Case No: **ZE18C00097**

IN THE EAST LONDON FAMILY COURT

11, Westferry Circus,
LONDON,
E14 4HD

Date: 14th January 2019

Before :

HER HONOUR JUDGE CAROL ATKINSON
(sitting as a Deputy High Court Judge)

- -

Between :

London Borough of Barking and Dagenham

Applicant

- and –

TAN's mother
KIM's mother
TAN (A Child)
(by his Child's Guardian) **Respondents**

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Alison Grief QC and Chris Barnes for the Applicant Local Authority
Mark Twomey QC and Shaun Murphy for the 1st Respondent (Mother of TAN)
Nick Goodwin QC and Matthew Stott for the 2nd Respondent (Mother of KIM)
Marcia Hyde for the 3rd Respondent Child (TAN)

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JUDGMENT

HER HONOUR JUDGE CAROL ATKINSON :

Introduction

1. Just after midday on 5th Oct 2017, the London Ambulance Service attended an 11-month-old baby called Kim in a state of collapse. She was immediately transported to the local hospital. On arrival her pupils were fixed and dilated. A CT scan revealed a large, right sided subdural collection. Kim was transferred, by ambulance, to Great Ormond Street Hospital and taken directly to the operating theatre. Although extensive efforts were made to save her life, Kim died at 22.35 on the same day.
2. At the time of her collapse Kim was being cared for by a babysitter who is the first Respondent in these proceedings. It is her child, TAN, a little boy aged 3 years, who is subject to the care proceedings. I shall refer to the babysitter as 'the mother' or 'TAN's mother' throughout this judgment. TAN's mother was arrested and interviewed by the police. She has been released under investigation. A charging decision is awaited. Meanwhile TAN was placed in foster care, initially pursuant to s.20 CA 1989. Then, after issue of the proceedings, pursuant to an ICO.
3. The LA, the LBBD, has never had cause for concern in relation to the mother's care of TAN. The evidence is that he has always been well cared for by her and despite their separation, through contact, she continues to demonstrate her capability as a parent. TAN and his mother maintain their loving bond.
4. The issue for me to decide at this stage in the proceedings, concerns Kim and the tragic circumstances of her death. Broadly, I am invited to consider:
    a. Whether Kim died because of inflicted trauma;
    b. If so, whether the mother inflicted that trauma.
5. It is the LA case that Kim's injuries were caused by a traumatic event. Whether that traumatic event was a shake, or an impact, the LA is unable to say. However, the LA is clear that the trauma must have been inflicted by the mother of TAN.
6. Kim's mother intervenes in these proceedings. I intend to refer to her as 'Kim's mother' throughout this Judgment. At the start of this hearing it was the mother's case, as it remains, that she did nothing to cause Kim any harm. As she was unable to explain how Kim suffered such significant injuries, consideration had to be given to the possibility that they had their origin in events taking place whilst in the care of Kim's mother. However, after the conclusion of the evidence from Mr Richards, the consultant neurosurgeon, TAN's mother bravely (in my view) conceded that whatever caused Kim's collapse must have occurred during the time that Kim was in her care and so Kim's mother should be formally ruled out as being a possible perpetrator of any injury.
7. That said, the mother nevertheless stands very firmly by her position that despite that concession she did nothing to cause these injuries to Kim. Specifically, she did not shake her, she did not

cause her head to come into contact with any surface – whether hard, smooth or soft – she did not drop her or accidently hit her head on anything. She is at a loss to explain how this tragic situation has come about.

Decision

8. After careful and anxious consideration of all the evidence in the case, I am satisfied of the following:
    a. The injuries suffered by Kim were caused by an inflicted trauma;
    b. That trauma was inflicted by TAN's mother;
    c. I cannot be certain of the mechanism but the evidence supports a shake/impact.
    d. The threshold is crossed on the basis of the likely risk of harm to TAN in the care of his mother following the finding that she inflicted harm on Kim.

Essential background

9. TAN's mother is 26 years old. She was born in a south east Asian country, which is where her extended family remains. She first came to the UK on a tourist visa in August 2013. She travelled for a second time to the UK on the same visa in November 2013. She decided to stay and has resided in the UK permanently ever since. Her tourist visa has since expired and so she has no proper immigration status in this country. That fact plays no part in my determination as to whether this young woman has caused Kim any harm, but it is of relevance to some of her behavior when questioned by the police and when asked to make a statement in these proceedings.
10. TAN's mother says that she fell pregnant with TAN after a brief relationship with TAN's father. TAN's father is registered on his birth certificate though she maintains that their relationship ended before TAN was born and he had indicated that he felt it was too early for him to be a father. He has taken no part in these proceedings to date and has no relevance to the issues arising at this fact finding.
11. There is no relevant history concerning TAN. Suffice to say that the LA concedes that no matters of concern have arisen in respect of his mother's care of TAN. Neither TAN nor his mother has ever come to the attention of the local authority and there have only ever been positive observations noted by those who have seen contact between the two of them.
12. TAN's mother is in a relationship. She met her partner Mr B in May 2016. He moved in with the family in summer July 2017. There is no suspicion or concern as to his involvement with these events.
13. Let me turn very briefly to Kim's mother. Kim's mother is 35 years old. She too was born in the same south east Asian country. She has two older children who still reside there with their maternal grandfather. Kim's mother maintains that she was the victim of religious persecution in

her home country which resulted in her imprisonment together with her husband. Her husband, she says, died in prison. She was assisted to escape and it was following this that she came to the UK arriving in October 2015. On arrival in the UK she sought asylum. Nothing turns on this history save possibly the fact that as an asylum seeker she too has an uncertain immigration status in this country and by virtue of that is unable to work.

14. Kim's mother met Kim's father around December 2015. Kim's mother reports they separated when she was around 5-months pregnant. It seems that in contrast to TAN, Kim and her mother had come to the attention of the local authority. However, given that the LA seeks no findings against Kim's mother and given the concessions made by TAN's mother this background information is of no relevance to my determination.

15. These two mothers met each other online though a [redacted] Community Page. TAN's mother advertised herself as a babysitter in September 2017 and Kim's mother responded. They agreed that Kim's mother would pay £30 per day and the arrangement started as soon as Tin's mother secured employment as a nail technician. As at 5th October Kim had been cared for by TAN's mother on 11 occasions, including 5th October 2017 – usually from around 9.15/9.30am until around 7.00pm. Nothing of significance occurred during those earlier 10 occasions.

16. It is agreed that on 4th October 2017 Kim was unwell and she had been a challenge to care for – wanting to be held all of the time. It is also agreed that in addition to the babysitting, TAN's mother earned money making food for people who ordered from her. She reports that it was an ad hoc arrangement. She had no regular orders. She simply made food when someone called to order. She disputes that she was cooking to fulfill an order on 5th October.

5th October 2017

17. On 5th October, Kim's mother had arranged for TAN's mother to babysit Kim. There is no dispute that immediately before her collapse and the calling of the ambulance, Kim was in the sole care of TAN's mother and had been with her for around 2 hours. Specifically, it is agreed that:

    a. TAN's mother collected Kim at around 9.10 – 9.15am, meeting Kim's mother at the bus stop which was a short walk from her property;
    b. Kim's mother then boarded the bus and went to work;
    c. TAN's mother took Kim, in her buggy, back to her home, passing her partner, Mr B in the street as he walked in the opposite direction on the other side of the road on his way to work;
    d. At around 11.52am TAN's mother made a series of calls to – Kim's mother and then to Mr B;

e. Shortly before 12 noon, TAN's mother emerged from the flat holding Kim to find someone who could help her. She approached a neighbour, Mr H, and asked him to help her call an ambulance;

f. Mr H called 999 at 11.57am. He described Kim as "*breathing but unconscious and [her] legs were stiff*".

