. There was no mention about the eyes;

43.4. It stated some swelling developed on the Child's head, whereas the instruction stated there was swelling present (possible timing issue); and

43.5. Father gave further details later suggesting that as he tried to catch the Child "it felt like I almost thrown him" i.e. an accelerated fall

44. It must be remembered that [Dr N] was not called to give evidence in the case and was not the reporting expert. Based on the background as [Dr N] understood it, he described the fall as akin to a fall from a domestic piece of furniture, a toddler falling over and banging their head on a hard surface or a child being dropped from standing height onto a surface such as a pavement. He identified skull fractures as uncommon outcomes following such events and the type of skull fracture that might be seen following such an event would be a simple linear skull fracture. He stated it would be very unlikely that an episode of domestic head trauma would give rise to such a set of complex fractures. He went on to consider the brain injury which had also occurred, which was very extensive and had involved the full thickness of the brain. The 2 clinical scenarios he felt would perhaps most commonly explain such a full thickness injury would be if there had been a penetrating injury such as might occur if the Child had fallen onto an object which caused the fracture and penetrated through the skull into the underlying brain or if there had been a crush injury which caused the bilateral fractures but also led to the penetration of the brain by the free fracture fragment which could be seen on the right side in the scans.

45. Both [Professor AM] and Professor Sellar were instructed on the basis of the parents' account of a fall from height onto a hardwood floor on top of concrete. The letter of instruction identified the view taken at the strategy meeting on [Day 4]. It also identified there had been multiple different medical opinions on the issue and the parents had provided accounts on a number of occasions, with some concern having been raised (not accepted by the parents) that these accounts differed in some respects. In addition, the instruction to Professor Sellar also stated that the account of the Father had not been taken before GOSH had come to the conclusion that this was an NAI and that Father is able to provide a video demonstration of the account. A full account was provided to the police together with a demonstration.

46. [Professor AM] was instructed on 6 August 2021 and Professor Sellar on 16 November 2021. Each expert was provided with a bundle of papers and asked the following questions:

46.1. Please consider the radiological imaging undertaken on the Child and list your radiological findings in this matter from each set of images, detailing any fractures or other abnormalities seen.

46.2. Please provide, as specifically as possible, the timeframe for any fractures / abnormality observed by reference to a window of opportunity? Please provide your reasons for the dating given to the abnormalities observed.

46.3. Please consider and list a) all possible causes of any fractures/abnormalities identified b) possible mechanism c) the most likely cause and d) the likely force required to cause any injuries observed and reported upon? *In answering this question please provide your reasoning for your opinion and please consider the accounts proffered by the parents. (court emphasis)*

46.4. Please consider whether, from your observations of the radiological information in this case, the Child a) is likely to be, b) could be; suffering

from any underlying disorder leading to bone fragility? In light of your conclusion, do you recommend any further scanning or testing of the Child and please explain your reasons for the same.

46.5. *Please consider the opinions provided on the radiological images by the hospital radiologists and provide your view in relation to the same in terms of whether you agree with the conclusions they have reached or not, providing your reasons for the same? (court emphasis)*

46.6. Please confirm whether there any features of the matters that you have identified, which are indicative or diagnostic of inflicted injury, and if so which features and why you reach this conclusion.

46.7. Please confirm your process for differential diagnosis, highlighting any factual assumptions and deductions made and any unusual features of the Child's case, including any contradictory or inconsistent features in respect of any of the injuries/anomalies observed either individually or collectively.

47. [Professor AM']s report was qualified on the basis she had understood there may be a report from a biomechanical engineer. In the Executive Summary she stated:
"Although uncommon, bilateral and/or complex skull fractures have been documented as following falls from carer's arms, particularly in infants below 6 months of age. Therefore, the explanation as given by his parents MAY have resulted in the identified fractures i.e., I cannot determine whether the Child's skull fractures were accidental or inflicted – from my perspective as a paediatric radiologist, either is possible."

48. Within the report [Professor AM] confirmed she had reviewed the following diagnostic images:
48.1. CT scan of [Day 1];
48.2. Skeletal survey of [Day 7] – 28 images;
48.3. Skeletal survey of 1[Day 9] – 9 images;

49. [Professor AM] confirmed she had also received 2 brain MRIs dated [Day 6] and 2[Day 9] and an MRI spine dated [Day 6]. She had not reviewed these, as being outside her area of expertise.

50. While the bibliography to [Professor AM's] report only contained 2 articles, one of which she had co-authored, the body of the report referred to 5 further papers and discussed their relevance to the case. She appended copies of each article to her report. She identified that she had not personally seen such severe fractures following a fall from a carer's arms. She also identified that detailed descriptions of the fractures were not given in the literature she had referred to and therefore they could not be compared to the Child's injuries. Her response to question 5 was to agree with the "hospital radiologists" that the Child sustained bilateral fractures and their subsequent investigations performed to exclude fractures at other sites.

51. [Dr G]'s witness statement of 20 December 2021 was limited to confirming the documents and his involvement in treatment.

52. Professor Sellar's report of 6 January 2022 stated "there is an error on opening the GOSH file". It did not identify what the error was, the consequence or any

action taken as a result. As argued by Father, it is implicit that the file could be opened.

53. The report summarised the professionals meeting on 18 May 2021, followed by a heading of "Inconsistencies in the parent's accounts" in bold without any further text.

54. Only one radiological report was identified in Professor Sellar's report, namely a report from Watford General Hospital of [Day 1] which concluded "these injuries are clearly discordant with the amount of trauma mentioned in the referral and would need further detailed correlation with the history and social circumstances on lines of possible nonaccidental injury. In answer to question 5 of his instructions, Professor Sellar confirmed he agreed "with the Radiology opinions expressed by the hospital radiologists – see above".

55. While discussing burst type fractures Professor Sellar identified [Dr N] as describing a mechanism for crush injury as, after the Child had fallen, his head was then stood/stamped upon.

56. Professor Sellar identified soft tissue swelling overlying the left parietal and the right parietal fractures. It was his opinion that a "history of a fall from about 4 to 5 feet, on its own, is very unlikely to cause the severe (Radiological) brain injury. Such a fall does not typically cause bilateral skull fractures. Bilateral skull fractures were occasionally noted by Weber during his experiments with infant cadavers (dropping them head first from 82cm). But these were caused by falls onto the midline of the skull. In the Child's case there are two areas of soft tissue swelling. One overlying the right parietal bone and the other effecting the left parietal bone. This very much suggests a minimum two impacts." He also stated "the extensive skull fracturing seen is very unlikely to have been caused by a fall as initially described by the father. Two impacts are suggested by the bilateral soft tissue swelling. The burst type fracture seen is typically caused by a crush injury (possibly stamping or being thrown against a surface). The presence of a burst fracture or crush injury is typically caused either by a severe accidental injury e.g. falling out of a window two stories up or a severe RTA (see below Ellis et al) or by a non-accidental injury."

57. His certification of the report stated he had (a) mentioned all matters which he regarded as relevant to the opinions expressed; (b) drawn attention to all matters, of which he is aware, which might adversely affect his opinion, and (c) where, in his view, there is a range of reasonable opinion, he had indicated the extent of that range in the report.

