Ref. CM21C05196
Neutral Citation: [2022] EWFC 187

IN THE FAMILY COURT AT CHELMSFORD

Priory Place
New London Road
Chelmsford

Before THE HONOURABLE MR JUSTICE NEWTON

IN THE MATTER OF

ESSEX COUNTY COUNCIL (Applicant)

-v-

(1) C
And Others (Respondents)

MR L SAMUELS KC & MISS K KABWERU-NAMULEMU appeared on behalf of the Applicant
MS L MEYER KC & MR S ABBERLEY appeared on behalf of the First Respondent
MR P STOREY KC & MISS A STOREY-REA appeared on behalf of the Second Respondent
MR D WATTS appeared on behalf of the Third and Fourth Respondents via their Children's Guardian, Deborah Jennings

JUDGMENT
21st DECEMBER 2022, 12.18-13.32
(AS APPROVED)

WARNING: Reporting restrictions may apply to the contents transcribed in this document, particularly if the case concerned a sexual offence or involved a child. Reporting restrictions prohibit the publication of the applicable information to the public or any section of the public, in writing, in a broadcast or by means of the internet, including social media. Anyone who receives a copy of this transcript is responsible in law for making sure that applicable restrictions are not breached. A person who breaches a reporting restriction is liable to a fine and/or imprisonment. For guidance on whether reporting restrictions apply, and to what information, ask at the court office or take legal advice.

MR JUSTICE NEWTON:

1. On 21 July 2021, a young baby, A, just 27 days old, was re-admitted to hospital. Whilst there it was not immediately realised quite how ill she was. Examination revealed that she had sustained the following injuries described as devastating: severe brain injury; bilateral subdural haematomas; acute severe widespread hypoxic ischemic injury in both cerebral hemispheres; extensive intraspinal haematoma and subdural bleed; up to 10 retinal haemorrhages in the left eye and extensive haemorrhages in the right at the most severe end of the spectrum; and bruising to the left hip and the right buttock. No account was then given to the hospital or subsequently which might explain these severe conditions. The doctors concluded that the constellation of injuries were consistent with being inflicted. The parents were arrested.

2. It took the local authority some weeks to commence proceedings in respect of A and her older brother, L, born on 20 January 2018, until that time, 23 August in fact when the first interim care order was granted, L had been cared for by his parents under the supervision of his grandparents. In any event, the court granted the applications for interim care orders and granted a short stay. The Court of Appeal refused permission to appeal on 25 August. A has therefore remained in foster care since her discharge from hospital. L was initially placed in foster care but for the last almost 15 months has been cared for by an aunt and uncle.

3. This fact finding hearing has been substantially delayed not just because of A's complex medical condition, but also to enable the completion of the expert enquiries, and Dr Saggar in particular to be concluded. A's condition has continued to be fragile. She has not recovered and has required intermittent specialist in-patient treatment.

4. The comprehensive reach of the court in its enquiries has resulted in a very large number of documents, there are some 13 or 14 bundles overall. I am especially grateful to counsel in this case, amongst the best in this field, who have worked tirelessly to keep the case on track, and demonstrating the importance of having really high quality specialist counsel so that this case could be completed properly within its expected timeframe. They have at all times confined themselves to the pertinent issues in the case.

Background

5. The parents met in 2009 and married the following year in April 2010. The mother was a foreign national but now has UK citizenship. Both parents are well-educated people. The mother was educated privately and took a degree in communication art. She obtained good employment with well-known international companies before coming to the United Kingdom. The father, similarly, read English literature and film studies and gained employment in a well-known catering and restaurant company where he remains in a managerial post.

6. The parents very much wanted a family but that hope consistently eluded them. Happily, with the assistance of IVF, the mother fell pregnant and L was born in January 2018. The pregnancy, however, was very far from uneventful. The mother suffered from placenta previa and a shunt had to be inserted into L whilst still unborn to drain away fluid. He had heart difficulties, a ruptured kidney, and a bleed on the brain.

7. The advising doctors at the time strongly suggested to the parents that the pregnancy should be terminated, but the mother and the father were determined to continue. L was given a very poor chance of survival. The mother subsequently developed sepsis and L was born by emergency caesarean section at just six months. The mother was acutely unwell. She lost a great deal of blood and was placed into an induced coma. As is obvious, she very fortunately recovered when brought round. L, as I have said, however, had a bleed to his brain and was profoundly unwell. He was not expected to survive. Miraculously, however, he has, and has continued to grow and develop and prosper in the care of his parents, albeit that he has some developmental delay.

8. The parents were obviously delighted when unexpectedly the mother became pregnant with A. The pregnancy was relatively uncomplicated and A was born, as I have said, on 24 June 2021 at 39 weeks. The birth, by planned caesarean was also uncomplicated save that it was noted that A was tongue-tied. She was fed a combination of breastmilk and infant formula, but right from the outset there were worries by the mother that she was persistently uncomfortable, unsettled and cried a great deal, and as her development progressed, her skin also became more mottled. In those early days and weeks, the records illustrate a mismatch between the observations of the mother - who I find was a highly attuned mother to this baby, and the perspective of the professionals. It is a continuing theme and one which I shall return to.

9. On 9 July when A was just over a fortnight old, she underwent a frenectomy for her tongue-tie. This is an uncomplicated procedure and she recovered well, but from that time onwards her feeding sharply deteriorated. The parents said that she would only take half of what she was taking previously. The mother repeatedly sought advice, but in fact did not really receive any until A was admitted to hospital. Prior to admission it is clear that the management of A's feeding in particular was really very difficult. The mother continued to note how very unsettled A was and particularly her crying, a theme which recurs again and again.

10. On the evening of 15 July after the parents had fed A, she vomited a small amount of milk. They called 111 for advice but eventually discontinued the call, having hung on for so long. Most of the conduct with 111 has been remarkably unsuccessful. And so it was that after subsequent feeds she vomited small amounts of milk that night. The following day, despite the mother's anxiety in relation to A and in particular about feeding, the parents attempted a planned trip to the Zoo. It was in fact the father's last day of paternity leave. Whilst there, the mother continuing to worry about A, was eventually able to speak to 111, by that stage the family were at the zoo.