18. Paramedics from the London Ambulance Service attended arriving at 12.04pm. Kim, who was observed to be very sick, was taken by ambulance to a local hospital. On arrival and registration at 12.44, Kim was unresponsive, her pupils were fixed and dilated. This was, as Mr Richards, the neurosurgeon, observed, not a good sign. A CT scan revealed a large, right sided subdural collection and she was transferred, by ambulance, to Great Ormond Street Hospital and was taken directly to the operating theatre.

19. When Kim arrived in theatre at 17.30 she remained unresponsive with fixed and dilated pupils. In order to relieve the pressure in her skull the surgeon performed a right frontotemporal craniotomy. Kim had to be resuscitated during the operation. After surgery Kim returned to the paediatric intensive care unit where she subsequently died at 22.35 on 5th October 2017.

The law

20. It is the local authority that brings this case and seeks the findings of fact set out in the schedule. It is for the Local Authority to prove those facts. The standard of proof is the balance of probabilities. I have in mind when considering these serious allegations, *Re B* [2008] (Children) UKHL 35. At para.70, Baroness Hale put it this way:

> *"I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under section 31(2) or the welfare considerations in section 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. 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. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies."*

21. Findings of fact must be based on evidence and not on speculation or hypothesis. As Munby LJ, as he then was, observed in *Re A (A Child) (fact-finding hearing: Speculation)* [2011] EWCA Civ 12:

> *"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation."*

22. I must take account of all the evidence and consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss observed in *Re T* [2004] EWCA Civ 558, [2004] 2 FLR 838 at 33:

"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."

23. The evidence of TAN's mother is crucial. However, that is not to say that she is under any obligation to prove anything or to come up with an explanation.

24. There has been a great deal of medical evidence in this case about which I direct myself as follows:

    a. There is no magic in the evidence of an expert. Experts do not assume some sort of special status. All witnesses come to the witness box as equals.

    b. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence.

    c. The roles of the court and the expert are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence (see *A County Council v K, D, & L* [2005] EWHC 144 (Fam); [2005] 1 FLR 851 per Charles J). Thus, there may be cases, if the medical opinion is that there is nothing diagnostic of non-accidental injury, where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts.

25. In *Re LU &. LB* [2004] 2 FLR 263, the Court of Appeal provided guidelines following the earlier case of *R v. Cannings*. At para.23, Butler-Sloss P. gave the following guidelines:

    a. The cause of an injury or an episode that cannot be explained scientifically remains equivocal.

    b. Recurrence is not in itself probative.

    c. Particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.

    d. The court must always be on guard against the over-dogmatic expert, the expert whose reputation or *amour propre* is at stake, or the expert who has developed a scientific prejudice.

    e. 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.

Developing this theme of injuries that could simply be *"not presently known or understood"*: per Hedley J in *R (A Child)* [2010] EWHC 1715 (Fam), I am reminded that in that case, Hedley J cited Moses LJ in the case of *R v Henderson & Others* [2010] EWCA Crim 1269, CA:

"There remains a temptation to believe that it is always possible to identify the cause of injury to a child. Where the prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative causes, it is tempting to conclude that the prosecution has proved its case. Such temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude beyond reasonable doubt an unknown cause."

Hedley J went on to make the point that a conclusion of *"unknown aetiology"* was not a professional or forensic failure; it simply recognises that there is much we do not know and that it is wrong to infer non-accidental injury merely from the absence of any other understood mechanisms. Thus, in cases where that possibility is realistic, a finding of "unknown cause or aetiology" remains an option for the fact finder.

26. I am aware that witnesses lie, and I bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear, distress. The fact that a witness has lied about some matters does not mean that he or she has lied about everything (see *R v Lucas* [1981] QB 720).

27. The essential components of a classic *Lucas* direction are set out in the judgment of Kennedy LJ in *R –v - Burge & Pegg*. [1996] 1CrApp R 193.

"The direction should, if given, so far as possible, be tailored to the circumstances of the case, but it will normally be sufficient if it makes 2 basic points: -

a. That the lie must be admitted or proved beyond reasonable doubt, and:

b. That the mere fact the defendant lied is not in itself evidence of guilt since Defendants may lie for innocent reasons, so only if the jury is sure that the Defendant did not lie for an innocent reason can a lie support of the prosecution case".

28. I have been directed to the guidance recently given by Keehan J who gave himself a revised Lucas direction that he *"should only take account of any lies found to have been told if there is no good reason or other established reason for the person to have lied"*. He took into account the decision in *Re H-C* [2016] EWCA civ 136, citing McFarlane, LJ, including at paragraph 10 that *"Judges should, therefore, take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt."*

29. Once I have determined the facts, then it is for the LA to prove that based on those facts, the statutory threshold is crossed. I must be satisfied, on the balance of probabilities, that at the relevant date TAN had suffered or was likely to suffer significant harm s attributable to the care given to him by his mother. The relevant date is the date upon which the LA took its protective measures and placed TAN into foster care. That was the day that Kim died.

THE EVIDENCE

The treating doctors

30. On arrival at Great Ormond Street Hospital (GOSH) a further CT scan revealed that Kim had a *'large mixed density right cerebral convexity subdural haematoma causing effacement of the right lateral ventricle, marked midline shift and effacement of the basal cisterns….evidence of uncal herniation…no skull fracture"*

31. The immediate concern was to evacuate the subdural haematoma and so Kim was taken to theatre at 17.30. I note that she remained completely unresponsive with fixed and dilated pupils; Scale 3 (the lowest) on the Glasgow Coma Scale. The neurosurgeons nevertheless decided to proceed with surgery 'accepting that the probability of survival was very low'.

32. In surgery a decompressive craniectomy was fashioned with the aim of reducing pressure in her skull. During surgery the dura was noted to be extremely tense. On removal of a part of the dura, a large haematoma presented itself and necrotic brain tissue herniated out through the craniectomy defect. Kim became unstable and an attempt was made to stabilize her by closing up the scalp. She arrested but was resuscitated following which she was able to generate a weak cardiac output. She was transferred to PICU for 'end of life care'. She died at 22.35.

The expert medical evidence

33. I have had evidence from a number of experts. In cases of unexplained child deaths, the post mortem procedure is carried out by two pathologists working in tandem. Dr Palm, a consultant paediatric pathologist and Dr Cary, a forensic pathologist. Following that post mortem, further macroscopic and microscopic examination was carried out by Dr Poole, the ophthalmic pathologist, Prof M, Consultant pathologist with specialism in orthopaedic pathology and Dr Jacques, consultant paediatric neurpathologist. The information from those extensive further examinations and from Dr Palm's examination of the organs was then pulled together by Dr Cary, in his final report. Dr Ramsay is a consultant neuropathologist and Mr Peter Richards is a consultant neurosurgeon.

34. The combined medical view at the end of this trial process is in direct opposition to TAN's mother's suggestion that there was no incident that caused Kim's collapse. As her legal team concede, the experts agree that trauma was the most likely cause for the group of injuries found in Kim. Despite that evidence, TAN's mother invites me to examine carefully the wider canvass which when combined with her evidence makes, she says, a non-traumatic cause a realistic possibility. That invites a more detailed analysis of this unified position presented by the experts. In addition, there are two areas of disagreement between the experts: the significance of the eye haemorrhages and the significance of the haemorrhages in and around the nerve routes and dorsal ganglia.

35. Before turning to the detail of the expert medical evidence let me deal with a matter that is now subject to agreement; the issue of timing.

Timing

36. There is consensus between all experts as to the likely, short, timeframe between the 'primary event' which led to the injuries identified and Kim's acute presentation becoming apparent on 5th October 2017.

37. On the issue of the timeframe the experts agree that the pathology is of limited assistance. Whilst the absence of haemosiderin in the blood and tissues suggests that the observed pathology is less than 48 hours old, the pathologists defer to Mr Richards who can report on Kim's likely clinical presentation and by that means assist in narrowing that window further. I will come to his evidence more fully in a moment but on timing he said the following:

> "*Fresh subdural bleeds causing compression and distortion of the brain of the hyperacute type seen in this case commonly cause severe neurological deficit within a very short period of time, usually minutes at most. .... With the injuries apparent I would not have expected any behaviour that could be considered as normal by a mentally competent carer. .... I would consider it likely, on the balance of probabilities, that the injury occurred either at the point when Kim became floppy and unconscious, particularly in view of the cervical nerve root damage identified which would usually be associated with immediate change, or within minutes if the change in state was as a result of the rapidly accumulating fresh subdural blood and distortion.*"

38. It was following this evidence that TAN's mother conceded that whatever happened to Kim, whilst it was not as a result of anything that she did, it must have occurred during the two plus hours that she was in her care.