58. The transcript of the experts' meeting of 16 February 2022 can be summarised as follows:
    58.1. Professor Sellar did not have personal experience of bilateral skull fractures resulting from a single fracture, personally, but it can occur
    58.2. [Professor AM] had certainly seen bilateral fractures, but could not really remember the precise mechanisms
    58.3. [Professor AM] agreed with Professor Sellar's view that it was possible Father's attempts to catch the Child may have accelerated the fall
    58.4. Professor Sellar stated that although complex fractures may occur from a fall from a parent's arms, they're not common and he had never, in his

experience, seen a fragment of bone being burst out from the skull, as in this case

58.5. [Professor AM] was of the view certainly the acceleration was likely to have increased the momentum levels, and, therefore, the force with which the Child's head would hit the ground. Whether it would be sufficient to cause the precise fracture sustained was another matter…

58.6. When asked about an impact on a wooden floor with concrete base suggesting it was more likely the fall, as described, caused the injuries, Professor Sellar stated "Well, the original story given by the parents to (the local) Hospital was that the fall was onto a carpet. So I would agree with the question that if the fall was onto a wooden floor with a concrete base, it would be more likely that the fall described cause the injuries to (the Child)…" [Professor AM] agreed a hard surface was more likely to cause a fracture than a softer surface.

58.7. Both experts were asked if it was possible, when combining the acceleration with the impact on a wood/concrete fall, this may account for the injuries. Professor Sellar described it as just possible, because nothing is impossible, but highly unlikely, and [Professor AM] agreed.

58.8. Professor Sellar finished off by saying, "The only thing I would say is that I have never seen an injury such as this to the brain, with brain extruding through the fracture site, from a simple fall, or even an accelerated fall, from one of the parents' arms."

59. [XE]'s statement confirmed that following a meeting which took place on [Day 8] between the parents, [XE] and [RA] Consultant Neurologist, [SW] Fellow, and [SC], Clinical Fellow, it was accepted the professionals note of the meeting was not as detailed as had taken place and [SC] and [SW] were asked to amend their notes.

60. [Dr TM]'s statement identified a difference in opinion between neurology, neurosurgery and safeguarding clinical colleagues about the case on [Day 6]. That was the reason why the consensus radiology statement was produced. Her statement identified that when a neonate or very young child falls from the carers arms as in this case, according to the literature, the injury sustained can be much more severe than uncomplicated fall from a short height. Fractures can be seen on both sides from a single injury in this age group and in the given mechanism. The overlying hematoma of scalp further corroborates the acute nature. The displaced skull fragment on the right with dural tear and herniation of meninges and brain as well as widening of lambdoid sutures on both sides suggest a high impact nature. The brain parenchymal injury was only on the same side of the brain, consistent with direct high impact trauma. Bleeding was seen predominantly on the side of the more complex fracture, further suggesting single high impact trauma. She was able to rule out a second older injury or shaking injury. She identified trabecular fractures were commonly associated with axial loading injuries like fall from height landing on the head, consistent with the given mechanism.

61. In the statement, [Dr TM] provided a conclusion as follows:
"In conclusion, based on the current radiological literature on impact head trauma, in my opinion, radiological findings of bilateral parietal fractures and underlying brain injury is compatible with the mechanism described (i.e., fall of the child from a height of about 5.5ft while being carried by the father). These

findings are compatible with a single high impact direct contact trauma to the right side of head."

62. [Dr TM] provided copies of the documents referred to in the consensus statement, of most relevant note being:
    62.1. "Forensic Aspects of Pediatric Features: Differentiating Accidental trauma from Child Abuse (2010)" by Bilo and Others which stated
        62.1.1. Skull fractures - …The degree of deformation of the skull at the moment that the fracture is sustained and the nature and size of the fracture and the associated injury will depend on a number of factors…:
            62.1.1.1. Trauma-related
                – Location of contact
                – The force of the impact at the moment of contact
            62.1.1.2. Anatomy-related
                – The scalp
                – The age of the child
                – Shape, build, thickness and malleability of the skull at the point of impact and other sites
        62.1.2. Force of impact at the moment of contact - The amount of energy released at contact is determined by four elements:
        • The shape, weight and nature of the object. It may be a solid object that will not give way during contact (such as a hammer, concrete floor or stone) or a more or less soft object with a surface that gives way at contact (such as a mattress or a floor covered with thick soft carpet). In soft and yielding objects, the deformation of the surface will absorb a large part of the energy released at contact. Yet, the literature has shown that a child falling on a soft surface can also sustain a fracture [12]. In a solid non-giving surface hardly any energy is carried over to the object.
        • The velocity resulting from the speed of the head and the object at the moment of impact.
        • A fixed or free-moving head. When the head can move freely, it will move along in the same direction as the object. In this manner, part of the energy at impact is absorbed by the movement.
        • The size of the contact surface. If contact takes place on a limited surface, all energy released at contact will be concentrated at this surface. If the site of impact is larger, the energy will spread itself over this surface
        62.1.3. The age of the child – … Young children do not have a diploid structure of the parietal bone, leading to an increased risk for sustaining a fracture in this bone in a short-distance fall [12].
        62.1.4. Skull Fractures and Intracranial Injury … the location of the skull fracture is not a good indicator for the location of the subdural haemorrhage.
        62.1.5. Dynamic Impact Loading: Accidental Falls - When a skull fracture is the result of a fall from a bed or a changing table, it is unlikely that there will also be other fractures, such as rib fractures or a mid shaft fracture of one of the extremities. In a non-accidental skull fracture, for example when a parent hits the child's head against the wall, or at the end of his/her wits throws the child to the floor, it will nearly always lead to a different kind of injury, either intracranial or in other locations of the body. The overall picture will look more like a serious accident;

however, the anamnesis will not be able to explain the injury and its location. In other words: an accidental skull fracture can nearly always be explained based on the anamnesis (history).

62.1.6. Fall studies in deceased children - … Weber did experimental research with deceased children of <8.2 months old. In his first article he describes three test series each with five children who he dropped in free fall from a height of 0.82 m on several surfaces (stone-tile surface, carpeted floor, foam-supported linoleum floor) [51]. Hereby, the horizontally positioned body and the parieto-occipital part of the skull hit the surface simultaneously…

62.1.7. Uncomplicated Fall Over a Short Distance (Maximal 1-1.5m) - … Tarantino et al. concluded that the biomechanics of a fall from the arms of a carer may be different from other kinds of short-distance fall, such as a fall from a bed, settee or changing table.

62.1.8. Skull Fractures in a Complicated Fall - In a complicated fall, the child does not have a short distance free fall, landing on a flat surface. There may be complications during:

• The initial moments of a fall: for example, the arms of a carer, a fall from a swinging swing or a fall with a baby walker.

• The fall itself: for example, a fall of the carer who holds the child on his/her arm, and in which the carer falls fully or partly on the child; a fall from a bunk bed in which the child comes into contact with parts of the bed while falling; or a fall with a baby walker from the stairs.

• The landing: for example, a fall on a non-flat surface or a fall on objects.

One also speaks of a complicated fall when the child falls from great height and the complications, such as sustaining a complex skull fracture and intracranial injury, are mainly the result of the higher velocity at landing.

62.1.9. Fall from the Arms of Parent/Carer - … Minns reports the possibility that infants, as early as 5 weeks old and when held with one hand against the shoulder of the carer, are able to lean back in such a manner that they fall. This usually involves a fall of approximately 1.5 m. As a result of such a fall, they may sustain a focal haematoma and even extensive skull fractures and focal contusion of the brain… Bechtel et al. described a number of situations in which children had fallen, for example, from the hands of parents/carers and consequently sustained skull fractures and other injuries

62.2. "Short Vertical Falls in Infants (1999)" by Tarantino and Others,

62.3. "Head injury from falls in children younger than 6 years of age (2014)" by Burrows and Others,

62.4. "A Forensic Pathology Tool to Predict Pediatric Skull Fracture Patterns (2012)" by Powell and Others, a study based on porcine animal modelling, which stated:

62.4.1. Developmental changes in the material properties of porcine skulls from 2-24 days paralleled those of the human skull from 2-24 months

62.4.2. With increasing energy of impact, fractures begin to cross sutures and propagate into adjacent bones of the skull.