11. As a result of the advice that she received, the mother took A to the nearest hospital which was at Colchester. It was there she was seen by the paediatric consultant who considered that everything was essentially normal. Similar advice to that which was given to the mother at other stages. The provisional diagnosis was that A might be in the early stages of a viral infection. A tolerated a feed at hospital. The father and L had returned to the zoo.

12. There has been reliance and some debate about the father's conduct whilst leaving the zoo, in particular because it is said that the father can be seen to have slapped L on the face. I have looked at that clip very many times. I do not think that it bears the

interpretation that has been put upon it. It is by no means the worst or the best behaviour, the father accepts he should not have done it, and it is clear that the father was somewhat wooden in his response, but watching it, it was clearly not done in temper.

13. In any event, as a result of the parents then meeting up they decided that it would be better for A to be transferred back to the original hospital, Basildon, where they had been before. The mother found A difficult to feed despite endeavouring to do so and A was crying and unsettled. There is a question as to whether she vomited on the journey to hospital as I think some of the documents suggest. Thus it was that A was admitted to Basildon Hospital on 16 July, I have heard from the responsible consultant paediatricians. A was treated for neonatal sepsis, testing revealed no bacteriological infection, but A continued to vomit and refused breastmilk. And again, there are similar descriptions of A being of normal tone, her reflexes being normal, and of starting to feed. The consultants took the view that A's presentation was suggestive of a gastroesophageal reflux and a possible milk protein allergy. It was recorded that she was settled in between feeds but continued to have poor breastfeeding and oral intake.

14. Through this period over the ensuing days, most of the recordings are positive ones in relation to the hospital, that is to say that the tests were normal, that she was taking more bottles, and as far as the hospital were concerned, A was improving. Tests were done for her suck reflex which was described as vigorous and she was described as settled and her feeding improved, but it was not reflected in the mother's perspectives who considered that A was really unwell indeed. The records show A being difficult to feed, of crying uncontrollably, of arching her back and being extremely irritable. In any event, as a result of the hospital's examinations the responsible consultants at the time considered that A could be discharged home and was so on 20 July at about half past 10 in the evening.

15. There is a debate, the mother describes it, it is not accepted by the doctors, as to whether her fontanelle was bulging and whether or not the veins on her head were also throbbing. I prefer the mother's evidence about that. It seems to me that she was clear that there were a number of worrying symptoms which were simply not acknowledged, let alone taken seriously, by the doctors. One of the problems, it seems to me, is that there has been quite a different perception between the parents and the treating doctors. It is not the first time as I say there was a mismatch. I have to say having listened to the consultants particularly in evidence, I gained a strong impression that they thought the mother was overreacting and one can well understand why she in turn may have thought that she was being simply "fobbed off".

16. In any event, when the family got home, they got back about 11pm. A was asleep so they put her to bed and it was agreed, as was the usual practice, that the father would care for A during the night, the mother obviously needing some sleep. The father describes A taking a feed at about 1 o'clock and having taken her downstairs and that she fed normally. He winded her and put her down, this time in the cot downstairs. He slept next to her. The father says that he woke up at about 4 o'clock and checked her, including her nappy, which woke her. He changed her and attempted to feed her but she took hardly any milk and appeared to be drowsy and disorientated. She appeared to be tired, so, he returned her to her cot. Intermittently she cried, apparently in pain over the next few hours. He did not think very much of it at the

time. The father then says that she woke up at 7 although he corrected that to 9 o'clock in evidence, and she only took a small amount of milk and did not vomit.

17. Once the mother woke up which I find was at about 9 o'clock or thereabouts, the father went out to register A's birth, taking L with him. The mother says that A was asleep when he left. There was communication between the parents about how she was and whether she had taken her feed. The mother said that she had winded her and she seemed restored, but when she was put down she was crying and seemed to want to be held all the time. The father returned by about midday, when the mother tried to feed her. She took some feed and was not sick and it was at that point the mother noticed that she was pushing her tongue out and curling it and moving or twitching her arms and she took a video which she sent to the father. The mother also noticed for the first time a purple mark on A's bottom which was about the size of a small coin. That had not been there in hospital the night before. The father says that the mother was telling him that she thought A was having a seizure.

18. She spoke to her neighbour as well as her mother that morning and described A as not being at all well. The mother showed the neighbour the bruise. The parents tried to feed A at about 3 o'clock. She took a small amount of milk and then was sick. She appeared to be disorientated and lethargic. She had pale and mottled skin, her eyes pointing in different directions. The mother was now convinced that A was very unwell and asked the father to take her to hospital and he got there shortly after half past 4.

19. Once at the hospital she was seen and triaged but it was some time before she was properly examined, and certainly a considerable time before it was realised that she was really profoundly unwell. Her level of consciousness was poor, she was responding only to pain, was not spontaneously moving her limbs, her fontanelle was full and pulsating, her reflexes diminished. The bruising was noted. A CT scan of the head showed extensive intracranial haemorrhages, intra-axial haemorrhage, and brain infarction. The blood tests demonstrated a significant drop in haemoglobin, A was transferred to Great Ormond Street Hospital.

20. There she was seen by the doctors and treated appropriately. The mother describes her as being weaker or lethargic. There has been some debate about that but that was the mother's perspective. I do not propose to do through the evidence from Great Ormond Street. I have the highest regard for the way in which she was treated at the hospital.

21. What is evident from the descriptions that I have given about that far from being, as it is submitted, a sudden collapse, it seems to me that from the time of her first admission, albeit that she sometimes responded, she was also from time to time profoundly unwell and certainly in the run-up to her final admission in hospital, rather than an immediate step-change as it is referred, there was a very gradual decline in her wellbeing and her health.

The legal principles

22. In determining the issues at this fact finding hearing I apply the following well established legal principles. These are helpfully summarised by Baker J (as he then was) in *A Local Authority v M and F and L and M* [2013] EWHC 1569 (Fam).

    a. The burden of proof lies with the Local Authority. It is the Local Authority which brings the proceedings and identifies the findings that they invite the Court to make. The burden of proving the assertions rests with them. I bear in mind at all times that the burden is fairly and squarely placed on the Local Authority, and not on either parent. Recent case law (such as *Re B* 2013 UKSC and *Re BS* 2013 EWCA 1146) reinforces the importance of proper findings based on proper facts; the principles are the same for whatever the proposed outcome. Here there is, as in many cases, a risk of a shift in the burden to the parents to explain occasions when injuries might have occurred. Whilst that can be an important component for the medical experts, it is not for the parents to explain but for the local authority to establish. There is no pseudo burden as Mostyn J put in *Lancashire VR* 2013 EWHC 3064 (fam). As HJ Bellamy said in *Re FM (A Clinical Fractures: Bone Density):* [2015] EWFC B26.