Pathology

39. The principal pathological findings are not controversial. They are as follows:

    a. Subdural and subarachnoid haemorrhage over the right side of the brain with associated cerebral haemorrhage and swelling of the underlying brain;
    b. Hypoxia/ischaemia to the brain with associated vascular axonal injury;
    c. Subdural, subarachnoid and epidural haemorrhage over the spinal cord;
    d. Nerve root haemorrhage;
    e. Bilateral, transretinal haemorrhage; and
    f. Bilateral optic nerve sheath (including intra-dural) haemorrhage.

40. I can summarise the contributions made by each of these highly specialised experts to those essential findings, starting with Dr Palm, the consultant paediatric pathologist. Her examination did not identify any evidence of an underlying natural disease process or a medical condition that could have caused T's death or resulted in the constellation of the findings observed after death.

"*In summary, the post-mortem examination did not identify any underlying natural disease process that could have caused or contributed to the death of this otherwise healthy 11-month-old baby girl*";

41. In addition to the major injuries set out above, during the post mortem, Dr Palm and Dr Cary had identified what appeared to be a bruise to the left frontal sub scalp (above the left eyebrow). In her written report Dr Palm concludes that this and other (non-significant) bruises "*were confirmed histologically as recent due to the absence of haemosiderin pigment or an acute cellular reaction*". This appeared to conflict with the commentary in her report setting out and recording that the sample identified as Block A17, relating to the bruise scalp L forehead showed "**possible sparse** haemosiderophages…. (**weakly positive** Perls stain)" [my emphasis].

42. In her oral evidence she clarified this recording explaining that this was her description of what she had seen during her initial examination. However, she had not been confident that haemosiderin was present at the time and her use of the words 'possible' and 'sparse' reflected this. She explained that because of her lack of confidence she had re-cut the sample and that taken together with the original, caused her to conclude that that haemosiderin was unlikely to have been present in the forehead bruise. She was firm in her oral evidence giving a clear account of how the technique of using Perls stain can sometimes lead to a false positive and why that was so. This detail was confirmed by Drs Ramsay and Cary. I do not intend to set it out here as it has become uncontroversial. The important point is that her conclusion was very firmly that there was not enough evidence to show the presence of haemosiderin.

43. This was a development of some significance during the hearing. Because of this evidence I am invited to conclude that the forehead bruise was histologically "*fresh*" (i.e. less than 36 – 48 hours old). I confirm that I am so satisfied and indeed so far as I am aware it is not suggested that I should reject that evidence. This is significant because it makes that bruise potentially contemporaneous with the subdural, retinal and spinal haemorrhages. As I shall describe, it is this feature that seemed to finally drive Dr Ramsay to agree that the subdural haemorrhage was most likely the result of trauma.

44. Dr Jacques is a Paediatric Neuropathologist. He separately examined the fixed brain, spinal cord and dura. He confirmed:

    a. SD and subarachnoid haemorrhage over the right side of the brain…associated cerebral haemorrhage and swelling of the underlying brain
    b. Hypoxia/ischemia to the brain with the associated vascular axonal injury
    c. SD, subarachnoid and epidural haemorrhage over the spinal cord
    d. Nerve root haemorrhages.

45. I can summarise his interpretation of the neuropathology was as follows:

a. Acknowledging that it was important to interpret his findings 'in the context of all the findings from the autopsy' he nevertheless considered 'the principle cause of the SDH over the brain is trauma'.
b. He notes that SDHs have a number of non-traumatic causes and these 'alternative causes need to be considered and excluded by other relevant experts…' but goes on to comment that 'I have not found features to suggest a non-traumatic event'
c. He concedes that the hypoxic ischemia may have been contributed to by the raised intracranial pressure
d. He opined that the SDH over the spinal cord is a recognised feature of trauma and a recognised feature of abusive head trauma. Likewise nerve root haemorrhages.
e. Epidural haemorrhages can also be in keeping with trauma abut it has been suggested may also occur as a post mortem artefact and therefore is of less specific diagnostic assistance
f. Whilst acknowledging that timing based on neuropathology is imprecise, he was nevertheless satisfied that the lack of haemosiderin or cellular reaction pointed to a few days in keeping with the clinical history

46. Prof Mangham is a Consultant pathologist with specialism in orthopaedic pathology and histopathological assessment of bone diseases and fractures. He examined the bones and surrounding tissue from the spine. Seen both macroscopically and microscopically, he considered that there was bilateral, multilevel haemorrhage in and around the nerve roots and dorsal ganglia. He opined that such bleeding is commonly seen in cases where there is suspected shaking of the infant and is often seen where there is co-existent Subdural haemorrhage. I deal with his evidence about the significance of the spinal damage further below.

47. Dr Poole the ophthalmic pathologist identified bleeding around the optic nerves and within orbital soft tissues of both eyes. Specifically, bilateral transretinal haemorrhages (the right eye more affected than the left) and bilateral optic nerve sheath (including intra-dural) haemorrhages. For Dr Poole these injuries were remarkable because they were so extensive. In his view the retinal haemorrhages were "*consistent with result of trauma, such as an impact to the head*". On the optic nerve sheath haemorrhages Dr Poole considered that the "*extra ocular haemorrhage*" observed was "*supportive evidence of a traumatic aetiology*"

48. Dr Poole was asked to consider whether the retinal haemorrhages could be secondary to raised intra-cranial pressure and whilst he agreed that this might increase the extent of pre-existing haemorrhages he did not consider that this or reperfusion following cadiac arrest could completely explain the retinal bleeds. In cross examination, Dr Poole summarized the situation as follows:

> "*Look at distribution of the bleeding in terms of width and depth and also the specific areas of the eye in which bleeding found and when one considers what is absent by way*

of ophthalmological finding and what is present; none fits with raised intra-cranial pressure….. Extensive bilateral nerve sheath bleed and bleeding around eyes militate against raised ICP alone being the aetiology."

49. Dr Cary, consultant forensic pathologist found no evidence of disease that caused or contributed to death during his PM and drawing together the detailed examinations of the other pathologists he concluded that:

    a. Death was due to complications arising from the presence of a space occupying subdural haemorrhage. In spite of decompressive surgery, irreversible damage had already occurred and there was progressive deterioration and death.

    b. During his evidence he repeated that *"There is solid evidence of an impact to the head contemporaneous with an acute subdural haemorrhage. This could be an impact with soft furnishings, the observations of people around the child are very important as to what occurred".*

    c. *"A non-traumatic case seems highly unlikely. Trauma seems to be the only realistic final conclusion". "I am hypothesising that the child was subject to a shake and a trauma".*

Dr Ramsay

50. Dr Ramsay was instructed after a largely unopposed application made on behalf of TAN's mother but after extensive enquiries were made to see if other UK based experts were available.

51. A controversy has arisen with regard to his instruction in the case. Raised as a preliminary issue by the local authority, criticism has been directed at Dr Ramsay and the solicitor acting on behalf of the mother, junior to Mr Twomey QC, at the nature of the correspondence taking place between them prior to his instruction and indeed prior to the application, made by the same solicitor, that he should be instructed. The thrust of the argument was that the exchanges revealed that he was someone who came to the case with a formed view.