62.4.3. It was typical in our experiments for a single impact to cause multiple cranial fractures in the impacted and adjacent bones of the skull. This result can have critical implications in abuse cases where multiple sites

of cranial fracture are often associated with multiple sites of blunt force trauma to the pediatric victim.

62.4.4. While scaling of the adult skull has met with some success in predicting impact response of the pediatric skull (Prange et al., 2004), the head of an infant is smaller and geometrically unlike that of an adult (Schneider et al., 1986) and the validity of predicting skull fracture patterns in infants from adult data has not been investigated. Using adult data to predict skull fracture patterns in the pediatric skull may also be problematic due to the different structural … and mechanical … properties of the infant skull

62.4.5. … the influence of sutures on skull fracture, is not clearly understood. Although the infant head is undeniably more compliant than the adult head, due to the nature of the birth process, the role of this compliance and possible viscoelastic response warrants further study in regard to impact biomechanics. It has been postulated that outbending plays a significant role in infant skull fracture, although this has not been confirmed with physical experiments. Skull fracture patterns have rarely been investigated experimentally to elucidate further information on the biomechanics of fracture, and the fracture locations relative to the impact location are unknown, as are fracture initiation and termination locations …

62.4.6. Implications For Policy and Practice - … The work, importantly, showed that the response of an infant head to impact is quite variable during its developmental stages. The fracture patterns can be altered by impact interface, impact energy and the degree of head constraint. Most importantly, fractures can often occur away from the site of impact and a single impact can generate multiple fractures. These are important concepts that can help determine many cases of infant abuse and separate them from accidental injury, such as falls from short heights…

62.5. "Head injuries in children under 3 years (2012)" by Crowe and Others, which stated:

62.5.1. At present, the understanding of head injury in children younger than 3 years is limited due to a lack of epidemiological studies.

62.5.2. … age-specific information is limited. The current literature available on the epidemiology and neurology of head injury in children under 3 years tends to focus on inflicted head injury or information is taken from small samples of generally 100 or less children

62.5.3. After a head injury, young children are more likely to attend a hospital emergency department for treatment than a doctor's office therefore, emergency based research is useful in understanding head injury in young children…

62.5.4. In the first 6-months of life the infant skull has a limited ability to resist or absorb energy from trauma

and

62.6. "Fracture Characteristics of Entrapped Head Impacts Versus Controlled Head Drops in Infant Porcine Specimens (2013)" by Powell and Others, which stated:The lack of sufficient scientific data from controlled experimental studies in the literature on cranial fracture mechanics still poses a significant challenge to medico-legal professionals in correctly diagnosing skull fracture as being due to abuse or an accidental fall.

63. When [Dr G] gave oral evidence he confirmed he had read [Dr TM]'s opinion, but not the literature. He confirmed his main concern was what he was told were inconsistent histories. He had not been aware the police had accepted there was no inconsistent history, but maintained his report was based on histories given directly to him. He accepted if the fall was sufficient enough it would be compatible with the injury. He was not able to comment on whether the force was enough to cause the injury sustained.

64. It was put to him that, based on current literature, his colleagues thought the mechanism described was compatible with the radiological findings and said he did not see any reason to disagree with his colleague's statements. He accepted his role was to set out the view of GOSH, but explained his remit was not to discuss the radiology findings, but to discuss whether the injury was compatible with the history given. Given what he had previously said, it was surprising to hear him state he was unable to comment on causation and accepted an accelerated fall was compatible with the injuries. He confirmed he had been aware of the consensus opinion at the time of writing his report on [Day 14]. He stated he had caveated his verbal opinion on [Day 15], based on the fact the history had changed. He also accepted his registrar had made errors in recording what [Dr G] had been told. He said he had been under pressure to commit to a statement if the injury was accidental or not and he did not feel he had enough information at the time to make that commitment.

65. [Dr G] agreed that the accepted risk factors in cases of Non-Accidental Injury were absent here, in that there was:
    65.1. No delay in obtaining treatment;
    65.2. No evidence of other injuries
    65.3. No history of previous concern
    65.4. The nursery was positive about the interaction between the Sibling and the parents; and
    65.5. No indication of any drug, alcohol or mental health issues.

66. [Dr TM] confirmed the consensus statement was agreed by 4 consultant neuroradiologists at GOSH, including the clinical lead. She explained it was not usual practice to upload documents such as the consensus statement onto the EPIC records database and they had no folder to upload such reports into.

67. She confirmed a fall onto the parietal bone can cause fractures remote from the parietal bone, as the energy of the impact dissipates through the skull, although it was unusual to have occipital or frontal fractures. She accepted that in the first 6 months of life the skull has limited ability to resist or absorb energy. The most frequently broken skull bone is the parietal bone. A fall striking the eminence may sustain a greater injury and there may be fragments of skull into the brain as well, with sharp edges potentially injuring both the covering of the brain and the brain itself. Given that infant heads are proportionately larger compared to their body size, they are more exposed to impact than other body parts, the bones are softer and more spherical, and the higher centre of gravity may increase the frequency of head injury. The Child was a small baby and [Dr TM] confirmed this can delay skeletal maturation, although many of them catch up. Where there is a direct traumatic injury with a detached fragment this can spring back once the force stops, as the skull tries to go back to its normal shape.

68. Trabecular fractures were explained as happening with a fall from height where the maximum impact is on the head, compressing the vertebrae, which corroborated the mechanism of injury.

69. When discussing the literature, [Dr TM] confirmed Bilo was the textbook most often referred to.

70. [Professor AM] was the third witness to be called. She confirmed her view that a fall from 5.5 ft might give one of the fractures, but not both, and that soft tissue swelling implies both sides of the head were hit. The only circumstances she could think of where a single impact might case bilateral swelling was if, on the way down, the head had hit something and then the other side hit the floor.

71. In questions from the Local Authority, [Professor AM] accepted the additional momentum would increase the force from just being dropped. While she accepted bilateral fractures could occur from a single impact, she stated soft-tissue swelling on both sides implied both sides of the head were impacted.

72. Over lunch [Professor AM] was asked to consider some of the literature produced. After lunch, in answer to questions on behalf of Mother, she stated it had reminded her that the fracture could have been the cause of the swelling, reverted to her initial report and confirmed that it was her opinion one impact could have caused the injuries. She also confirmed the literature rarely describes the nature of the fractures, whether they were complex, branching, whether they were with a fragment of bone elevated, how wide they were etc… She did not dispute a fall, ie the mechanism given by the parents, could cause the fracture. The question she had was whether it would cause the severity of fracture seen here. She accepted the highest risk mechanism of injury was a fall from a carer's arms. She also accepted that a lot of the literature dealt with older children.

73. [Professor AM] confirmed she knew the 4 consultant neuroradiologists who had prepared the consensus statement, and respected their opinion. She confirmed she did not disagree with the consensus opinion that the injuries were compatible with the history given. She also accepted the presence of subtle changes in the upper thoracic vertebrae could represent trabecular fractures. She described the sutures between the bones in the skull as gaps, with no bones there, which would close eventually. While she had not seen a fall causing the severity of injuries sustained by the Child in the literature, she accepted there is little literature on the issue.

74. The infant skull is more malleable and thinner. [Professor AM] accepted deformation depends on a number of factors, and she had not known of Powell's paper on Predicting Pediatric Skull Fracture Patterns before. She accepted that in the first 6 months the skull has limited ability to resist or absorb the energy from trauma and the influence of sutures on skull fractures is not clearly understood.