    > "Where… there is a degree of medical uncertainty and credible evidence of a possible, alternative explanation to that contended for by the local authority, the question for the Court is not "has that alternative explanation been proved" but rather… "in the light of that possible alternative explanation can the Court be satisfied that the local authority has proved its case on the simple balance of probability."

    b. The standard of proof of course is the balance of probabilities (*Re B* [2008] UKHL 35). If the Local Authority proves on the balance of probabilities that baby A was killed by the mother or sustained inflicted injuries at her hands the Court treats that facts as established and all future decision concerning the future welfare of B, based on that finding. Equally if the Local Authority fails to prove those facts the Courts disregards the allegations completely.

    > "the "likelihood of harm" in s31(2) of the Children Act 1989 is a prediction from existing facts or from a multitude of facts about what happened… about the characters and personalities of the people involved and things which they have said and done [Baroness Hale]"

    c. Findings of fact must be based on evidence as Munby LJ (as he was then) observed in *Re A (A child) Fact Finding Hearing: (Speculation)* [2011] EWCA Civ 12:

    > "It's elementary proposition that findings of fact must be based on evidence including interferences that can properly be drawn from the evidence, not on suspicion or speculation."

That principle was further emphasised in *Darlington Borough Council v MF, GM, GF and A* [2015] EWFC 11.

d. When considering cases of suspected child abuse the Court must inevitably survey a wide canvass and take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss P observed in *Re T* [2004] EWCA Civ 558 [2004] 2 FLR838.

> "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."

e. The evidence received in this case includes medical evidence from a variety of specialists. I pay appropriate attention to the opinion of the medical experts, which need to be considered in the context of all other evidence. The roles of the Court and the experts are of course entirely distinct. Only the Court is in a position to weigh up the evidence against all the other evidence (see *A County Council v K, D and L* [2005] EWHC 1444, [2005] 1 FLR 851 and *A County Council v M, F and XYZ* [2005] EWHC 31, [2005] 2 FLR 129). There may well be instances if the medical opinion is that there is nothing diagnostic of a non-accidental injury but where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts, that is on the balance of probability, there has been non-accidental injury or human agency established.

f. In assessing the expert evidence, and of relevance here, I have been careful to ensure that the experts keep within the bounds of their own expertise and defer where appropriate to the expertise of others (*Re S* [2009] EWHC 2115 FAV), [2010] 1 FLR 1560). I also ensure that the focus of the Court is in fact to concentrate on the facts that are necessary for the determination of the issues. In particular, again of relevance here, not to be side tracked by collateral issues, even if they have some relevance and bearing on the consideration which I have to weigh.

g. I have particularly in mind the words of Dame Butler-Sloss P in *Re U: Re B* [2004] EWCA Civ 567, [2005] Fam 134, derived from *R v Cannings* [2004] EWCA 1 Crim, [2004] 1 WLR 2607:

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

    ii. Particular caution is necessary where medical experts disagree.

iii. The Court must always guard against the over-dogmatic expert, (or) the expert whose reputation is at stake.

h. The evidence of the parents as with any other person connected to the child or children is of the utmost importance. It is essential that the Court form a clear assessment of their reliability and credibility (*Re B* [2002] EWHC 20). In addition, the parents in particular must have the fullest opportunity to take part in the hearing and the Court is likely to place considerable weight of the evidence and impression it forms of them (*Re W* and another [2003] FCR 346).

i. It is not uncommon for witnesses in such enquiries, particularly concerning child abuse, to tell untruths and lies in the course of the investigations and indeed in the hearing. The Court bears in mind that individuals may lie for many reasons such as shame, panic, fear and distress, potential criminal proceedings, or some other less than creditable conduct (all of which may arise in a particular highly charged case such as this) and the fact that a witness has lied about anything does not mean that he has lied about everything. Nor, as *R v Lucas* [1981] 3 WLR 120 makes clear does it mean that the other evidence is unreliable, nor does it mean that the lies are to be equated necessarily with "guilt". If lies are established I do not apply *Lucas* in a mechanical way but stand back and weigh their actions and evidence in the round. I bear in mind too the passage from the judgment of Jackson J (as he then was) in *Lancashire County Council v C, M and F* (2014) EWFC3 referring to "story creep".

j. Very importantly, in this case in particular, and observed by Dame Butler-Sloss P in *Re U, Re B (supra)*

> "The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generations of experts, or that scientific research will throw a light into corners that are at present dark"

That principle was brought into sharp relief in the case of *R v Cannings (supra).* As Judge LJ (as he was then) observed

> "What may be unexplained today may be perfectly well understood tomorrow. Until then, any tendency to dogmatise should be met with an answering challenge."

As Moses LJ said in *R v Henderson Butler and Oyediran* [2010] EWCA Crim 126 [2010] 1 FLR 547:

> "Where the prosecution is able by advancing an array of experts to identify non-accidental injury and the defence can identify no alternative course, it is tempting to conclude that the prosecution have proved its case. Such temptation must be

> resisted. In this as in many fields of medicine the evidence may be in sufficient to exclude beyond reasonable doubt an unknown cause. As Cannings teaches, even where, on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown."

23. Strongly submitted, and I bear in mind, is the need to avoid speculation or jumping to a particular conclusion from an unknown cause: *E v Harris* 2005 EWCA Crim 1980 (in relation to the triad of head injuries); *Re R, Cannings and R v Henderson* all demonstrate situations where injuries singly or taken together could give rise to presumptive or misconceived findings, especially where there may be (as here), naturally occurring conditions that may have caused or contributed to, a particular medical finding.