52. For what it is worth I agree that the pre-instruction correspondence was inappropriate in that it went too far in discussing the likely issues in the case and invited the comments that it ultimately received. However, it is of enormous significance that Dr Ramsay himself agreed with that proposition offering a wholehearted apology when these exchanges were put to him: "Q: *Without any papers your first thought is could Mr Richards be making the error of affirming the consequent. Is is appropriate to comment on the case without papers.* A: *When you put it like that way I have to agree. The better approach is to say please send me the paper work and I will look through that and tell you what I think. I think one factor at play was that it was fairly soon after the case I referred to in my report. I think I agree it was the wrong approach for me to have taken.*"

53. However, I do not consider that these exchanges, though unfortunate, can be said to necessarily undermine his professional opinion. I do not think that Dr Ramsay gave evidence in order to shore up the mother's case. He did not, in my assessment, betray himself as a 'hired gun'. As I shall set out, it is clear to me that the opinions that he expressed during his evidence were based in his own experiences and were so far as he was concerned scientifically sound. He was completely honest and open about his 'scepticism' around what he considers to be the controversial area of the 'triad' and its tendency, in his view, towards confirmatory bias. I considered he was open about that because these are his considered views – not because they helped TAN's mother.

54. I think it is also worthy of note that he was clearly a man who was prepared to be persuaded on most things. For example, he immediately shifted his position with regard to what he previously considered as an unsatisfactory level of sampling for AVM once he discovered how extensive that testing had actually been; his confirmation that trauma was the most likely cause of injury once the bruise became likely contemporaneous with the subdural insults was made and sustained. The differences between him and the others on the minor issues below were not that the retinal and spinal injuries could never be evidence of trauma but rather that they were not necessarily specific for trauma.

55. Starting with his initial report, his case analysis opines that *'T developed a large SDH that was large enough to severely displace and distort the brain, leading to an intraoperative cardiorespiratory arrest.'* He goes on to comment that *'the ancillary findings'* – by which he means the eye pathology, the blood in the spinal nerve roots and dorsal root ganglia and spinal subdural space *'could be secondary to the effects of the rising ICP and the cardiorespiratory arrest OR the primary effects of the causal event.'* Dr Ramsay's original report also raised the theoretical possibility of two "*nontraumatic causes of subdural bleeding*": (a) blood clotting disorders, and (b) "*rupture of a dural vascular malformations (sic) such as an arteriovenous malformation (AVMs)*". However, the conclusion in Dr Ramsay's report, I found really rather unhelpful:

> "*Kim died of a large subdural haematoma and its complications…..The cause of the bleeding is unproven. There is no definitive evidence for causal trauma or for a natural explanation*".

56. Having started by advising that there was no 'definitive' evidence of either a traumatic or natural cause, as is very succinctly set out in the submissions made on behalf of the Guardian by Ms Hyde, by the end of the Experts Meeting there was a surprising amount of agreement between Dr. Ramsay, Dr. Carey and Dr. Jacques. In particular there was agreement that:

    a. the cause of the subdural bleed was likely to be trauma;
    b. the cause of the subarachnoid bleed was likely to be trauma;
    c. the bleeding over the spinal cord was likely to be trauma;
    d. a clotting disorder was unlikely or excluded;

e. a vascular malformation or AVM was unlikely;

f. the cause of Kim's injuries was according to

i. Dr. Ramsay likely to be trauma;

ii. Dr. Jacques most likely trauma and

iii. Dr. Carey very likely trauma;

57. This left disagreement between Dr. Ramsay on the one hand and Dr. Carey and Dr. Jacques on the other with respect to the significance of the retinal haemorrhaging and the nerve root haemorrhages as indictors of trauma absent an identified head injury site and absent associated ligament, muscle or bone damage to the spine.

58. Once again, I agree with the comments made by Ms Hyde that following that meeting and having achieved what appeared to be some clarity in his position, Dr. Ramsay responded on 30 November 2018 to 'clarificatory questions' put to him rather unhelpfully on behalf of TAN's mother. I agree that these wide-ranging questions appeared to 'tempt' Dr. Ramsay away from the large measure of agreement he had expressed at the Experts Meeting back into 'his natural home of scepticism' although he did stand by his view that "the pathological findings are typical of the effects of blunt force head trauma". Finally, during his oral evidence he was reeled back in without too much difficulty to a position which was consistent with the views he had expressed at the Experts Meeting.

59. Personally, as I have said, I have no problem with Dr Ramsay identifying himself as a sceptic. Nor do I think it reasonable to criticize a scientist for describing themselves as such. I welcome the views of a 'sceptic' because it seems to me that I can be satisfied that evidence has truly been tested; differences in medical opinion leave me having to test propositions and examine them in even greater detail. Given that we agree that there is much that we do not know about medicine it is in my view imperative that we have experts who are prepared to analyse cases such as these carefully applying high scientific standards and not making assumptions or falling prey to confirmatory bias. However, in the disagreement between Mr Ramsay and the others with regard to the retinal and spinal pathology I detected him adopting a position from which he was not to be moved and an unwillingness to consider the whole evidential picture.

60. What I notice about Dr Ramsay's written evidence is the terminology used. He expresses himself in language more fitting to the criminal courts– 'definitive evidence' for instance. The impression given is that he is seeking certainties. As he said in the experts meeting 'I'm perhaps a bit irritatingly tentative about definitive conclusions, particularly in criminal cases'. Of course, as all experts said during their evidence, there are no certainties.

The significance of the retinal and spinal pathology

61. Whilst it is accepted that with the sudden onset of significant bleeding within the brain there was an increase in pressure and despite the agreement between the experts that the subdural bleed was

most likely as a result of trauma, I am asked to resolve the outstanding issue about the aetiology of the retinal and spinal pathology. I have decided that I must resolve these issues if I can as they may have a direct bearing on some of the alternative hypotheses and they certainly inform any decision on likely mechanisms.

Retinal haemorrhages

62. Dr Poole readily accepted that a sudden and dramatic rise in ICP could increase the extent of '*pre-existent retinal haemorrhages.'* However, he indicated that in his view it was unlikely to explain the findings in this case. He cited a number of factors as not supportive of the suggestion that raised ICP alone was the cause of the ocular findings here:
    a. When caused by raised ICP, bleeding is usually located on or adjacent to swollen optic nerve and corresponds to the posterior not periphery;
    b. There was no swelling of the optic nerve head;
    a. The distribution of bleeding in terms of width and depth and also specific areas of the eye in which bleeding is found.
63. Dr Poole said of Dr Ramsay's assertion that the eye pathology could be as a result of cardiac arrest, meaning as a result of cessation of blood pressure and then recommencement causing damage (reperfusion): "*I can't comment on that I don't understand the suggestion"*.
64. The basis upon which Dr Ramsay was asserting that the retinal haemorrhages could be caused by cardiorespiratory arrest was clarified in oral evidence during which he confirmed that this was based upon '*an assumption'* that what operates in the brain as a reperfusion injury must also operate in the eye. As Counsel put to him, this was very much against the mainstream view, as identified in the case of *A Local Authority v S [2009] EWHC 2115 (Fam).* Dr Ramsay may not have been aware of the case, but he was aware that his views were likely to be considered 'controversial'.
65. The point is fairly made that Dr Ramsay is a neuropathologist. His CV does not include ophthalmology. He stated in the experts' meeting and oral evidence that he 'regularly looks at eyes'. He has no formal qualification or training in ophthalmology. Whilst accepting the logical proposition that a trained specialist would have more knowledge than him, he nevertheless continued to assert his theory in relation to the causation of the retinal, optic nerve sheath and orbital tissue haemorrhage in opposition to the opinion of Dr Poole.
66. It is only fair to observe that arguably Dr Cary strayed briefly into the same territory during the experts meeting when he commented in respect of the wider injuries observed in and around the eyes that:

    "*Those of us who do a lot of these cases have realised that although the retinal haemorrhages may be a result of raised intracranial pressure and are certainly made worse by that, the optic*

nerve sheath haemorrhages and in particular the orbital haemorrhages are a really good independent market for head trauma."

However, as distinct from Dr Ramsay, in his oral evidence Dr Cary made clear that he deferred always on matters involving the eyes to Dr Poole.