75. Drawing together [Professor AM]'s testimony, she agreed with the following propositions:
    75.1. Most frequently broken bone in infants is the parietal bone;
    75.2. Infants have larger relative head sizes;
    75.3. During a fall the head is proportionately more exposed;

75.4. The centre of gravity, being closer to the head, may increase the frequency and severity of head injury in this age group;
75.5. Cranial bones are softer and more compliant;
75.6. The shape of the infant skull, being more spherical, results in only a small surface area absorbing the whole impact;
75.7. Where an infant head falls onto an ungiving surface the surface does not absorb the energy of the fall, which remains in the head

76. Overall, [Professor AM] accepted she did not know how an infant skull would react and she stood by her initial report that the injury could have happened as described or be inflicted.

77. [Professor AM] finished her evidence at the end of the day. Notice was therefore sent to Professor Sellar, who was due to give evidence the next day, that [Professor AM] had reverted to her original report.

78. Professor Sellar did not agree with the consensus statement from the GOSH consultant neuroradiologists. While he accepted it was possible the accident could have caused the injuries, that was only on the basis anything is possible and it was not probable. He took the height of fall from the papers and said he had seen descriptions from 2 feet initially to 5.5 feet. He referred to [Dr N]'s opinion that a simple fall from a carer's arms would not be responsible for complex fractures and the burst nature of the injuries. When asked about [Professor AM]'s reversion to her original opinion, that the bilateral swelling could have been caused by a single impact, he said it was possible.

79. In answer to questions from the Local Authority, Professor Sellar stated it required quite a high impact injury to cause herniation of the brain through the skull vault. While a fall from a carer's arms could cause such injuries, he said he had not seen it documented in literature and had not come across it. He referred to a paper from Ellis which had collected 7 cases, the largest number of such cases in literature and indicating how rare such injuries were, and identified of those 7 cases one was a fall from a second storey window, one was a road traffic accident and the other 5 were all non-accidental injuries.

80. When asked upon behalf of Mother, Professor Sellar confirmed he had read the bundles. When asked whether he had followed his instructions he said he did not remember giving a detailed discussion on whether he agreed with the GOSH radiologists or not. He said he had not been aware of the consensus statement when he prepared his report and his reference to hospital radiologists' opinions had been to the one from Watford. He was asked about reading a number of medical documents from GOSH in the medical bundle and either could not remember reading some or suspected he had not read them. When asked why he had not commented on the GOSH radiological reports he suspected he did not have them and clarified that the error on opening the GOSH file meant he had not read it.

81. It was put to Professor Sellar that he would surely not prepare a report where he was asked to comment on radiological opinions without reading them. He disagreed, saying the most important thing was to report on the radiology as he saw it and reading other reports before that could lead you down the wrong path. He was asked why he had referred to [Dr N]'s report if that was the case.

He was also asked why he did not go back to the Guardian's solicitor, who was the lead in his instruction, asking for the reports. He said he would very much have liked to have their opinions after he had looked at the scans. He was then asked when he had not asked for an accessible bundle of the GOSH records and he was unable to say. He explained that when the Guardian received his report and saw he had been unable to open the GOSH file he imagined if it was important it would have been sent to him.

82. He was asked about answering the question about the opinions on the radiological images by the hospital radiologists without reservation and said he had answered it based on the report he had seen. He accepted it had occurred to him that there would be other reports, but he stood by the fact he had put in the report that he had not been able to see them (referring to the error opening the GOSH file). He agreed that when finalising the report it would have been very useful to see how the report compared to how others had reported.

83. It was put to Professor Sellar that he had reported contrary to instructions and contrary to good expert practice, with a crucial deficiency in his report, but he disagreed. He was unable to say if he had read [Dr G]'s letter of [Day 14] before writing his report and said even if he assumed he had the bundle he had no idea if he read them and there may be areas he had skimmed through. It was identified to him that [Dr G]'s report referred to the consensus statement and he was asked if he had read that before he prepared his report, to which he answered he would imagine so, but it was very difficult to know. In response it was pointed out to him that he had not made any reference to it in his report, and when asked if he had not referred to it because he had not read it he said "possibly". He was also unable to say if he had been aware that on [Day 15] [Dr G] had met the parents and told them on balance of probability the injury was most likely accidental. When it was put to him that he had plainly not read the record of discussion of [Day 15] he said he had no idea.

84. Professor Sellar described it as unfair to say he had not made one step to acknowledge his duty to be accurate and complete. He described as it being "ideal", as an expert, to be looking at the range of opinions to analyse and comment on them, but did not seem to accept it was a crucial and integral part of his role. He also stated he reported to the best of his ability with the records he had and he had hoped to receive the reports in future and add an addendum, because that is typically how it works.

85. Professor Sellar confirmed he had not read the literature referred to in the consensus statement before preparing his report. He had read Bilo since. He could not recall reading the Taratino paper before preparing his report. He had not read the Settle or Crowe papers before reporting, or considered the research by Powell and others. He was asked why he had not discussed the literature in his report and said he did not feel it was particularly appropriate. He also confirmed he had not read the Powell report on predicting paediatric skull fracture patterns since his report. He commented that he was not able to go through all the papers sent.

86. He accepted a drop from a caregiver's arms, compared to e.g. a fall onto a toy on the ground, was much more likely to cause a complex fracture and that falls onto a hard surface were also more likely to cause complex fractures. The higher

the fall the more likely a fracture will be caused. The harder the surface, the more fracturing. The heavier you are the more likely you are to suffer a skull fracture if you fall head first. Age determines the amount of maturity of the bones, with less mature bones more likely to fracture. He also accepted a single impact can cause multiple fractures relatively distant to the point of impact. While extensive skull fractures are rare, he said they may occur. He also accepted a baby rearing up, backwards, and diving to the floor does occur.

87. He was taken to task about whether he had expressed a reasonable range of opinion. He referred to paragraph 5/6(2) of his report which stated "such a fall does not typically cause bilateral skull fractures" as setting out the range of opinion. He referred to huge literature out there and felt the consensus statement was moderately selective. Professor Sellar also referred to a paper by Hobbs, saying complex fractures were more likely to be non-accidental, which had not been referred to in his report, but had been referenced by [Professor AM].

88. Professor Sellar stated he had not read the Powell report because it related to pigs, and he thought the Weber paper was more useful. The Weber paper was discussed. It was not one of the papers set out in the appendix to Professor Sellar's report, which was limited to a report by Ellis et Al on Acute Identification of Cranial Burst Fracture: Comparison between CT and MR findings. In the run up to the hearing the parties had sought this from Professor Sellar, but he had been unable to produce it due to insufficient notice and only had access to the summary. The advocates had found a copy, which was in German with an English translation, and produced this at the hearing. He accepted the paper concerned skulls preserved in formaldehyde, and it was not perfect. He had not incorporated any criticisms or critical analysis of the paper in his report. It was put to him that his interpretation of the Weber paper was wrong, by Father's representative.