24. I have in mind also what Hedley J said in *Re R* [2011] EWHC 1715 (Fam), [2011] 2 FLR 1384:

> "A temptation described is ever present in Family Proceedings and in my judgment, should be as firmly resisted as the Courts are required to resist it in the Criminal Law. In other words, there has to be factored into every case which concerns a discrete 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… a conclusion of unknown aetiology in respect of an infant represents neither a professional or forensic failure.it simply recognises that we still have much to learn and…it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism"

25. Finally, when seeking to identify a perpetrator of a non- accidental injury the test as to whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or real possibility that he or she was the perpetrator (see *North Yorkshire County Council v SAV* [2003] 2 FLR 849). In order to make a finding that a particular person was the perpetrator of non-accidental injury the Court must be satisfied on the balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interests of the child although where it is impossible for a judge to find on the balance of probabilities that for example parent X rather than parent Y caused injury, then neither of them can be excluded from the pool and the judge should not strain to do so (*Re D* [2009] 2 FLR 668 and *Re SB* (children) [2010] 1FLR 1161).

The expert evidence

26. Dr Kieran Hogarth well-known consultant neuroradiologist at the Royal Berkshire Hospital. He confirmed that the neuroimaging demonstrated on 21 July 2021 at 22.19 a number of serious injuries:

(1) A copious acute fresh subdural bleed over each of the cerebral hemispheres of no more than 10 days old;
(2) Low density changes in the cerebral cortices and white matter in keeping with the ischemic injury;
(3) Slight bulging of the fontanelle.

27. The MR scan taken on 23 July 2021 demonstrate:

(1) Extensive intraspinal haematoma and large volumes of intraspinal blood and most consistent with being between one and three days old, ie, close to when the CT scan was performed;
(2) Oedema in soft tissues in their mutual ligament;
(3) Bleeding around the thrombosed veins;
(4) Extensive subdural haemorrhage;
(5) Acute hypoxic ischemic injury in both cerebral hemispheres of no more than 10 days old and not compatible with ordinary brain function. He opined that that would have occurred from the point at which she last seemed well and that was a useful marker. He also identified ligamentous injury;
(6) Intraventricular subarachnoid bleeding.

28. He concluded that overall A had sustained a massive and devastating injury to her head and spine that must have occurred close to the CT scan and most likely within 24 hours. The extent of the marks, however, could have masked earlier bleeding. It was implausible he thought that that such devastating injuries would be present without there being clear signs of abnormal function. And the constellation of injuries here including the near fatal head, spine, and retinal injuries, could only be explained by trauma, no other explanation being available other than birth-related trauma which in his report he dismissed.

29. In relation to unknown causes which he could not so easily dismiss, he did not think that they were responsible in this case. He concluded that the findings pointed strongly to inflicted injury. He agreed with Mr Jayamohan that no help was garnered from L's history and condition who clearly also had had a bleed in his brain. On timing he did not disagree with Mr Jayamohan's perception suggesting that the court needed to look at the clinical picture for more help.

30. It was suggested to him that there were a number of unusual and unknown factors in this case. He did not think that an earlier bleed fitted well with his overall understanding of the picture, though did not rule out bleeding at birth or subsequent bleeding. He did not think that the SATS recordings would have caused the problems which were observed, and nor I think exacerbated particularly the symptoms which she sustained.

31. He was subsequently recalled and the timing issue was investigated with him more. Overall, it seemed to me that he, and indeed Mr Jayamohan, were flexible on timing, he acknowledged that there were differences and difficulties with timing and significantly they were crucial to the way in which the court could identify when these injuries might have occurred. He agreed, as one would expect with a witness of his standing, that this was a difficult and a challenging case, he accepted that the injuries which were seen could well be as a result of a gradual onset and a rapid or a

slow burn. That is to say, overall he was open-minded as to the wider possibilities, albeit that his central thesis and opinion remained the same.

32. Mr Jayamohan consultant paediatric neurosurgeon, well-known to the court, from the John Radcliffe in Oxford. He noted the poor feeding from 9 July, the vomiting, the skin pallor change, and the haemoglobin drop between the 17th and 21 July. He dated the fresh blood on the CT scan as less than 10 days old, that is to say from 11 July. Importantly, the hypoxic ischemic damage on the CT scan he considered was not very acute so placed its dating between the evening of the 19th and the evening of the 20th, that is to say when A was in hospital. He concluded that the changes between discharge from the hospital on 20 July and the re-admission on 21 July were on balance, in his opinion, caused by some event, some traumatic event, occurring during that period. He considered that the drop in the haemoglobin levels was significant, as clearly it is.

33. He was of course affected by the widespread nature of the changes, both the severity of the hypoxic ischemic injury and of the subdural bleeding and also by the collections and the subarachnoid haematoma along with the spinal blood. He was clear that they could all be explicable within the initial timeframe that he gave, that is to say the 24 to 48 hours period. He, in common with all the experts I considered, was understandably affected by the severity of what was observed. He thought that the admission between the 17th and 20 July was most likely as a result of a gastroesophageal cause or milk but he was not opposed to the suggestion that it may also have had a neurological genesis.

34. In respect of L, as I have already said, his conclusions were that they were in keeping with his prematurity. He acknowledged, as I have heard him say before, that looking for a unified diagnosis which can be instructive can also lead to the very wrong conclusions. And having regard to all the findings which he was asked to consider (which included vomiting and skin change from the 17th, and the observations by the family, and in particular he was struck by the back arching and the vomiting and not taking of feeds), he accepted could all be caused by brain irritation, ie, an encephalopathy which he could not rule out. So, an event from the 16th or even possibly earlier could have progressed and worsened to the 21st. As he told me, the injuries if they were there, could develop suddenly or be a slow burn.

35. He did not think that severe meningitis would tend to cause such profound changes but viral infections could if they were sufficiently severe. He was especially troubled, or accepted he might be wrong, about the timing which did not fit. The injury he thought looked severe and established and at least 24 hours old but acknowledged that there was here no collapse, no cardiorespiratory collapse as one would normally expect in these circumstances.

36. Looking at the CT in isolation, which of course is artificial, he would have timed the injury as earlier. He did not consider that any damage caused by intubation would make the bleeding worse or difficult. In fact, if anything, it would put the timing further back. He acknowledged that there may be something idiopathic going on here and he was recalled and asked about a number of things, including the lack of research.

37. Finally, he concluded his evidence with the genetic abnormality of hEDS which somewhat hung in the ether. He had not really understood, I do not think, the full import of what Dr Saggar had said and indeed having had the matters put to him was of the view that he might want to review the whole case which clearly had not occurred. Overall, as always, I was assisted by both the two previous witnesses, both of whom I have heard many times before. They are witnesses of moderation, they are open-minded, they are prepared to acknowledge that we do not know everything by a very long way.