67. In cross examination Dr Ramsay was pressed by Ms Grief QC to describe why he was not prepared to give way in the same way. He said:

'my judgment is well founded…. I accept he [the ophthalmic pathologist] *is more experienced examining eyes but I am not sure I can defer to him for those reasons.'*

He was asked if he had training in ophthalmology and he said:

' I have training in ophthalmology from other ophthalmologists over the years. I accept I have no qualification in ophthalmic pathology. It is self-evident that he [the ophthalmic pathologist] *will have a greater knowledge than me but I do believe that my experience over the years makes me capable of examining specimens'*

I pause to observe, of course that he had examined no specimens in this case.

68. I have examined this evidence with great care. I am quite satisfied that the evidence of Dr Poole is to be preferred. Dr. Poole's evidence was cautious and considered. It was based upon his expertise as a specialist ophthalmologist. He was not dogmatic, for example, willing to accept that retinal haemorrhaging was *suggestive* of rather than *specific* for trauma. Further he demonstrated that his opinion was based on his specific findings of the extent and the location of the haemorrhaging in this case.

69. I see no justification for Dr Ramsay to step outside of his expertise but more importantly I agree with the proposition made on behalf of the Guardian that 'in contrast Dr. Ramsay appeared more anxious to disprove the notion of a general theory of retinal haemorrhaging having trauma as their primary cause rather than engaging in the specific evidence in this case. He was unwilling to look at the whole clinical picture as advanced by Dr. Carey or accept that clinically retinal haemorrhaging was associated with subdural bleeds and encephalopathy.' His refusal to defer to Dr. Poole whose position did not accord with his own is evidence of this.

Nerve root damage

70. At the experts meeting there was discussion and disagreement as to whether the nerve root damage was *specific* for trauma. Again, as Ms Hyde points out this discussion was not on the agenda for the experts meeting and was instigated by Dr. Ramsay because it *"bothered the hell out of me to be used as specific for trauma"***.** This was particularly so, he said, when there was no associated evidence of other traumatic injury to the associated ligaments, muscles or bones. He would not accept that absent such other indicators that nerve root damage was specific for trauma and in particular for the mechanism of shaking and argued that in Kim's case the nerve

root damage could be the secondary effects of tonsillar herniation and congestion in the area of the Foramen Magnum (caused by the space-occupying subdural haematoma) along with the hypoxic-ischemic injury.

71. Both Dr. Jacques and Dr. Cary opined at the experts meeting that it was important to take the clinical evidence as a whole in coming to an assessment as to causation rather than to consider a particular injury in isolation. Further Dr. Carey emphasized that there was not simply nerve root haemorrhaging but haemorrhaging into the dorsal root ganglia for which his explanation was trauma. Dr. Jacques agreed that the extensive haemorrhaging in nerve root and dorsal root ganglia was a pattern consistent with trauma. He disagreed with Dr. Ramsay that the extent of the nerve root damage could be explained by congestion in the area.

72. In cross examination, Dr. Jacques conceded that Dr. Ramsay's theory of the nerve root damage being secondary to the subdural bleed and the raised ICP "was plausible for upper cervical damage" but he "did not understand how you would get multi-level haemorrhaging".

73. Professor Mangham was not at the experts meeting and so was unable to join with this discussion. In his oral evidence, however, he made it plain that he was highly sceptical of Dr. Ramsay's suggested mechanism for the nerve root damage as secondary to the causative event. He was not aware of any clinical or research to base this view on. He echoed Dr Jacques' evidence by saying that such a theory could not explain blood at the lower levels of the vertebrae and on both sides at C5 – C8, blood in and around the nerve roots and into the root ganglia. He also opined that it was "extremely unlikely that blood can track into the nerves". He indicated that "coning (Dr. Ramsay's congestion) occurs at the very top of the cervical spine but the bulk of the haemorrhaging was at the lower parts of the spine at C5-8."

74. In evidence Dr. Ramsay indicated he would not accept that nerve root haemorrhages and dorsal ganglia root haemorrhages are "automatically highly indicative on neck trauma. No doubt that acceleration/deceleration can produce this sort of injury but in the absence of other injuries I am somewhat sceptical" . His view was that the "anatomy of the neck is rich in venous drainage and which means a high supply of venous blood" and further "on top of that herniation where the brain passes into the spinal canal there maybe tamponading and the blood flow is compromised including blood flow to the veins which pushed the blood further down". He further said "If a stretch to the neck produced these haematomata then I would like to see other evidence of trauma at the same sight. In terms of it being a specific marker of actual induced injuries, I am very sceptical about that". He was not shifted in cross-examination from this position. Professor Mangham did not accept that associated ligament damage was always present if there was a traumatic causation – "answer is yes and no. Depends on the degree of the trauma. Is a question of the severity of the trauma".

75. Following the end of the evidence and submissions I received a response from Professor Mangham to questions posed regarding some literature to which he was referred in cross

examination. I have read his responses. Without hearing his evidence on this paper I do not feel able to consider those responses properly. I have satisfied myself that this has no impact upon my assessment of his evidence.

76. I can see why Dr. Ramsay is sceptical as to the general proposition that nerve root haemorrhages are necessarily a **specific** indicator of trauma absent any other associated injury. Dr Jacques was not so definitive considering that they were capable of being consistent with trauma. However, considering the specifics of this case and all of the medical evidence as to trauma for the reasons given by Prof Mangham, Dr Jacques and Dr Cary including the extent of the haemorrhageing reaching as it did into the lower spine, and the dorsal root ganglia and the difficulties with 'trickle' given the coning, I consider it more likely than not that this damage is consistent with trauma.

77. Though his evidence will take up a relatively small number of pages in this Judgment, as his report has in the Bundle, the evidence of Peter Richards has been central to the case. No issue is taken with his conclusions. However, I want to observe that he has been clear, concise, utterly boundaried in not straying beyond his own considerable expertise and extremely balanced, recognising always how much we do not know. However, there is a great deal that Mr Richards does know. I found his evidence poignant as it emphasized for me the tragedy of this situation in the element of pure chance for Kim in the vein that he says was ruptured. This brought with it almost inevitably fatal consequences, in his view, but probably bears no relation to the level of trauma inflicted.

78. Mr Richards reported that, the features identified by the pathologists were those of a recent head injury. The head injury would have caused the fresh subdural bleeding and the fatal effects were those of cerebral compression due to the volume of the fresh subdural bleeding. He opined that it is likely on the balance of probabilities that *'had the SD bleeding been of a lower volume such that the brain was not compressed and distorted, T would have survived…how significantly she would have been injured…cannot be determined*'.

79. Mr Richards noted that the exact point of the bleeding had not been identified but his view was and has remained that the commonest cause of SD bleeding is a tear of a vein crossing the subdural space. In this case, *'the fact that the subdural bleeding was of significant volume to compress the underlying brain would suggest, although cannot be definitively stated, that it was one of the larger veins that travel directly from the surface of the brain into the dura in a bony area…'*

80. What is missing in this case is a history of any event likely to cause head injury. Mr Richards considered that it would have to have been excessive force to tear a vein as in normal circumstances veins do not rupture spontaneously or following trivial trauma. *'Any event likely to cause this would be apparent to a mentally competent carer….'*

81. I have already set out above his view on timing and clinical presentation at the time. He said *'I would have expected there to be an acute change with catastrophic consequences either at the*

point of injury or within minutes of it…during these minutes she would not have been behaving normally and is likely to have been visibly alarming deteriorating towards coma…'

82. On the issue of mechanism he said this:

> *'Mechanism cannot be completely determined on the basis of available information. Such bleeds more common following direct impact trauma to the head particularly the side of the head where the haematoma occurs. They can however occur with acceleration/deceleration forces where a large vein is unfortunately avulsed… acceleration/deceleration are also clinically associated with spinal subdural bleeding but from a neurological perspective I would have a note of caution in interpreting all these features because of the critically raised ICP and the need for urgent surgery with associated rapid shifts in the intracranial anatomy. '*

83. Having sounded that word of caution regarding the importance of the surgical interventions and the potential for impact on the identified abnormalities of that and the rapidly raised ICP, he nevertheless deferred to the pathologists on the issue of whether any of these other abnormalities were in this case secondary. He said this:

> *'.. if the court accepts that the retinal* haemorrhages *and spinal subdural* haemorrhages *that the pathologists identified were related to the mechanism of injury rather than the secondary effects of the fresh SD* haemorrhages *and acutely raised ICP, then these changes are clinically more associated with events where a child is forcibly shaken at a level of force greater than that encountered in normal life.'*

84. In his oral evidence he told me that it was always unlikely that T would have survived the surgery and indeed he was surprised the attempt was made. He stressed that the tearing of a large vein, as in this case was unusual. In most cases a small vein is torn and the consequences not fatal. For Kim this was just 'bad luck'. However, once it had torn her likelihood of survival was always slim. He was at pains to stress that this is in a sense a double tragedy because the fatal outcome is in no way indicative of the level of force used.