89. The relevant extract from Weber is as follows:

Experimental Design

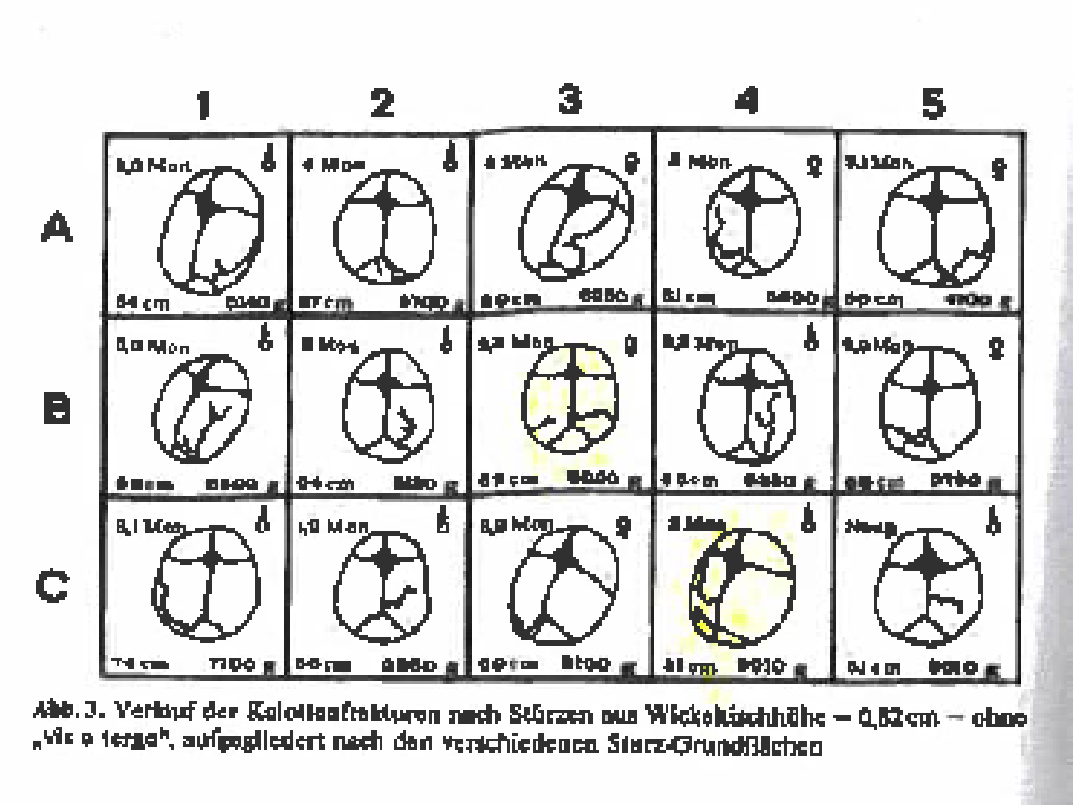
The investigative cohort consisted of 15 infants, who had died at ages up to 8.2 months as a result of pathological internal causes. Upon external examination, findings on palpation, and radiography, there was no indication of a previously existing fracture. In three series of 5 cases each the fall took place on a stone-tile floor A, on a carpeted floor B, and on a foam-supported linoleum floor C (Fig. 2), whereby the body in horizontal position and the parieto-occipital region of the skull simultaneously impacted, i.e., without "vis a tergo" [= a propelling force from behind]. Shortly thereafter the collection of investigative findings took place at autopsy.

Results

90. Professor Sellar's report stated the cadavers were dropped headfirst, and he spoke about the fact the report related to skull fractures and dropping cadavers, where you would not get skull fractures unless the cadaver was dropped head first. The experimental design clearly states the body was in a horizontal position. When this was put to Professor Sellar he stated that because it dealt with skull fractures he had assumed the design was different and the cadavers had been dropped head first.

91. Professor Sellar was asked about the reference to falling onto the mid-line of the skull and explained the mid-line was where there is the sagittal suture and the 2 parietal bones join together. The Weber paper refers to the parieto-occipital region of the skull. Professor Sellar said that was the midline, but agreed it also goes all the way around the back of the head, there was a range of areas where the skull may have been hit and if it was parietal occipital it was landing on the back of the head. He also accepted, as a general proposition, that if a body lands horizontally it was likely to cause less force in the head than if it lands head first, because the weight of the body would not follow through.

92. Professor Sellar explained it was his experience that bilateral fractures were typically continuous across the midline, but not always the case. The Weber paper had not stated the fractures necessarily join up. Professor Sellar explained he had taken it from the images provided. The following diagram from Weber was specifically referenced:



93. Professor Sellar identified picture C4 as showing fractures that joined up. It was put to him that what he was referring to were the suture lines in the skull, with 2 separate fractures on the left hand side, and he accepted the picture could be interpreted in that way.

94. He accepted the Powell research did not include anything to suggest cranial fractures needed to meet in the middle, and that he could not say with confidence one impact would have to result in a continuous fracture line.

95. Professor Sellar sought to rely on [Dr N]'s report. It was pointed out to him that he had misquoted [Dr N]'s report, because the word "stamped" did not appear in [Dr N]'s report at all. Professor Sellar explained this as his interpretation of [Dr N]'s use of the word "stepping".

96. Professor Sellar accepted he had been sent almost 1,000 pages of medical records on 19 November 2021. He was not able to say why he had not read them, but referred again to his comment on the error with the GOSH notes. He accepted the Watford records described a fall onto a wooden floor. He was unable to say where he had read a description of a fall onto a carpeted floor (albeit set out above in the background), but accepted the account given the minute after arrival at hospital was onto a wooden floor. He referred to the huge amount of literature and the limited amount of time to do these cases. He later spoke about the fact that in an ideal world you would read every line of every note before you come to court. When asked why he had not requested more time he stated he was continually hassled to produce reports as soon as possible. He was unable to say whether he had picked up from the papers that the Watford paediatrician thought the story was consistent or that the police thought the parents' account was plausible and consistent.

97. Professor Sellar accepted that the absence of bruises elsewhere on the body, other fractures, subdural haematomas, evidence of encephalopathy or retinal haemorrhages made a stronger case for accidental injury. He had not stated that in his report because he did not wish to stray into ophthalmology or orthopaedics. He believed it was for the court to put this together along with evidence from different experts and this was not within his expertise.

98. In discussion about a revised history, Professor Sellar opined that Father's explanation to the police was because he realised the severity of the injuries sustained. However, when this was analysed Professor Sellar accepted Father had not known the result of any scans, or that questions were being asked about whether the injury was inflicted, before he gave his explanation to the police.

99. [Dr N] was described as probably the most experienced neuroradiologist in this field by Professor Sellar. He also stated there is a huge problem dealing with very rare circumstances and it is difficult to be dogmatic. When it was put to him that he just did not know whether what Father described had caused the Child's injuries his answer was no, but reading the limited literature that there is and based on the experience of [Dr N], it was most likely to be caused by a fall from a much greater height.

100. At the end of Professor Sellar's evidence he accepted:
    100.1. Attempting to catch the Child and introducing spin meant we were dealing with different forces to those considered by Weber;
    100.2. There was a potential it had increased the force of impact and the direction of energy transfer through the skull;
    100.3. There was no research on the issue.

FINDINGS AND DECISION

101. The Local Authority accept that the account given by the parents has been consistent throughout. They attended hospital promptly, having dialled 999 on the way.

102. There were no other signs of injuries or indicators of abuse. There was no evidence the Child or the older Sibling suffered from any disability. This was not a socially isolated family, or one that had been known to Social Services

previously. There was no history of the parents having been abused as children or there being any domestic abuse in the household prior to the incident in question. The Health Visitor had reported a warm relationship between mother and both children. Both parents were observed to respond in a timely and appropriate manner to the Child's wants and needs, and to show appropriate emotional warmth to both children. No concerns had been raised by the older Sibling's nursery. There was no history of substance abuse, or that either parent had any mental health concerns. Their presentation following the Child's admission to hospital was observed to be entirely appropriate. In short, none of the Risk Factors from Re BR are present.

103. There is a report of an incident between the parents in [Month 2]. That has to be considered in the light of the circumstances that applied at the time and the stress the parents were under. However, despite that and the parents separating, Mother has remained steadfast in her position this was an accident.