38. The next witness, Professor Fielder, Professor from the City University. Despite the fact that he had said that there were several puzzling features to this case, he maintained especially strong and unequivocal findings. To the right eye, A had injuries at the most severe end of the spectrum. The optic nerve was significantly damaged and she had retinoschisis. The left eye was relatively unaffected but there was widespread damage to the visual pathway and some retinal haemorrhages. There were more concern about her continued vision in that eye, largely because of the damage to the visual pathway as opposed to the damage to the eye itself which is what was the matter with the right eye. It was not anticipated that she would have any sight in the right eye and of the left eye, as yet it is unclear.

39. He was very clear that in his opinion A had suffered serious ocular and visual pathway trauma, all of which was caused non-accidentally. He said that the severity of the damage to the optic nerve could only be traumatic, but he was quite unable to explain how such a very severe and definite shaking would cause a shearing injury in one eye and leave the other eye virtually untouched. He was not able to reference a single previous clinical example either from clinical practice or from the literature. He placed the timing as between two and five days before the scan which was on 22 July at 14.55 a maximum of 10 days. He said it could even have been possibly caused prior to that.

40. At the experts' meeting, he described a number of puzzling features, or thought there were a number of puzzling features, but still found it difficult to articulate what they might be. In evidence when these matters were put to him, he did not answer the question properly. It seemed to me that his mind was closed, and with respect to him, he rather stumbled at the end in his ability to really explain to me or not the wider perspective, which he simply was not able to do.

41. Dr Patrick Cartlidge consultant paediatrician, who is extremely well-known to the court. Having regard to the constellation and severity of the injuries and the constellation of opinion offered by the other experts, he concluded that A most likely had sustained a head injury by shaking and most likely after 1 o'clock on 21 July and the late morning the same day and he gave a similar explanation for the developing bruising. He maintained that view during his evidence. He of course was asked about hEDS which he did not consider would explain much of the injury, nor the extent of the subdural bleeding. It was put to him that Dr Saggar did think it did and he replied quite shortly that he disagreed with him, that he thought that it did fit trauma.

42. The various possibilities were put to him and what became clearer, I thought, during his evidence which, as always was very helpful, that having reconsidered the issues of infection and sepsis, was clear that he was unable to say what effect it might have and

was unable to say how that might interplay with any overlay of any genetic condition. Clearly, of course, if Dr Saggar was correct, there was a greater capillary fragility which he also paused to reflect upon.

43. He was asked also to consider whether or not the symptoms in the previous hospital admission could be responsible or could be as a result of encephalopathy. Whilst he confirmed the view of the treating doctors (that it was gastroesophageal reflux or possibly milk), he accepted that his conclusions on that might not be right and proffered a comment on one of the photographs of A's head, the prominence to the back of the head, all of which he thought might be something which the court would want to consider. As ever, Dr Cartlidge was moderate in his evidence, he maintained his opinion founded on the other opinions, and his own that he had considered, but I concluded was open-minded about the other possibilities as I perhaps would expect from a witness of his experience.

44. Dr Saggar is a well-known geneticist whom the court has heard very many times. He could not identify any genetic or neurogenetic cause for A's presentation but having regard to his assessment of the mother (who he considered was on the hEDS3 spectrum), considered that A had a 50 per cent chance of that inheritance. The problem is that as A was very unwell he was unable to carry out a proper examination of her. So, she either has a 50 per cent chance of having this condition or a 50 per cent of not having this condition. There would still need to be some precipitating cause albeit that it would obviously be very significantly less. The issue for him has been that the experts inevitably always look for a unifying aetiology, a unified diagnosis, but that can be an obstruction; he was not able to find an explanation to explain everything and frequently that is the case.

45. He was very taxed by the complicated parts of the picture, describing this as a complicated case. He was taxed too by some of the symptoms reported by the mother in the earlier admission, the cat cry, the irritability, the feeding history, the sickness, reflux, the gliosis, the small head, and of her shaking her head. And also by, for example, simple things like Mongolian blue spots and inverted nipples, there does seem to be a correlation between that and other aspects of physical manifestation which are not properly understood, in fact so far as I can tell, are not understood at all.

46. The main issue for him, I conclude, was that he did not think that A had ever really been well and listed a whole list of symptoms, some of which I have mentioned already, which caused him to reflect. As he put it, there is something different and unusual in this case, to other cases that he had seen, and from a witness of his experience, that is something which the court takes seriously. He of course had carried out some genetic analysis but it is only at best a sample and it raised a number of other questions as one might think of other variants which might be of clinical significance, they might not. For example, skin fibroblast, isovaleric aciduria and a number of others. In fact, there is a whole range of testing which has not been carried out. At the moment, in a broad sense, the tests have shown what they show, but as he pointed out, so little is known. He spoke about the recent publication of information from Rome in September 2022 and how this condition is a bit like an iceberg that when it rolls it displays other and different symptoms. Overall, I was very assisted by Dr Saggar who was focussed, considered and open-minded, as I would have anticipated.

47. I heard from a number of other witnesses, I do not propose to identify them. I have commented in passing on the treating doctors in Basildon and in passing on the doctors at Great Ormond Street, save to say that I was particularly impressed with the evidence of Dr Abermele who seemed to me to be a treating doctor at the highest level and whose evidence was especially impressive.

48. I turn to the evidence of the parents and the family generally. The mother gave evidence from time to time with the assistance of an interpreter. She told me about the bruising, the feeding, the crying, and A's sleep pattern, and of the vomiting. Of 21 July, she was very clear that she was worried about her daughter, that she appeared to be weak, that her tongue looked bigger, she began to get more and more anxious, and she spoke about her time in hospital and how A had been in the first admission. It seems to me that aware of the dangers of the court forming an impression, the mother gave a very favourable impression from the witness box. I had watched her closely during the currency of this hearing.

49. What became more and more obvious, as occasionally happens, was that the more the mother gave evidence and the more she was questioned, the more obvious it was that she was telling the truth, that she of course was genuinely concerned for A. But the mother has an ability to understand what is taking place. It seemed to me that she had a sensitivity to what was occurring and above all, I was clear that she was a completely truthful witness. She was a good witness.