The source of the subdural bleed

Rupture of a bridging vein

85. On the specific facts of this case, the medical experts are unanimous in accepting that the most likely source of the bleed was a ruptured vein caused by trauma.

Chronic bleed

86. In oral evidence, Dr. Jacques said *"there was no evidence of cellular reaction to support a chronic subdural bleed"* and *"there was nothing in the examination of the dura to suggest a*

chronic subdural. This degree of sampling would normally reveal it". What he saw was *"an acute bleed".* To the suggestion that the chronic subdural had been lost during the surgical procedure Dr Jacques said such *"was beyond a plausible explanation."*

87. Dr Richards indicated that the bleed as identified on the CT scan taken on 5 October 2017 was what is neurosurgically referred to as hyperacute. He said under cross examination that a chronic bleed may have reached a critical stage at the point of collapse: *"if the history given on the morning of the 5th gave no concern up to the point of collapse would exclude it".* He indicated that if there had been a progressive bleed it would have led to a carer *"calling 999 long before the collapse if it had been progressive"* and *"there would have been a reduction in consciousness"*. In answer to the suggestion that the sub-scalp bruise indicating trauma the day before he said: *"can't exclude it completely. If a collapse from the day before . . . don't understand the mechanism and never encountered it in my career".*

88. It is worth noting at this point that the account given by the mother of Kim's presentation during the morning of 5th October does not accord with what one would expect to see had there been a chronic bleed. Accordingly, taken together with the medical evidence I am satisfied that this explanation can be excluded.

Blood clotting disorders

89. Standard blood screening was carried out before Kim's death. The clotting screens conducted demonstrated no obvious clotting disorder and indeed the platelet count was somewhat elevated. In short there was no abnormality identified. The blood samples were not tested for the rarer forms of clotting disorders and following Kim's death it has not been possible to test further.

90. Consideration has been given to the likelihood of rare forms of blood clotting disorders such as Hemophilia, von Willebrand's disease and the Christmas factor (factor XIII deficiency). Hemophilia was excluded by the experts as not relevant given Kim's gender. On von Willebrand's disease and the Christmas factor (factor XIII deficiency) there were no other signs that Kim suffered from either disease. In particular, there were no signs of abnormal, easy or excessive bruising upon Kim's presentation to hospital or during her life before; T had no other sites of abnormal bleeding save for those associated with trauma; Mr Richards pointed out that she was operated upon and apart from the blood associated with subdural haemorrhage had no other signs of abnormal bleeding. The view of Dr Ramsay expressed in the experts' meeting and confirmed in oral evidence was that a clotting disorder was *"very unlikely".* All experts shared this view.

Venous malformation

91. Dr Ramsay raised within his first report the question of an arterial venous malformation ('AVM'). Dr Jacques indicated that he considered that whilst he could not completely exclude the

possibility of an AVM it was *'very unlikely'*. Dr Ramsay came to the experts meeting having originally mis-stated the number of samples taken by Professor Jacques. He corrected himself in the meeting and having done so conceded that the sampling was 'extensive'. As a result, he too concluded that an AVM was "unlikely".

92. The possibility that the AVM was entirely contained with the tissue that herniated from the craniotomy (estimated to be 3-4cm) and therefore undiscovered was explored. That tissue was not sampled and is now lost. Mr Richards indicated that he would be surprised if an experienced surgeon like Mr Jellani would miss an AVM (likely to be of some size to cause this level of bleeding). His evidence was also that clinically his experience of AVMs was that they bled into the brain and would therefore have been discovered during the 'extensive' sampling.

93. The LA argues that in addition to the above the rare and undiscovered AVM hypothesis is excluded by the other pathology in this case – including the retinal and spinal damage. Thus the medical evidence is that this alternative is also very unlikely.

The broader canvass

94. On behalf of the mother I am invited to carefully consider possible alternative explanations for the subdural bleed which ultimately led to Kim's death. Despite the fact that all medical experts are united in their view that these alternatives are highly improbable/unlikely (and in the case of Dr Cary – have been excluded) it is argued that, notwithstanding this, taken together with all of the other evidence including TAN's mother's evidence and the broad canvas of other evidence, those options should be regarded as realistic possibilities.

95. TAN's mother's evidence is crucial in this case. It has the power to cause me to pause for thought in respect of the apparently unified views as to the most probable cause of Kim's injuries. Indeed, if there is good enough reason, it has the power to cause me to reject that medical evidence in favour of a conclusion that there must have been an unknown or alternative reason, other than trauma for Kim's injuries.

96. Before turning to the events of that morning as recounted by TAN's mother, I want to remind myself that she comes to this case and faces these allegations against the background of a history unblemished by even a hint of poor or neglectful parenting. She has lived in the LBBD peacefully, working hard to support herself and TAN, and caring for her child in a more than adequate way. What we know is that she is an insightful and sensitive parent to TAN and her excellent parenting of TAN is reflected in his presentation and in their relationship with each other.

97. This is a positive factor and must be borne in mind. Mr Twomey QC is right to draw parallels here between the direction given to juries about good character in criminal trials. I agree. There is much that we can learn from the criminal jurisdiction, particularly on the issue of self-directions and the approach to evidence. I am something of a bore on the subject.

98. Good character can be used in assessing the evidence of a witness and quite specifically in two ways. In a criminal court it is capable of supporting the view that the person in question would be less likely to commit the offence with which s/her is charged and secondly, that they may be more worthy of belief. Good character always weighs in the balance in favour of the defendant. How heavily it weighs is a matter for the jury to decide having examined all of the evidence. Of course, juries are also told that good character of itself cannot provide a defence to a charge. If it did – no one would ever be convicted. Also, good character weighs less heavily in the balance so far as the propensity argument is concerned in a case such as this. The reason is that these cases usually involve a momentary loss of control in circumstances in which there has often been no previous similar or otherwise reprehensible behaviour. Nevertheless, I bear all of those positives in mind as I consider the mother's account and in the light of it, whether it is possible for me to determine what caused Kim's collapse.

99. I remind myself, as set out elsewhere that it is not for TAN's mother to prove anything. It is not for her to satisfy me that she did nothing to cause these injuries to Kim. It is for the LA to prove that she did. There is no other lay evidence which assists me in my determination here.

Mother's account

100. TAN's mother agrees that the day before Kim's collapse, 4th Oct, she had cared for Kim from 9.30 until 7.30pm. A long day, but no doubt made doubly so by Kim being unwell. She confirms that she had to carry Kim around in her arms all day.

101. TAN and his mother and Mr B occupied one room on the ground floor of a multi-occupancy house. They shared a small kitchen and bathroom. Mr B was working but the mother needed to work too so that they could survive. The babysitting was important to them financially. So too was the mother's 'business' of making food to order.