104. This case has benefitted from considerable medical input, from both treating professionals and experts. The treating professionals agreed to disagree on whether the mechanism described by the parents was compatible with the injuries, hence the production of the consensus neuroradiology statement.

105. The primary purpose of hospital records is for treatment purposes. They are produced in what may be very stressful circumstances where time may be of the essence. It is a consequence of how the role of treating medics has developed that the records often include subjective assessments of information and opinion evidence. There is also the risk of "telephone" re-interpretation over time, with others applying greater significance to certain information than had ever been intended by the original note-maker. The role of the expert is to assist the court cutting through to the heart of the information.

106. The Local Authority produced a statement from [Watford Consultant Paediatrician], consultant paediatrician at Watford. The statement accepted none of the hospital records could be considered to be verbatim records but they identify an essentially consistent story given by the parents of the Child falling from Father's arms. [Watford Consultant Paediatrician]'s belief and recollection was that the parents did not describe a height but that this was estimated by different doctors to be between 4-5 feet. The main difference in the records was noted as the receiving doctor recording a fall onto a carpeted floor, whereas the triage nurse and [Watford Consultant Paediatrician] recorded that the floor was wooden.

107. The approach taken by the police is one consistent with the modern approach to information. They viewed the parents' explanation as completely plausible and stated, in response to [Dr G]'s view that there were significant inconsistencies and notable omissions recorded in the histories given by the parents, that *"reading through the points raised …I would suggest that the minor differences in the accounts given are in line with what each parent saw and how they interpreted it. Also, the details recalled at different times could be purely due to how memory works and the fact that these parents witnessed something traumatic. Had both parents given identical accounts and maintained them throughout I would be more likely to expect this to be lies"*

108. [Dr G] and [Dr TM] attended court to assist as treating consultants, not as independent experts. That is not to minimise their importance, but to identify the difference between their evidence and that of Professors [O] and Sellar. There is no suggestion they were obliged to do so. It must be remembered that their relationship with the parents as treating professionals will inevitably result in a degree of intimacy and therefore subjectivity when evaluating the case as a whole. This is the opposite of what is required of the expert witness, who should be objective, impartial and detached. Conversely, [Dr G] was also involved at a child protection level and this will have also affected his subjectivity.[28]

109. [Dr G] sought to caveat the opinion he expressed to the parents at the meeting on [Day 15], as recorded in the record of the meeting, which conflicted with his opinion in his report of [Day 21]. This did not tie in with the information the social worker then provided to the police and the fact the Child was discharged home. Having considered the evidence the court is satisfied the record of that meeting was accurate and he had not expressed the caveat he later sought to add.

110. The parents criticise the failure to include the consensus statement in the medical records. However, if the consensus statement were that the injuries were inflicted the question has to be asked whether they would accept that should also form part of the medical record. The difficulty here is that it would appear that adverse opinions, such as those of [Dr G], were included in the records.

111. The consensus statement was an extremely important document in this case. Whilst it is unfortunate that it was not produced earlier, what is important is that it was identified and obtained. The same applies to the Weber research. The focus in the NHS is supposed to be a no-fault culture based on supporting learning to prevent recurrence[29]. Whilst the parents may wish there to be criticism of the delay in providing this information, which may have impacted on the decision to issue proceedings, the court sees no reason to hold treating professionals to a different standard before the court.

112. Any suggestion GOSH may have prevented proceedings being issued is with the benefit of hindsight. There was a difference in views among professionals at GOSH. Unless and until those views were tested before the court they remained a difference of views. Given the decision of the court is on the balance of probabilities, the decision of the court is not one they are required to accept. It is one they are required to respect, even if they respectfully disagree with it. However, for that to occur they need to understand the basis of the decision which has been made and there may be lessons to be learnt by GOSH in their approach to this case. Both may justify disclosure of this judgment and the closing submissions of the parents to them.

113. The Local Authority brought these proceedings based on the severity of the injuries and the report of [Dr N]. However, [Dr N] was not the expert authorised by the court. It was therefore somewhat surprising to find Professor Sellar seeking to defer to [Dr N]'s opinion, when struggling to justify his own opinion,

[28] Oldham Metropolitan Borough Council v GW & Ors [2007] EWHC 136 (Fam) paragraphs 96-100
[29] NHS Serious Incident Framework 27 March 2015

when Professor Sellar was the expert called to report in the case and appeared before the court to justify the opinion. [Dr N] understood the mechanism he was dealing with, and therefore the basis of his report, was a typical domestic impact head trauma, akin to a fall from a piece of furniture, a toddler falling over and banging their head on a hard surface or a child being dropped from standing height onto a surface such as a pavement.

114. At the conclusion of [Professor AM]'s evidence a discussion took place about whether a summary of [Professor AM]'s evidence could be agreed and sent to Professor Sellar before he gave evidence the following day. It was clear it was too complex and there was insufficient time for this to be achieved. In the circumstances the information provided to Professor Sellar about the change of position was limited. However, while he started evidence on 23 March 2022 it then continued into 24 March 2022. If he wished to consider the documentation further and reconsider his opinion between the 2 occasions he could have done so and he did not.

115. There was limited subtlety in the cross-examination of Professor Sellar, which should not be read as a criticism of counsel in any way. At the time he went into the witness box he knew he was the only expert giving evidence the injury was unlikely to be accidental and that he would be challenged on that. Professor Sellar was specifically taken through his duty to the court, his certification in his report and what the parents said were breaches of his duty and deficiencies in his evidence.

116. An expert has a duty to the court and to the parties. It was clear from Professor Sellar's evidence that he had not fully or properly considered the papers sent to him. While he felt "There is an error on opening the GOSH file" made it "clear as day" that he had not read the GOSH records, that was not clear to the parties, or the court, prior to his evidence. While no party sought to clarify this with him prior to his attendance at court, an error implies a problem or a mistake. It is wholly different from "I was unable to open the GOSH file".

117. When the court authorises expert evidence it is based on an estimate of fees, and when the work can be done by, following enquiries made with the expert or their office. The Legal Aid Agency will only authorise a limited number of hours, and therefore limited cost, for an expert to prepare their report. For the type of report provided by Professor Sellar the standard limit is 10 hours. Professor Sellar estimated 45 hours and he was instructed on this basis, with the solicitor confirming prior authority had been sought for this. He was asked, in the letter of instruction, to identify if his fees were likely to exceed the 45 hours. There was no evidence before the court that he ever did so. If he was unable to do the work in the time due to lack of authorised hours he was under a duty to seek an increase. If he was unable to do the work due to workload he should not have accepted the work or committed to completing it in the time allowed.

118. The court is informed Professor Sellar charged for the full 45 hours. Upon behalf of Father it was identified that, if he was unable to open the GOSH records, he considered just over 300 pages of relevant material. His time was broken down as 12 hours for "Preparation, includes reading & review of documentation – medical records, reports and bundle"; 6 hours for reviewing the scans and images, 8 hours for results/formulation, consideration and clinical

formulation and an extra 19 hours for report writing (a total of 45 hours). While the report ran to 45 pages, it contained 27 pages plus appendices. Of the 27 pages only 7 pages provided a substantive opinion, there were 2 pages of background and 12 pages of information pulled in from records and literature.

119. Professor Sellar accepted in evidence that he knew there would have been reports from the scans at GOSH. He knew he was missing reports he had specifically been asked to comment on, yet he provided his report without seeking those reports or specifically stating he had not seen them. This was despite his certification that he had done his best, in preparing the report, to be accurate and complete, and that he had drawn attention to all matters, of which he was aware, which might adversely affect his opinion.