50. The same sadly cannot be said for the father. The father was neither a good nor a poor witness. His anxiety was so great that it was palpable. So much of course rests on this decision so it is hardly surprising. He describes himself as shy and reserved and I am sure that is so. He spoke of his background and his history. He has made a good life for himself and has a good employment. I assess him as a straightforward man, committed to his wife, and is a trusted husband and father. He spoke powerfully of his relationship with his wife, it is a happy close marriage, they are good friends, close friends, they share activities and share responsibilities, and until the advent of children led a traditional uncomplicated existence. He spoke, I thought, rather movingly about L who had not been expected to survive and of course, the considerable risk to his wife too. L's chapter, his development so far has been remarkable. He has obviously thrived in the care of his mother and his father.

51. He spoke of A as being an unexpected blessing. He spoke of the events at the zoo and of what is known as the slap to the face. As I say, I do not attach the same significance that others have to this as I do not describe it as a slap because I do not think it is. He spoke of the events, the first admission to hospital, and subsequently. I think what was clear was that the more he was pushed about the events of 21 July, the more difficult it was to follow. It was never going to be a surprise that he was going to be questioned about the distinction between his police interview shortly after the event and what he said in his statement some several weeks later. It is difficult to conclude whether or not he was not telling the truth but I do take into account the unimaginable pressure of giving evidence in these circumstances, and not really being able to think clearly, even though there was nothing wrong in the questioning that was put to him. Overall, I do not think assessing his demeanour in the witness box is so helpful, one way or the other.

Discussion

52. Inevitably in such a case, and bearing in mind the Rubric that today's medical certainty may be discarded by the next generation of experts, together with a hypothesis in relation to causation must not be dismissed because it is unusual, all resulting in the exercise of considerable caution when considering the significance of the expert opinion, particularly where it is said that a condition is unusual or a case is challenging or difficult. And in that sense, it seems to me that particular scrutiny is required where medical witnesses agree that A's case is unusual or challenging. That characteristic undoubtedly heightens the need for the most careful and cautious scrutiny with particular attention being paid to the possibility that injuries, individually or collectively, result from an unknown cause. That is particularly so where the medical evidence is only one part of the evidence and there is no direct evidence of inflicted injury. And that diagnosis may of itself be just as much as a hypothesis and just as contentious as an unknown cause. Self-evidently, as I hope I have made clear, it is not for the parents to prove anything. Those often repeated principles apply with an acute focus to this case.

The approach of the medical witnesses

53. As I hope has been evident from my short resume of what they said, all the doctors gave evidence appropriate to their professional standpoint. All are well-known specialists within their disciplines and conspicuously respected the frontier of their knowledge and expertise. And each, I thought, was (a) willing to acknowledge the perspectives of the others; and (b) despite a submission to the contrary, possessed a good knowledge of the science and research beyond their specialisations and obeyed the boundary of their own.

54. Additionally I bear in mind throughout this judgment that it would be easy to suggest that instead of looking at the whole canvass, each piece of evidence is examined in isolation, what is known as a linear approach. And each witness, examiner, and the court, must endeavour to consider each area separately and together, otherwise a fog descends and it really is impossible to navigate in any analytical way the different areas of enquiry.

The findings on the medical issues

55. It is important to bear in mind that for the most part the experts, who sought a unified diagnosis, have found this case to be unusual and challenging. Unusual and challenging because as Mr Jayamohan said, the pieces of the jigsaw do not all fit. More specifically, some did fit and some did not fit at all. Unusual too because ordinarily, particularly where injuries are so severe, there is not infrequently a sudden and marked symptomology development, a step-change in the behaviour of a child, often - but not always - accompanied by a cardiorespiratory collapse.

56. Here, of course, there has been significant debate about whether there was a step-change and if there was a step-change where it occurred. There can be no doubt that the evidence is open to interpretations in different directions.

57. The case is also challenging because there is no dispute that the mainstream medical view, absent a number of exceptions, is that intracranial injuries, widespread bleeding, and widespread ocular damage, almost verge on diagnostic of themselves, yet it is known that such injuries can occur in different ways.

58. It is the principle foundation of the case advanced by the local authority that A was well when she was discharged from hospital on 20 July at about half past 10 and that something happened after that prior to her admission to hospital the following afternoon when she was unwell. The neuroradiology is central to that. There is no dispute as to the findings, and as to the injuries within her head. The issue arises on timing and a conflict between the interpretation of what is seen on the CT scan, for example, and the recorded clinical picture which at best places it within a bracket.

59. Timing is obviously central to the quest to identify the potential causes of these severe injuries. Dr Hogarth placed them within 24 hours and in fact at one point, well within 24 hours of the scan being conducted. Mr Jayamohan, however, considered that the hypoxic damage seen on the scan was not very acute and put it as between 24 and 48 hours old. As I have said, from the evening of the 19th to the 20th when A was in hospital. Taking that aspect in isolation which is obviously artificial, he would say that the injury had not occurred on 21 July, but both he and Dr Hogarth, as one would expect, immediately acknowledged their flexibility in that approach and indeed, as I have said in Mr Jayamohan's case, he may even be wrong.

60. Both experts, whilst referring to their ultimate conclusions, reflected on a number of other important factors and in particular bleeding from birth and/or re-bleeding. Significantly too to my mind, A was under four weeks old. I do not propose to repeat the seminal researches of Whitby, Looney and Rooks, well-known to experts, lawyers and Judges specialising in this field, but that research is important in the context of this case. There are limitations to the research. There is no real understanding as to cause, it even occurring by birth by caesarean section. And there is a lack of research in many aspects, including for illustration only spinal bleeding at birth. Importantly to my mind, neither expert ruled out a bleed arising from birth. Itself not unimportant, I have heard it said on so many occasions by both of them that they were able to rule out bleeding at birth but not on this.

61. Dr Hogarth did not counter Mr Jayamohan's finding that the hypoxic ischemic injury was not very acute at the time of the scan, and there was some discussion about that, nor his doubt as to whether the identified changes in the neck did in fact demonstrate ligamentous injury. An aspect brought to the fore by Mr Storey KC was the issue of encephalopathy or irritation of the brain. The experts acknowledge that the collections seen on the 21st and 23 July were such that they could have masked earlier chronic bleeding, and both agreed that the evidence could be taken as suggesting encephalopathy, explainable as it had been earlier, by gastroesophageal reflux.

62. Nevertheless, it is the fact that when A was taken to hospital and admitted on 16 July, her condition and culmination of concerns - and I do not of course overlook the tongue-tie operation before, the poor feeding, the vomiting, the crying, the cat-like cry, the irritability and other aspects which concerned the mother, including the skin and the arching of the back, the fontanelle and the bulging of her veins - all give the overriding impression of a baby who was very unwell. It may or may not have been accompanied by feeding issues but with respect to the mother it seems to me,

although she appears to have been characterised as overanxious, it may well be concluded that she was not. And I was struck that Mr Jayamohan in particular appeared to be uncomfortable that those earlier apparent observations were not possibly recognised or acknowledged by the hospital as potentially being caused by encephalopathy. There is, as I say, considerable evidence, a body of evidence, that A was unwell and it seems to me that that acknowledgement is significant in the context of this case.

The ophthalmology evidence

63. Retinal haemorrhages are often strongly associated with trauma. As I have said, there are often exceptions including birth. Professor Fielder was absolutely clear that A's injuries, which are not bilateral, were caused as a result of a severe inflicted injury. The right eye in particular had been severely affected at the most severe end of the spectrum. The left eye less affected in the circumstances which I have indicated. He aged the injuries as between two and five days.

64. A matter upon which I have commented before, Professor Fielder spoke to A's case as demonstrating several puzzling features and I was interested to know what they were and how they might affect his, and therefore the court's, perspectives on his findings and conclusions. Not for the first time in this case was I troubled by a lack of explanation, central to his expression of several puzzling features, and more generally, his ability to remain open-minded.

65. The asymmetry between the eye injuries is something which is relied upon as significant in this case. I was left with the anxiety that Professor Fielder was unable to give any example from his clinical practice, or from the research, of where that occurred. He put it in this way, that it was well-known that in medicine we cannot always provide the reason for a particular finding, but as has been observed on many occasions the two eyes are not equally affected. He was unable however to identify a previous case and said: "Well, it is a strange question having the details of other cases with this constellation of science when it has occurred is not frankly the point. I agree it is unusual. The honest answer is I do not know." He retorted on a number of occasions: "This child has suffered from an abusive traumatic head injury.".

66. Ultimately the Court was not assisted because he was unable to give further detail to the anxieties which he said he had, and which were not reflected in his evidence, and additionally also by the lack of illustration to the difference which was put to him, that is of holding such a decisive view and understanding the basis for it.

hEDS Type 3

67. Oddly enough, this aspect seemed to cause more disagreement than might at first have thought likely, especially with having such a moderate witness as Dr Saggar. There does appear to have been some misapprehension or misunderstanding about the thrust of his advices, certainly when one reads the transcript of the experts' meeting. His examination of A (because she was so unwell) was difficult and inconclusive and it is an odd fact that such a diagnosis - which is not so uncommon - is even now not well understood and is frequently misinterpreted. His evidence in relation to the mother was, as I have said, she was on the hEDS spectrum and that A had a 50 per cent chance of inheriting it, or not inheriting it. He excluded vascular EDS. If she had

inherited this trait, it would lead of course to a greater degree of bruising or bleeding. There would still need to be some event.

68. I have had the great benefit of hearing Dr Saggar many times, he brings to the court not just the experience of speciality based on his experience in this area which is substantial, but also as a physician long before that, and importantly, of keeping an open mind. That does not mean to say that everything is possible but nonetheless it is something which is very much of central core of this area of science. It is submitted to me that he strayed beyond the limits of his expertise but I disagree. I am familiar with how an hEDS assessment is carried out. I am familiar with how the assessor looks to any features which may or may not be of assistance in the case. Some are and some are not. Some might be relevant, some not.

69. He reminded the court, as if the court needed reminding, of the danger of seeking a unified diagnosis. He was exercised by a number of factors which I have repeated several times that were recorded from the mother during the first admission to hospital, the cat-like cry and all those other factors. All of those seemed to him to be matters which troubled him, he was troubled about his ultimate assessment of the case.

70. I was also struck by his observations in relation to the conference in Rome and the iceberg. Of course, the tests that are carried out are only a small fraction of those that would ordinarily be carried out and their significance is not really understood. Fundamentally, he was troubled that there was something unusual and unknown about this child.

71. With that background I turn to the evidence of the parents in particular as well as the grandparents who spoke well of their children and my assessment of them in the witness box. That assessment has been strongly determinative of my conclusions. It does not reverse the burden of proof but no account is given by either of them of any mechanism, regardless of the level of force of those injuries. The mother I found was anxious, anxious about A's care, and actively seeking assurance and advice from family, neighbours, as well as medical professionals. Perhaps because she had had such a life-changing experience with her son L and her own difficulties, she was even more attuned to her daughter, attuned to the fact that despite assurances to the contrary she felt that something simply was not right.

72. The mother's written and oral responses - and if one bothers to think about in unimaginable circumstances of being separated from a young ill child at that time - are detailed and extremely informative and helpful. I find that the mother has a very significant mental acuity that has gone unnoticed. She seems to me to have a detailed and complex understanding of the issues in this case and an understanding of those issues that were affecting her daughter at that time. Occasionally there was a slight language difficulty but oddly enough that only served to heighten the overwhelming and growing obviousness that here was a woman who was doing her level best to tell the truth and was at all times doing so.

73. I observed her carefully through the proceedings and also in evidence and of course I am mindful of the dangers of an impression from the witness box, but having listened and watched her closely, either she was a consummate professional actress - which clearly is not so - or she was a thoroughly truthful woman, a woman of intelligence,

and as I have said earlier, acknowledging that the mother could be hoodwinking us all, I am sure she is not.

74. The father, as I have already said, was not such a good witness but I did not think that he was a schemer or a liar or treating the court to some theatre. I did conclude that he was sinking under the weight of the proceedings and the very effective cross-examination. He obviously was nervous, he was fearful of making a mistake. I suspect he is quite shy and whilst he is educated, I hope he will not mind me saying, he is not in many ways as sophisticated as the mother. I am aware, of course, that he is fighting for his life, for his daughter, his son, his wife, his marriage, his life, without being overdramatic about it, everything that he has built and established. And he course must have known that he would be the main focus of the enquiries of what occurred during the night of 21 July, particularly from Mr Samuels KC.

75. Overall, I am satisfied that he portrayed the person he is. He is loyal to his wife and his family, he is a straightforward individual, a committed father who has played his part on 21 July just as he always had with his other children. And I would add that his love and respect for his wife, which is well placed, is such that seeing the distress that it has caused her and the children, I do not consider that he could or would have put his wife and children through what has happened over the last 18 months simply to save his own skin. I go a stage further, having regard to my assessment of the mother, and of her mental acuity, I do not think that she could in any sense be taken for a fool. She knows the father better than anybody and has not questioned his veracity or what he did that night.

76. The burden of the case against the father is obviously based on the perspective of the expert evidence and identifying a step-change about which there has been so much debate, during the course of that night or the early hours of the morning on 21 July. Whilst much of what he said did not assist him, the more he was asked about his accounts to the police and to the court, the more confused and difficult it was to understand. He would have been expecting those challenges but I do doubt that his reactions to the questions are helpful in my determination of the truth. The points might be well-founded, they might not, it is just impossible to say.

77. I finally consider each part of the evidence in the context of all the other evidence. I cannot overemphasise that it is the Judge over the expert or experts who bears the responsibility of making the findings in these extremely difficult cases involving allegations of child abuse. And on any view, this is an extremely difficult case.

78. Only the Judge hears the totality of all the expert evidence, the medical evidence, the parties, the lay evidence, and has the benefit here of questioning by highly specialist counsel which so often exposes aspects that are less apparent, or even not apparent, from the written reports even after, or as here, the experts - each of them leaders in their field - have had the opportunity to reflect and discuss it with their colleagues. And only the Judge is able to consider all the expert evidence with all the other parts of the expert evidence and that is of significance, and only the Judge can consider all that evidence in the context of the evidence of the case and what they say and what they say about each other before each other.

79. As the case progressed, certain themes became more prominent as each witness gave evidence, and at the conclusion of each experts' evidence, those themes can

collectively be put together. Whilst of course there are always uncertainties and obviously there are always unknown unknowns, here each witness in different ways described A's case as difficult, unusual, or challenging, containing several puzzling features or of the pieces of the jigsaw not fitting. And the significance and debate about the step-change and the size and the significance and development of A's health since birth are all aspects in that canvass.

80. Perhaps it is true that of all that, it is on the edge of medical knowledge and experience and I of course bear in mind the words now so long ago of Dame Butler-Sloss in *Re U* which are so pertinent here. So, despite the firmness of the conclusions, the science is not fully understood, and the research whilst developing - which is good in parts and absent in others - but much of it raises as many questions as it answers. That is not by way of criticism, it is simply an illustration that many of the fields which the court has heard about are developing. And that is why, after all, Professor Saggar is so open-minded.

81. It is through that prism with the background of challenging, puzzling, or jigsaw-fitting perspectives that it is instructive to look at what the difficulties in this case may be, what the uncertainties may be:

(1) A was a child who was unwell requiring previous admissions to hospital. She was a child who was under four weeks old. A displayed many symptoms which could demonstrate that something was very wrong even from birth reflecting repeated concerns by her parents, repeated medical referrals, and repeated admissions to hospital;

(2) The symptoms which she is said to have suffered from include feeding difficulties, reflux, sickness, a small head, irritability, a cat-like cry, a bulging fontanelle, prominent veins, and none of the experts could exclude brain irritation or encephalopathy;

(3) The debate and acknowledgement, as I have said already, that this baby is under 28 days old and could have suffered either from a bleed at birth or a re-bleed;

(4) The identification of a step-change that led to such debate in the hearing. Had it occurred before 21 July? Did it occur on 21 July? It seems to me that the experts, many of them, Dr Cartlidge, for example, did not find there to be a step-change.

82. On any view, whilst clearly A deteriorated significantly once she was in hospital for the final time, the evidence is more consistent with a gradual deterioration as I find, rather than a sudden change, a sudden collapse or cardiorespiratory failure. The severity of her condition was not identified, even once she was at hospital. She was there for a couple of hours before it was finally realised how ill she was. If her condition predated 21 July, the severity of her condition was not identified by the hospital who interpreted it as a feeding or milk issue. And the marked difference between the injuries and possibly therefore mechanism in her right and left eye is unexplained. The growth and pattern of bruising has not been explained other than possibly explored through possible fragility of the capillaries.

83. The potential impact of hEDS has not adequately been explained. It is not known whether or not she has inherited that from her mother, differences between the experts as to the extent of the hypoxic injury, differences as to timing, differences as to their assessment and relevance of infection whether it be bacteriological or viral,

differences of opinion as to whether the experts could really say that this was an early diagnosis of gastroesophageal reflux and a more measured qualification of that diagnosis when they ultimately gave evidence. No explanations as to the development and marking of the skin, the mottling, the blue spots.

84. Bringing those factors together with a wider canvass and the very strong evidence from the mother in particular, a strong stable marriage of long duration, a partnership in every sense of the word, the parents experienced with dealing with vulnerable children needing a high degree of care, the truthfulness of the mother as I find, and the high quality of care provided by both parents, they having a stable and supportive marriage, and the injuries where there is nothing to be said against these parents other than the injuries themselves, this family is a devoted, well grounded family. It is impossible to say that no such injury could ever have occurred but it seems to me on the issue of likelihood, I should take all those factors into account.

85. Undoubtedly, A suffered significant harm, but bringing those factors together, I am not satisfied that it was caused by the care given by the parents. Of course, I have had significant anxiety about this case but have taken the time to think and pause about my ultimate conclusions. The case undoubtedly was properly brought by the local authority I do not find it proved on the balance of probabilities that A sustained injuries whilst in the care of either of her parents and as a result of any action of which either parent is culpable.

86. Here was a pattern of significant unwellness which developed into hospitalisation. Here was a decline in brain function which occurred from an unknown cause or causes. I do not find that there is a failure on the parents to seek medical attention, it is not made out. The hospital themselves took two hours to work out that A was unwell. The parents had sought assistance, they had repeatedly taken her first to Colchester, then to Basildon, and then again to Basildon, bearing in mind what the mother was told when they were discharged and having regard to the way in which the mother had consistently maintained her anxiety, it seems to me is no basis for that contention at all.

87. Bringing all those matters together, I conclude on the balance of probabilities therefore that the local authority has failed to prove the findings that it seeks and its application under section 31 of the Children Act is therefore dismissed. I shall order a transcript of this judgment.

This transcript has been approved by the Judge