102. TAN's mother's fullest account in these proceedings of Kim's collapse is provided in her 2nd statement. This account was confirmed in her oral evidence. She describes how events early on in the day were unremarkable save that T seemed out of sorts and had not properly taken her food, vomiting it up twice shortly after her arrival. Nevertheless within 30 minutes of the collapse, whilst she was making milk, she recounts that she was able to stop Kim from crying by giving her the ipad to watch cartoons. After several minutes trying to feed her, she says in her statement that she picked Kim up from the floor and held her in her arms returning to the bedroom. She reports that Kim stopped crying when she picked her up. She changed her nappy wondering if she was uncomfortable; it was wet with urine. She continued to try to feed Kim milk but she still would not drink. In her statement she maintains that T was not crying all this time but she looked tired and sleepy. In clinical terms the account given of this phase in the minutes before collapse is crucial. It betrays no abnormal behavior that would alert the mother

or a clinician to the possibility that Kim was catastrophically unwell. The behavior described is unremarkable for an 11 month old.

103. TAN's mother then describes how Kim 'suddenly became limp in my arms whilst I was holding her. Kim's eyes were barely open at this time and she was not moving. Kim's eyes were in a frozen state. I was not sure if she was feeling sleepy or if she was unwell. I took her to the bathroom on the ground floor and I gently put some water on her face to try to wake her up but Kim did not wake up. Both of Kim's eyes were half-opened at this time and I was very concerned. I then went back to my bedroom with Kim'

104. TAN's mother recounts how she called Kim's mother but she did not answer. All the time she was holding Kim in her arms. She noticed that 'all five of Kim's fingers were curled up in both of her hands like she was holding a ball and Kim's whole body became rigid. I also noticed that Kim's feet were pointed as if she were in a tip-toe position (straight and not at an angle like usual). I checked Kim's mouth and her tongue was a bit towards the back of her mouth.'

105. TAN's mother realized that she needed to call for an ambulance to get Kim urgent medical attention. She went outside the flat with mobile phone and with Kim in her arms to try to get someone to call 999. She called her friend who could speak better English, to see if she could call an ambulance. Her friend did not answer her phone. She then saw her neighbour, Mr H.

106. In her statement and first police interview she maintained that she did not leave the children alone. In her second police interview she suggested that she did but for no more than a moment. This was just after she changed Kim's nappy on the bedroom floor. TAN was on the bed whilst this was happening. She then went into the kitchen to dispose of the nappy. She was out of the room for about 1 – 2 minutes. TAN's mother said that she was not aware of anything untoward whilst she was out of the room but says that Kim collapsed almost immediately thereafter. She states that she did all that she could to secure help for Kim. The telephone evidence and schedule of telephone calls corroborates what says about this.

107. TAN's mother said that she does not know why this happened. She recounts no history of trauma or accident. In cross examination she denied that she had shaken Kim, hit her head on anything, thrown her down or even dropped her.

Inconsistencies and lies

108. The LA relies upon inconsistencies in the mother's accounts as between the statements in these proceedings and the accounts given in interview. These inconsistencies are relied upon as lies. That is unnecessarily complicated. They are simple inconsistencies.

109. The main thrust of the argument is that during the course of the accounts the location in which the mother was holding Kim when she went into a collapse changes from the kitchen to the bedroom and more significantly despite being asked in her first police interview if she had ever left the children alone together she did not reveal the detail added later that she had left the

children together for a short time whilst she took the nappy out to the kitchen. It is worth observing that there is no suggestion from TAN's mother that anything happened to Kim during that momentary absence. Given the proximity between the two rooms it would have been just moments.

110. In my view, there is nothing of significance in these apparent 'inconsistencies'. In the first place the changes, such as they are, are minor and not in the slightest material to the mother's account. She does not, for instance suggest that anything happened to T in her absence. There is nothing of significance in the location of the collapse given that in each account she is holding Kim when it happens. Mr Twomey QC made the very good point that in fact her narrative has been consistent to that extent; she has always accepted that Kim went into a state of collapse when she, TAN's mother, was holding her. Even the momentary absence is followed by a period of unremarkable behaviour before the child is again picked up and then later collapses. That is a position she has maintained despite the evidence of Mr Richards, suggesting as it does, that what caused the collapse must have happened just minutes before it was noticed. On one view, when she was holding Kim.

111. Turning to the issue of 'lies'. The LA seeks to highlight a considerable number of lies they say that the mother has told and upon which, subject to a *Lucas* direction, they say that I could rely as support for their case that she is not telling the truth about what happened on 5th October. To assist the LA has divided the lies broadly into three categories:

    a. Lies she and Kim's mother agreed to tell which sought to obscure the fact that TAN's mother was looking after Kim on a paid basis to allow Kim's mother to engage in paid employment;
    b. Lies told by TAN's mother to protect Mr B from coming to the attention of the authorities; and
    c. What the LA asserts are subtler lies told by TAN's mother, which related to her care of Kim on 5th October 2017.

    It is argued that whilst the lies falling into categories (a) and (b), above, may be 'explained' by the application of a *Lucas* direction, it is not clear how the same could apply to the lies in category (c).

112. For the avoidance of doubt, I absolutely agree that the lies that TAN's mother admits having told about her relationship with Kim's mother (not revealing the nature and extent of their arrangement) and seeking to conceal her relationship with Mr B are of no assistance to me in the determination of whether she is telling the truth about what happened to Kim. As someone with no proper immigration status in this country, the mother is living 'under the radar' and will be well used to exercising care in her communications with institutions and their agents for fear of jeopardizing further her stay here. I make no finding as to who encouraged those lies to be told as between the two women. In the immediacy of the moment I accept that their need was to

maintain secrecy around their arrangement lest it jeopardized their already precarious status. The same applies to revealing details about Mr B, it seems to me. I take those matters no further.

113. The LA does ask me to consider three 'lies' which it is said go directly to the care she gave to Kim:

    a. after providing details of her boyfriend in her 2nd statement, stating untruthfully that "*he does not live with me and he was not present at my home on 5 October 2017*".
    b. in her police interview and in her 2nd statement, TAN's mother lied about the time that Kim was dropped off.
    c. her account of where she was feeding Kim when she was kicking her legs and refusing milk (i) changes location, and (ii) adds a series of events to the sequence she describes as between her police interview on 6th October 2017 and her 2nd statement

114. Bearing in mind the *Lucas* direction set out above I do not consider any of these matters lend any support to the LA case and for the following reasons (using the same numbering):

    a. In my judgment the first of those lies is indistinguishable from the lies told to prevent Mr B from coming to the attention of the authorities in the first place. Having admitted that he was her boyfriend, no matter that she had given his date of birth, it is perfectly logical to me that she would try and minimize his involvement in this incident hoping to keep him from closer scrutiny. What is more, I have no idea what is suggested was to be gained from such a lie and how it goes to the issues in the case?
    b. Whilst I can see that there is an argument that reducing the time she had Kim in her care might assist in diverting attention away from her to T's mother, I struggle to accept is it likely that this is why this lie was told. It seems to me more likely that this too was part and parcel of the attempt to conceal the true nature of the relationship between the two women. The longer Kim was with her the less believable their original story and the more questions would have been asked.
    c. Finally, the changes in account relied upon are more properly categorized as inconsistencies and have been dealt with by me as such above. The first difficulty in seeking to rely upon these inconsistencies as 'lies' is identifying with any certainty whether these are lies.

115. One final area upon which the LA relies concerns the late submission of a statement from the mother regarding conversations she overhead at the Temple. On the second day of the hearing I received a statement from the mother setting out that over a week earlier she had been to the Temple with Mr B. Kim's mother was there too. There were no exchanges between them. However, the mother gives a rather curious account of overhearing some gossip between other women at the Temple about Kim's mother. She asserts that she heard it said, by these women, that Kim's mother had a baby who died and that she (Kim's mother) had <u>told</u> one of these women

that T had fallen off the bed a few days before the death. In her statement the mother says that she did not see her lawyers in the case until the first day of the trial. It was then she told them about what she had heard. Hence the late arrival of this evidence. At this stage of the hearing the mother was still arguing a case on timing. If there was any evidence of an earlier fall whilst in the care of Kim's mother, although that did not fit the medical evidence, it would have been supportive of TAN's mother's case that she was not responsible and therefore something must have happened to Kim whilst in her mother's care.