120. At the time that Professor Sellar reported it is clear there was a range of reasonable opinion that the injuries were accidental. He was dealing with a complex fall, involving gravitational and rotational forces, onto a hard surface. His statement that "The history of a fall from~ 4 -5 feet. This on its own is very unlikely to cause the severe (radiological) brain injury" ignored the complex nature of the fall.

121. There is an obvious and fundamental difficulty in research data in relation to injuries such as were sustained here. Unless the mechanism of injury was observed independently and accurately then researchers are unaware whether they are dealing with a common occurrence, an "outlier" (a rare but possible occurrence) or an inflicted injury. This applies as much to cases where significant injuries are sustained as when a child sustains little or no significant injury whatsoever, although those circumstances may never be reported and mean statistics are not a fair representation of the true picture. There is also a question of whether research is statistically significant, ie are there sufficient cases for a pattern or range of injuries to be derived/defined. As a result, the research pool of reliable date is very limited. It has been supplemented by experiments on dead babies (Weber) and pigs (Powell). Within the research, there is limited information on how injuries were sustained, when the devil is in the detail. This may be indicative of unclear histories overall.

122. Professor Sellar made reference to research in his report. He had not considered the main work by Bilo et al. He mis-quoted or mis-interpreted the research of Weber in preparing his report. None of the medical literature rules out the likelihood the injuries were caused as described by the parents.

123. Both [Professor AM] and Professor Sellar did not identify relevant literature when providing their reports. Professor Sellar's failure was compounded by not properly considering the documentation he had been sent and not advising his instructing solicitor that he had been unable to access some of the records. If he had read the records properly he would have identified there was a consensus statement from the neuroradiologists at GOSH which he did not have and needed to see.

124. When presented with the relevant literature [Professor AM] did a quick about turn and reverted to the previous report. Professor Sellar sought to justify his opinion, during which it became clear he had not read the relevant documents, not fully read the literature which had been provided and had mis-read and

misinterpreted the relevant research. The characterisation of him mis-representing the report of [Dr N] in the reference to stamping, as sought by Mother, is a step too far in this court's judgment, but the reference is indicative to a lack of care in preparation of his report. The court, and the parties, were expecting, and entitled, to hear the evidence of Professor Sellar and not to hear the evidence of [Dr N] by proxy.

125. [Dr TM] and Professor Sellar disagreed over whether there was evidence of trabecular fractures, consistent with a fall. Professor Sellar was aware of the issue, because it was covered in [Dr G]'s letter of [Day 14] as well as him referencing the consensus neuroradiology opinion. They are entitled to disagree, but Professor Sellar was required to set out the range of opinions in his report and did not do so. Professor Sellar accepted they would be consistent with a fall on the head.

126. Professor Sellar accepted that he and [Professor AM] were equally qualified to comment on fractures to the skull and spine. By the conclusion of the evidence of Professors [O] and Sellar they accepted as a proposition that the energy from impact to the unyielding wood/concrete floor would have nowhere to go but round the inside of the skull and that the consequences were simply unpredictable.

127. Professor Sellar spoke about the burst nature of the injury. Excluding the burst fracture, all professionals accept a fall from Father's arms could have caused the injuries. Professor Sellar believed the herniation of the injury had not been considered by [Dr TM] and her colleagues, despite the consensus statement referencing the herniation in 2 separate places.

128. With a simple drop onto a flat surface you would not expect a piece of the skull to be pushed into the brain and cause the damage that was done. However, this was not a simple drop onto the floor and there were unknown rotational forces in play. Professor Sellar relied on a paper by Ellis which included no description of the circumstances that led to the burst fractures described and was based upon 7 cases, one of which was caused in a road traffic accident, one was a fall from a second storey window and 5 were NAI. The court reminds itself the Ellis paper is an American paper and an American second storey is a British first floor, although it is accepted this point was not put to him.

129. Professor Sellar identified consideration of the broad canvas of evidence was outside his experience. Mother seeks to criticise that failure. However, that is exactly the reason why there is the court process and the court is required to take into account the broad canvas of evidence. That includes opinions from the perspective of the police, social workers and medical professionals. The issue arises that to expect a medical professional to approach a case from a social work perspective is to attempt to redefine their role in the overall process.

130. It must also be remembered that the court makes decisions based on the best information available at the time. As previously stated, what may be unexplained today may be perfectly well understood tomorrow. The issue for the court is whether the Local Authority are able to prove their allegations on the balance of probabilities. They are unable to do so, and accept they are unable to do so.

That position is also endorsed by the Guardian, who shares the concerns in respect of the expert evidence

131. The Local Authority accepts that having heard the evidence of Professor Sellar and [Dr G] they:
   131.1. have failed to consider all the evidence that was available to them at the time of their reports and letters;
   131.2. were approaching the questions under a false pretence that the parents accounts were inconsistent and failed to take into account the views of the police and other professionals around the plausibility of their accounts.
   131.3. do not appear to have necessarily reached an independent opinion on the cause of the injuries, with it appearing that Professor Sellar based much of his opinion on the views of [Dr N] and [Dr G], where [Dr G] had, for reasons he was unable to explain, changed his opinion from accidental to non-accidental after speaking with the safeguarding team at GOSH

132. The Father described Professor Sellar as an expert who, as the court accepts was evidenced by Professor Sellar himself:
   132.1. does not read the material provided
   132.2. does not make it crystal clear to his instructing solicitor that he has been unable to access crucial material
   132.3. does not follow the terms of his letter of instruction
   132.4. relies on summaries and/or views of others without verifying those summaries and/or views against the primary source material
   132.5. relies on the opinion of other experts in the knowledge that they did not have all relevant facts/documents before forming a view
   132.6. fails to acknowledge where factual disputes may be relevant
   132.7. fails in his duty to mention all matters that are relevant to the opinions he expresses and anything that might adversely affect his opinion
   132.8. fails to mention the range of reasonable opinion and the extent of that range
   132.9. suggests to the court that opinions of others (in this case neuroradiologists) have been taken into account when they have not
   132.10. misquotes another expert and therefore acts in way which is likely to mislead the court
   132.11. fails to grasp what research (within his own expertise) demonstrates
   132.12. misrepresents what research says and/or shows
   132.13. comes to the case with a preconceived opinion which he is then unreasonably reluctant to revise, even in the face of clear evidence

133. Reverting to the allegations pursued by the Local Authority the court is able to find as follows:
   133.1. The court is asked to determine that the injuries were caused as a result of a minimum of 2 impacts **– not established**,
   133.2. that they would not have been caused as a result of a simple fall from 4 to 5 feet – **the parents' case is a complex fall from a slightly greater height with added spin. The mechanism described is not the one the court was asked to consider. The court accepts the mechanism described by the parents could have caused the injuries sustained.**
   133.3. the injuries were caused as a result of a blunt or crushing injury to the Child's head **– everyone is agreed that this was a complex fall onto a flat, hard surface with downward and rotational force**.

133.4. the court is also asked to consider whether the sustained injuries were inflicted by either of the parents – **not established**; and

133.5. that the parents had not provided an accurate account of how the injuries were sustained **– accepted as inaccurate by the Local Authority before the hearing commenced. It is accepted the accounts given by the parents were consistent from the outset**

134. The parents spoke about complete exoneration. The Local Authority spoke about rare circumstances where there is not a basis on which the court can make a finding. The court is able to go so far as to say there is no evidence before the court on which the court could make any finding other than that the injuries were caused accidentally, as stated by the parents. In accordance with the binary approach, henceforth it must for all purposes be treated as having been caused by accident.

135. Mother seeks further findings against GOSH, [Dr G] and Professors [O] and Sellar. The court would respectfully point out that it is not for the parties to define the nature or extent of the findings the court should make. GOSH was not a party to these proceedings. [Dr G] may have attended as a treating consultant to give evidence, on behalf of GOSH, but he was not GOSH and he was not authorised to legally represent GOSH. He also falls into a different category of witness to [Professor AM] and Professor Sellar, because he is not an expert authorised by the court.

136. [Dr G] expressed his opinion in his letter of [Day 21], which he was entitled to do. He was not providing an expert opinion for the court and was therefore under no obligation to reference the consensus statement or accept it. He also explained, in the witness box, that he was relying on the history given to him and his clinical experience. When expressing his opinion it is a matter for him what weight he chooses to attach to what evidence. It should also be noted, as he was not an expert before the court he was not on proper notice that findings may be sought against him.

137. Mother seeks findings that Professor Sellar failed to be honest and open with the court when preparing his report and did not act with the integrity to be expected of an expert witness in that he:

137.1. Failed to read and consider the Child's medical records and the analysis of the scans but relied on the report on a scan undertaken by the general radiologist at the Watford general hospital when, had he considered the records, he would have seen the reports from the various consultants at GOSH even if he did not have the consensus opinion.

137.2. Failed to follow the letter of instruction asking him to comment on the hospital radiology opinion.

137.3. Gave unsatisfactory evidence as to when he received the medical records and when (if at all) he ever considered them.

137.4. If as he says he was unable to access the records sent to him, failed to ask the guardian for an accessible version of the records before reporting to the court.

137.5. Misrepresented the report of [Dr N] by giving the impression that [Dr N] had described the accident as a "*stamping*" either expressly of by implication when [Dr N] did no such thing.

137.6. Failed to provide the full Weber paper and misrepresented the research of Weber when he described Weber as supporting the notion that the skulls of the cadavers were dropped head first and suffered fractures which crossed the sutures.

137.7. Failed to read and consider the literature provided by the neuroradiologists even before giving his evidence to the court citing that he did not have enough hours in the day and thus was unable to advise the court properly or at all.

137.8. Even when faced with incontrovertible material undermining his opinion failed to take into account such material when giving his evidence but rather raised matters not raised in his report namely the suggestion that soft tissue damage would run the whole length of the fracture line and the fracture would cross the suture in the case of a single impact.

137.9. In his evidence sought to obfuscate so as to conceal the obvious fact that he had been at least careless in the preparation of his report, the experts meeting and the giving of his evidence.

138. The court has already discussed a considerable amount of Professor Sellar's evidence. The court is satisfied the observations and findings already made are appropriate and in accordance with the guidance in Re W (A Child). The court does not accept, however, that it is appropriate to make findings of dishonesty against Professor Sellar without at least giving him a further opportunity to be heard on the point. The court has to consider whether it is appropriate to extend these proceedings further to allow him an opportunity to be heard on the issue and the simple answer is it is not. It is not a proportionate use of the court's time and resources, while taking into account the need to allot resources to other cases.

DISCLOSURE

139. The Local Authority does not oppose publication of the judgment, and in fact states there is a public interest in doing so, in particular highlighting the lack of understanding of such injuries. Mother agrees, stating this is an important case and it is right that it is in the public interest that the issues relating to this type of fall and the medical/radiological opinion and what is expected of experts giving evidence to the court should be known in particular by legal and medical professional. Father supports Mother's view. The Guardian agrees publication of the judgment is in the public interest as:

139.1. It is necessary for the public to understand the lack of knowledge regarding injuries of the nature suffered by the Child and the limited research available on the subject.

139.2. It is in the public interest to understand the limitations of expert evidence.

139.3. It is in the public interests to understand how expert opinion can be misleading and the importance of experts being properly prepared and fully exploring alternative explanations when reaching their conclusions

140. The court reminds itself a decision in the Family Court is not binding on other courts, although it may be persuasive. It is not for the Family Court to make new law on the expectation of evidence of a medical professional. At the same time, publication is in accordance with transparency and would appear to be in the public interest. Therefore an anonymised version, removing all reference to the names of the parents, children, family, hospitals and treating consultants (see

below) will be required, along with dates being removed, to a schedule which will not be included in any published version and should be agreed by the parties.

141. Mother seeks to argue [Dr G] and [Dr N] should be named in any published version of the decision. Father appears to seek to add [Dr W] from GOSH to the list. In relation to whether the professionals and / or hospital should be named, the Local Authority is neutral on this issue. The court is reminded it will need to be satisfied that any witnesses are sufficiently aware that adverse judicial findings and criticism may be made.

142. The court is not satisfied it is appropriate to name any of those professionals in any published version of this decision. They are not experts in the case, so are not on proper notice of such. [Dr N] was not instructed on an ongoing basis, was provided with limited information, was not aware of the development of the evidence, may well have accepted his view could not stand if asked in light of the additional information and was not asked to attend to have his report challenged. [Dr W] was not called to give evidence. The court reminds itself that the court should not do anything to dissuade experts from providing the assistance that the court needs.[30] Publication of the details of the consultants and hospitals is also likely to increase the risk of jigsaw identification significantly. However, the court accepts the decision of the court may be of assistance to GOSH and the treating consultants when considering safeguarding in future and therefore is satisfied a full copy of the decision should be supplied to GOSH, along with the closing submissions of the parties.

143. Mother argues the decision should be published with the names of [Professor AM] and Professor Sellar, who were both named court appointed experts. She says there is a significant public interest in them being named. A concern is that these are experts currently working as expert witnesses in family courts as well as giving evidence in many other matters. Father agrees.

144. It was put to both witnesses on behalf of mother that their preparation of this case was careless at least, in the case of Professor Sellar also misleading, and as a result the parents have been put through an appalling ordeal. Without wishing to minimise such, the court reminds itself the evidence of both experts was obtained after proceedings had been issued. Neither expert was fundamental to the decision to proceed to court.

145. Father reminds the court of how [Professor AM] responded to cross-examination, considered the further documentation provided and faced up to and accepted matters put in cross-examination. This stood in stark contrast with the evidence of Professor Sellar.

146. The mother's position is that regardless of what names (if any) are to appear in the published decision, a copy of the decision with no anonymisation should be provided to the General Medical Council (GMC) and that permission be given for transcripts of the various witness evidence be obtained either at the mother's or the GMC's request in due course. Permission is also sought for the papers in these proceedings to be disclosed in their entirety to the GMC as may be required.

[30] Oldham Metropolitan Borough Council v GW & Ors [2007] EWHC 136 (Fam) at paragraph 98

147. The Local Authority does not oppose a version of the judgment which is not anonymised being disclosed to any professional body if such permission is sought from any party. Father does not oppose disclosure to the GMC. Neither does the Guardian. The court is satisfied this is not an issue on which Professors [O] and Sellar are entitled to be heard and the matter can be determined now. The court is satisfied it is in the public interest to give permission to the Mother to disclose the full judgment to the GMC and, should it be required, to obtain transcripts of the evidence of both witnesses.

148. It is the view of the court that before deciding whether the names of Professor Sellar and [Professor AM] should be published they should be given the opportunity to be heard on the issue. The court has included dicta from A v Ward to focus the mind in that regard, but they may wish to take legal advice. Therefore, a copy of the draft judgment should be provided to them and they be asked to provide, within 21 days, written submissions on the issue of publication of the judgment with their names to be included, rather than anonymised.

149. Finally, the court wishes to thank the advocates for their assistance and the parents for their patience.

Post-script: the delay in formal handing down of this decision has been to allow completion of the process of the 2 court-appointed experts being heard on the issue of anonymisation, which is being published in a separate decision.