116. I should add that by the time the statement was presented to the court, Mr B, the mother's partner had finished giving his evidence. He had not recounted any of this although he was apparently at the Temple with her at the time. He later confirmed this visit in written answers to a series of open questions though there is some doubt as to whether he had given conflicting oral evidence about seeing Kim's mother at the Temple. He also recounted being told by TAN's mother that she had overheard this gossip though the description of what he recalls she said she overheard is slightly different. He says he told her to forget about it.

117. What do I make of this? I am satisfied that this account is either completely untrue or it is an embellishment. If this mother had heard it said that Kim's mother had described her child suffering an accident just days before her collapse, I consider that she would have alerted her solicitor to that fact immediately. We know that she has previously called her solicitor late at night to explain an error in her evidence. Her solicitor, who practices at this court is a dedicated and accessible professional. If the mother simply wanted to discuss the potential significance of what she had heard I have absolutely no doubt that she would have felt able to call her. She did not. Why not?

118. I am driven to the conclusion that that is either because it did not happen at all or she did hear gossip about the woman with a dead child but she did not hear that Kim's mother had admitted a fall in the days before to one of them (something, I should add, that she denies). There is some support for the latter explanation in Mr B's evidence. He does not specifically recount that the mother told him that the gossiping ladies had said they had heard this from Kim's mother. Even if I am wrong about that, he remarks that he told the mother to ignore it 'because she only overheard it from the other people' and not from Kim's mother. This event was clearly of such little significance to him that he ignored it. I am satisfied that it was of little significance and that was why it was not mentioned until the commencement of the hearing.

119. The significance of it in the context of the hearing, however, is that it was used to provide some evidential basis for the assertion that Kim's mother had left Kim on a bed unsupervised and she had fallen. I am satisfied that it is not true that this was said. I have considered all possible innocent explanations and I am left concluding that it was a lie intended to strengthen the case that Kim suffered trauma whilst in the care of her mother or more probably whilst out of the care

of TAN's mother. What it tells me is that there was at this point in the hearing a preparedness on the part of TAN's mother to alter the truth to assist her in her own defence.

120. I want to add this, however. I note the speed with which she withdrew her position that Kim's mother might have been the perpetrator. It followed the evidence of Mr Richards and I am unsurprised by that. In the witness box when asked about this incident the mother appeared to row back from it. She was asked why she had not told her lawyers immediately and she said that this was because she did not think it important at the time. I think that is true because in my judgment she did not hear that Kim's mother had admitted a fall. However, she seemed to me almost embarrassed by the account. She was very keen in her evidence to emphasise that Kim's mother was blameless. It is right, as Counsel for the LA observe, that the emotion with which she pressed Kim's mother's innocence was palpable and yet absent in her own defence.

Discussion and analysis

121. Standing back and surveying that wider canvass I am quite satisfied, as I set out at the beginning, that in spite of her undoubted positives, TAN's mother is not revealing the truth about what happened to Kim. I think that she is simply unable to verbalise it. I hope that might change but as I observed in the hearing there was and remains little chance of that whilst she is subject to a criminal investigation.

122. What I have here is a unified body of medical evidence that supports the finding that on the balance of probabilities the SDH which ultimately led to Kim's death was caused by the tearing of a large bridging vein. With the same single voice the medical evidence shouts out that the tearing of that vein was caused by trauma. This view is arrived at after consideration of all known medical alternatives. There is the same unanimity that the known alternative medical explanations are very or highly improbable. The unknown cause of course still lingers and I have listened carefully to the account of this mother to see whether her account and the wider canvass make either the unknown cause a realistic possibility or the highly improbable, probable. They do not.

123. The mother has without doubt been an attentive and loving parent to her son. She has been beyond reproach. There is no evidence of underlying issues such as alcohol, drugs or mental health concerns. However, she was, I find, living in highly stressful circumstances. Living below the radar, trying to remain relatively unseen, the ongoing anxiety that her and her boyfriend's lack of status brought, the financial uncertainties visited upon her by her lack of status.

124. Add to that having to care for two children with very different needs in terms of stimulation in the confines of two rooms for 10 hours at a time. Not going out. Kim was unwell, as children often are. We see from the text exchanges that some weeks before they had both been unwell, preventing her from being able to cook. The day before she had carried Kim all day. When Kim

was refusing her food the following morning she must have wondered if this was going to be repeated.

125. I agree that it is likely that at the point of Kim's collapse her reaction was to seek help and assistance for Kim immediately. I think that she did that because she is fundamentally a decent young woman and her focus at that point was Kim and nothing else – not her son, not the risk of discovery of her status.

Likely mechanism

126. The LA has pleaded in its schedule that TAN's mother 'inflicted' an injury upon Kim. In its final submissions for the first time it seeks definition of the mechanism by a shake or "shake throw". The phrase 'shake throw' comes from the written evidence of Dr Cary. As this was not pleaded until now we have not been able to explore with him what is meant by that though it does conjure up a very specific picture in my mind.

> " *In my opinion the various pathological findings noted in the brain, the spinal cord, the cervical spine and the eyes are typical of head injury of the shaking/impact type. There is some evidence of recent impact to the left frontal region in terms of the presence of bruising. Furthermore, the presence of a large volume subdural haemorrhage is more in keeping with an element of impact rather than shaking alone. Of course impact with soft furnishings may produce no sign of sub-scalp bruising or skull fracturing in any case. The nature and extent of changes in the eyes, the cervical spine and the spinal cord are strongly suggestive of an element of shaking rather that pure impact alone'.*

127. I am unable to describe what the precise traumatic mechanism was that led to this injury. Only the mother knows what it was. I accept the evidence of Mr Richards and Dr Cary that the force must have been excessive by which I mean that any capable parent would know that they were using too much force. The evidence is clear that the extensive injuries in combination are capable of supporting either a direct impact or a trauma involving acceleration/deceleration forces or both.

128. There is no account given of a fall or any other undisclosed accident. These would have been memorable events and so I am entitled to conclude, and I do, that in those circumstances the traumatic event did not occur in this way. Further, the experts have said that a low-level fall is unlikely. The basis for this is in the extensive nature and constellation of these injuries, in particular the retinal and spinal damage. For the avoidance of doubt, I accept that evidence.

129. I have set out at paragraphs 82-83 above, Mr Richard's view about mechanism. He favoured impact but given my confirmation of the pathologist's evidence with regard to the retinal damage, he adds to that, shake. Dr Cary sees very clearly elements of both shake and impact here. All things considered, on the current evidence the best I can do is indicate that the mechanism, more likely than not, involved a shake/impact by which I mean either a shake or an impact or both.

More important for me however is to repeat the point about the lack of correlation between the level of force used and the outcome.

Threshold

130. For the avoidance of doubt, I make the findings set out on the local authority schedule amended to reflect any additional findings set out in the body of this judgment.

131. There has been no suggestion that in circumstances in which I found the facts proven the statutory threshold crossed would not be crossed. For the sake of completeness however I should confirm that I consider it is so.

132. In circumstances in which I am satisfied that the mother has inflicted a trauma upon Kim it seems to me that as at the relevant date, which is the date of Kim's death, there is a clear inference that her son, TAN, is at risk of significant harm attributable to the care that she would give to him. That is not to suggest that, as I have already said, her relationship with her son is not a good one or that she has not been capable of caring for him up until that relevant date. The simple fact is that a child was harmed and without more, which is where we are at the moment, it is a reasonable inference that her own child was at risk of harm as at that date.

133. Finally, I would like to extend my grateful thanks to all Counsel and solicitor advocates in the case. Without their hard work and focused efforts, I would not have been able to get this judgment out before the holiday. The preparation of the case by all has been second to none and hardly a word has been wasted. The case has run to a tight timetable and questions have been focused and sensitive. At the end of such a case there are no winners but the main protagonists can rest assured that the evidence has been thoroughly and rigorously tested and all proper avenues fully explored.

See Also: