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Guilty until Proven Innocent Transcript

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Crime and Punishment: 'Guilty Until Proven Innocent?'

Professor Jo Delahunty QC

Last month's Gresham lecture was entitled 'Crime and Punishment 1: 'When Legal Worlds Collide: exploring and explaining the differences in outcomes between cases in crime and care[1]'. In it I explored ways in which a criminal court and family court deal with events concerning the same child victim and the same alleged abuser/s. I set out the core differences in the legal framework between crime and care. Since I couldn't deliver that lecture in person I will weave in some of the main differences, very briefly, into this lecture.

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Tonight I also deliver its companion piece: Part 2 of this Crime and Punishment mini-series. I will focus on a real case involving a dead baby, a young couple, and the mother mourning her dead son, pregnant and facing a murder charge, accused of causing the death of first born child by shaking him to death and beating him, fracturing many bones in his body, in the build up to his fatal collapse.

I hope to show you by this case and its aftermath and some other examples why medical science is so central to the determination of justice in the Family Court room and why society and the press should not be quick to judge based on incomplete knowledge (and examination) of the facts.

To remove a child from its parents, falsely accused of harming it, is the greatest injustice that can be visited upon an innocent parent: but sometimes that is the price paid when, based on the medical science known to the courts at the time, it appears that the injuries were inflicted by a parent despite their denial and the court sanctions permanent separation of parent from child to protect the child from feared future harm.

The courts duty to protect the child from harm requires hard choices: to return a child to an abusive parent can lead to further injury or death. But to remove the child and place it for adoption on medical and scientific evidence than turns out to be flawed is to make a mistake that devastates the family. Adoption is a final, irrevocable step that cannot be undone.

The Family Court is asked to make such hard decision every day of the week across the land. This lecture takes a few cases as examples of the way the family justice system seeks to come to the correct decision for the child with the assistance of scientific experts and legal aid specialist lawyers to test the evidence called to allege abuse: a shaken baby or benign cause mimicking abuse? That is the question at the heart of many a care case. Al Alas and Wray was one such case that hit the headlines.

Note: The term 'shaken baby' is now not used by professionals, it presumes that you know the cause of the problem, that a baby has been shaken. Non Accidental Head Injury is less emotive and accurate and is used in this lecture.

Declaration: I acted for Chana Al Alas in the Family Trial before Theis J that I describe below

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WARNING: THIS LECTURE CONTAINS DESCRIPTION OF INJURIES TO A CHILD THAT VIEWERS AND LISTENERS MAY FIND DISTRESSING

JAYDEN WRAY: a baby boy dead at 4 months

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I introduced this case in my previous lecture: now I explore it in more depth as promised: the criminal case, the family case that followed and how each court sought to unravel the self-same allegation made in each that Jayden had been killed by his parents.

The Background

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The birth: The mother, Chana, was just 16 and the father 19 when Jayden was born on 7.3.2009. His mother breast fed her baby from birth.

There were no concerns re. Jayden or the couples parenting until the baby was admitted to University College Hospital (UCH) on 22.7.09 aged 4 months. Jayden died 3 days later at Great Ormond Street Hospital (GOSH).

The clinical picture pre collapse: Jayden had fed and gone to sleep as normal but the parents had woken to find his tongue 'stuck' to the roof of his mouth. He wouldn't feed. The parents rang the out of hours emergency medical help line and were told to take him to the GP, which they did later that morning. At some point they noticed 'fit like' movements.

The GP: They told the GP: he noted the unusual appearance of the tongue, carried out a physical examination, noted the parental concern re fitting but described the baby as 'awake' on examination. Given that Jayden had been taken by the parents to UCLH a week before over concerns he had flu, the GP erred on the side of caution and referred the baby to UCH walk in clinic. This was not seen to be a clinical emergency. No ambulance was called by the clinic and the parents made their way to UCH by public transport. CCTV footage was obtained which showed the families progression from surgery to UCLH and into its corridors.

The receiving hospital University College Hospital (UCLH): On clinical reception Jayden showed further signs of fitting observable by nursing staff but not identified or immediately acted on by the receiving consultant paediatrician. The fitting continued and only after a second assessment by the same paediatrician, was Jayden referred to A & E where he was assessed as 'A' (for Alert) on the AVPU range and 13/15 of the Glasgow Coma Scale. Despite emergency treatment to contain his seizures Jayden's condition deteriorated rapidly, the fits increased in intensity and he showed signs of decerebrate posturing (the involuntary extension of the upper extremities: the head may be arched back, the arms are extended by the sides, and the legs extended). Jayden was referred for intubation and a skull x ray to see if emergency neurological surgery was needed. There was a 90 minute delay in intubation, the tube was wrongly inserted and led to the collapse of a lung, this was not immediately detected, when it was remedied was untimed and, what was intended to be a 30 minute absence from paediatric care, turned into a 4 hour period after a skull fracture was detected and clinical concern turned to Non Accidental Injury (NAI). **The examination of his clinical presentation, deterioration and medical treatment in this 4 hour period off ward became a critical factor in the care case.** Although a UCH radiologist queried rickets based on a chest X ray taken to look for infection, this was discounted by the paediatrician on the basis that calcium levels appeared normal. Jayden remained in the radiology department for 4 hours while he underwent further CT scans and a MRI scan, which showed he had suffered a skull fracture, brain injury and subdural haemorrhage. Professionals at the hospital were now deeply suspicious that the parents had inflicted Jayden's injuries. He was transferred to Great Ormond Street Hospital (GOSH). In the meantime his condition had further deteriorated, and he was still showing signs of seizures.

Transfer to GOSH: arrival at 19.45 22/7/09. Once at GOSH, Dr Peters, Consultant Paediatric Intensivist assessed Jayden's condition as incompatible with life; Jayden's presentation pre admission to and at UCH was not given in detail by UCLH or enquired after by GOSH. Dr Peters acknowledged that the system in place for transfer of the notes was "chaotic". NAI was strongly suspected by Dr Peters and his team and investigations undertaken to consider that possibility. Jayden was found to have retinal haemorrhages to add to the picture presented by subdural haemorrhages and encephalopathy. By 22.10 that evening Dr Peters felt able to record in Jayden's notes '*in the absence of any explanation this has all the features of inflicted head trauma*'. (This remained Dr Peter's evidence throughout the criminal and care proceedings despite the clinical picture that emerged therein). In addition, skeletal fractures were identified by Dr Hiorns, consultant paediatric radiologist upon reviewing a skeletal survey. Dr Hiorns concluded that all 11 fractures detected were likely to have been caused by non-accidental injuries, and specifically discounted metabolic bone disease as a cause. She also timed the fractures as all between 0-7 days old, i.e. potentially contemporaneous with the baby's collapse. The police and social services were notified and child protection protocols initiated.

The parents were now under suspicion of abusing and killing their baby.

The Death: on 23.7.09 the parents were arrested at GOSH at Jayden's bedside on suspicion of GBH. They never saw Jayden again. Jayden died on 25th July. Although released on police bail, conditions prohibited their ability to return to GOSH

Jayden was christened and died at GOSH on 25th July 2009. No parent or family member was allowed to be present.

The Post Mortem: Dr Irene Scheimberg (paediatric pathologist) was instructed by the Coroner to perform the post mortem (against the express wishes of the police who wished the coroner to instruct their nominated paediatric pathologist Dr Cary). Dr Scheimberg detected radiological signs of rickets on the GOSH X rays which were confirmed by her physical examination of the ribs and skull.

During the course of the post-mortem she deliberately snapped one of the ribs to assess its strength. She described easily snapping it with her fingers by a flicking/twisting motion. This was confirmed by Dr Rouse, her companion Pathologist who observed the post mortem. Dr Scheimberg said she has been snapping baby's bones at post mortems for 15 - 20 years; she does it as a matter of course. She later explained the experience: she found it 'brittle' it was 'too easy to crack'. She said she finds it hard to find the right word, but to her brittle means is that it is too easy to break compared to a normal bone. She said it did not feel like the rib of a 4 ½ month old child, it felt more like a new-born baby.

Dr Scheimberg initiated requests for Vitamin D testing of Jayden and his mother and faced subsequent police criticisms in the criminal trial for so doing. It was suggested she had gone beyond her remit as a pathologist. Jayden's parents later had cause to thank her for her initiative and independence.

Tests results initiated by Dr Scheimberg later showed that Chana had severe vitamin D deficiency. Dr Scheimberg opined that Chana's severe deficiency had been passed to Jayden in utero leading to congenital rickets, a condition that became more severe in life as the mother's Vitamin D deficiency remained undetected and continued to be passed on to Jayden through her breast milk as she fed him. Unbeknown to her (or anyone else) the fact that she breastfed Jayden exclusively almost certainly further contributed to her baby's Vitamin D deficiency. Chana had never been given any advice about Vitamin D deficiency. Her own levels were not tested, neither were her baby's. Taking supplements was not advised at the time. The fact that her skin was black would further have affected her ability to manufacture Vitamin D as a consequence of sunlight on her skin

The Cause of Death? Conflict between the Pathologists

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As said, Dr Scheimberg (instructed by the Coroner) conducted the post mortem alongside Dr Rouse. Dr Scheimberg concluded that the death was as a result of hypoxic ischemic injury (brain injury as a result of inadequate oxygen supply): cause of death undetermined in the context of severe Vitamin D deficiency and rickets.

Dr Cary (forensic paediatric pathologist instructed by the metropolitan police) attended the postmortem having been instructed by the police to do so because of police concerns that Jayden had died of unnatural causes. He observed but did not undertake the post mortem. He concluded that Jayden died as a result of non-accidental injuries (shake/ impact).

You may ask how it can be that two such eminent and experienced experts working in the same specialist field can come to such different conclusions when they both have the same bare material to work from. This, as I will explain in my next lecture, is why the choice of experts is so critical in both the care and criminal jurisdiction as ones choice can make a fundamental difference to the court's deliberations.

The outcome: The parents were charged with murder and causing or allowing the death of a child. The criminal trial would not be heard until some 2 years later. In the meantime their names and faces were plastered over the media.

They could not return to their flat as it was now a 'scene of crime'.

They could not bear to do in any event as it was scene of sorrow for them. In moving home they lost the companionship, but not the support, of the mixed community who had seen them emerge and grow into loving young parents. After periods of 'sofa surfing' they secured a new flat. At their criminal trial it was revealed that the police had inserted listening devices in it to see if anything of note emerged from the couple's conversations. The mother, Chana, instructed Jenny Wiltshire, a specialist criminal defence lawyer to act on her behalf in the criminal trial: Jenny began the process of constructing the legal team (Mike Turner QC and Anya Lewis) and selecting the experts that would defend Chana from the murder allegation.

A New Start?

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Chana and Rohan remained a couple despite the stress of the proceedings. Chana became pregnant. Social services were informed of her pregnancy by the health services as soon as Chana declared her pregnancy to them. This was and is normal procedure. Chana instructed Anne Thompson, a specialist family solicitor to act on her behalf in the child protection investigation.

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Note: there is good reason to have specialist solicitors acting separately for the same client in the criminal and family investigations. Aside from the specialist skills each solicitor brings to their role, they function in totally different legal environments. In the criminal trial the issues is whether the crown can prove that the defendant committed the alleged crime. The standard of proof is higher and the obligations upon the defence to disclose all the material they accumulate in the course of their work for the client is governed by different legal and professional ethical rules. In a family case the issue to be resolved is not the 'guilt' or innocence of the parent but whether the child suffered harm at their hands. The focus is on the child: not the adult, AND, if there is no living child to which a risk of harm might attach, there are no family proceedings. The criminal court looks to the past to determine Guilt. The family case only looks to the past to determine if a future risk of harm exists to a child. A family solicitor cannot withhold evidence material to the welfare of the child from the family court, even if revealing it is contrary to their client's interest. To protect the professional duties of both criminal and family

solicitors, each operates within their own fields, does not trespass on the other and a 'firewall' in terms of communication is put to place to ensure information is only exchanged under clear professional guidelines.

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It was made plain to Chana and Anne Thompson that the concerns about the circumstances of Jayden's death were so worrying that the baby would not be considered safe in the parent's care whether they remained a couple or separated. It was decided by Social Services that their care plan would be one of immediate removal of the baby at birth.

Family members were assessed by social services but the family (maternal and paternal) could not conceive that either Chana or Rohan could have hurt Jayden. The parents and their family were adamant that Jayden had died from natural causes. Despite a positive independent social workers assessment, the family's belief that neither Chana nor the father would ever have hurt Jayden made them all unacceptable family placements in the view of the local authority. It was said they lacked insight into the risk of harm posed to Jayda by Chana Al Alas and Rohan Wray.

As a result placement within the family was deemed to be inadequately protective by social services and a foster placement was proposed.

Note: until the baby is born there is no basis for issuing protective child protection proceedings over it. The child does not exist as a separate legal entity until it is born (and survives). Until Chana became pregnant social services had no interest in the couple. The police investigation had as its focus the circumstances of the death of Jayden. That had no relevance to child protection services unless and until another child came within the parents lives that might have been at risk of harm from them based on concerns re their past care of Jayden.

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A Baby is Born: Jayda

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Jayda was born to the couple on 17th October 2010. Chana was compelled by social services, the hospital and the police to give birth in isolation without the presence of her partner or any family member to support her, witness the birth or to hold the baby.

Chana was 18 years old.

Police and social services feared that Chana, her partner or family members might deliberately injure the new born baby to try to prove that Jayden's injuries had been birth related.

Jayda was removed; literally, at birth into police protection. Chana was not allowed to hold or see her new born baby and was only given a picture to have at the insistence of her midwife. The police took out a Police Protection Order which authorized the removal of Jayda without recourse to the court. The local authority applied for an Emergency Protection Order to follow on from the police action. Unlike the PPO, an EPO cannot be made unilaterally by social services.

No decision affecting the removal of a child can be made by social services alone. That might be the LA plan but only a court can approve such a step. As soon as a LA applies to the court for an order regarding a child under the Children Act 1989 and seeks to become involved in a families right to family life, the court must be appraised of the matter to make any orders sought, the parents are identified as respondents, as is the child and they are entitled to separate legal representation on legal aid.

The LA applied to the court for permission to remove the baby. It was granted, The Emergency orders were replaced by Interim Care Orders and these orders permitted the LA to place Jayda in foster care.

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The parents were now facing allegations of killing Jayden in both the criminal and family court.

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Although these orders were described as 'interim', the continuation of them for so many months was never anticipated. It would be over a year before the family trial came to a conclusion and permanent decisions over Jayda's future could be made.

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The Criminal Trial

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Chana Al-Alas was by the time of the trial, 19, and Rohan Wray, 22. They had lived under the shadow of

suspicion for over 2 years. It had taken that long for the Crown and Defence team to amass their evidence from a large number of medical and expert witnesses. Both parents denied murdering their child and causing or allowing his death. The prosecution said the brain damage could only have been caused by the trauma of Jayden having been shaken or his head having been hit against something. But the defence said it was only after Jayden died that it was discovered he had rickets owing to an undiagnosed Vitamin D deficiency in his mother. They argued this would have caused him to have weak bones, including a weak skull, and could have caused a series of fractures.

The Old Bailey court heard that Jayden died from brain damage and swelling but nearly 60 medical, professional and expert witnesses were unable to agree the cause.

On 9th December 2011, a jury returned not guilty verdicts on the direction of the judge after prosecutors withdrew the charges.

Judge Stephen Kramer said: "The further and deeper one delves into the evidence, the more complex it becomes. We could not have got to this stage without a proper investigation, examination and exploration of the evidence on all sides."

Question: why did the acquittal of Chana Al Alas and Rohan Wray not lead to the end of the family proceedings and the return of their baby, Jayda, to them?

Remember what I set out in last month's lecture about the differences between the standard of proof required in crime v care:

Crime v Care

What is the Purpose of Proceedings?

Why do we need a trial to determine who did what, when, why? Accountability? Punishment? Risk assessment? Rehabilitation?

Crime: Has the defendant committed a criminal offence against the victim or not? The outcome is specific to the adult defendant: conviction or acquittal, prison or freedom.

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Family: Has a child suffered serious harm? If so, by whose action? What risk is there of future harm? The outcome is focused on the welfare of the subject child, not the respondent adult.

- Fundamental points:
- 1) The family court only looks to the past in order to make a decision about a child's future
- 2) A family court does not conduct proceedings to establish whether or not a parent or associated person has harmed a child unless that child, or another in the family, may be at risk through the actions of that person.
- 3) The primary purpose of a family trial is not about the guilt or innocence of the alleged abuser, it is about the protection of a child.
- 4) The family court makes every decision for the child taking the child's welfare as its paramount concern. S 1 of the Children Act 1989 is the foundation stone of the care court's thinking and acting[2].
- If there is no relevant child that could be affected by the family court trial, there is no trial, i.e. if the injured child dies and there are no other children who might be at risk of harm from the alleged

assailant (e.g. no siblings), then there will be no family court trial into the circumstances of the child's death but there will be an inquest and may be criminal prosecution.

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- **What is the Legal Basis for the Trial? What is the 'Offence'?**
- Crime: A criminal offence is alleged to have been committed i.e. an unlawful act punishable by a state or other authority.
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• Family: The local authority only becomes involved when the problems in the family give rise to professional concern that the children within it have either been seriously harmed or are at risk of serious harm or neglect by their carers or those their carers associate with[3].

• 'Harm' covers a wide range of ills: emotional, physical, sexual etc.[4]- we aren't talking about minor parenting shortcomings - the harm has to be 'significant' and the legal and factual threshold proven (the 'Threshold Criteria'[5]) on the balance of probabilities to justify why the state is seeking to intervene in a family's right to a private family life.

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What is the Standard of Proof?

Crime: Beyond reasonable doubt

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Family: Balance of probabilities

- Why is there a different standard of proof? Why is that fair to the alleged abuser? How could he/she be acquitted by a jury on a 99:1 analysis but found culpable by a judge on a 51:49 balance?
- In the criminal court the standard is higher (beyond reasonable doubt: satisfied so as to be sure) because it is thought better that a guilty person goes free than an innocent person be convicted. Taking away someone's liberty and branding them a criminal is so serious a charge between the state and a citizen that society must be as sure as it can be that they are guilty.
- In a family court, the standard is lower (balance of probabilities: more likely than not), because the purpose of any hearing is to protect a child. If there is a risk that they could come to significant harm, the consequences could be too serious to subject them to the risk. So the standard of proof is lower i.e. err on the side of caution rather than risk avoidable significant harm to a child even when this breaches a parent's right to bring up their child.

AND so:

Despite the acquittal at the direction of HHJ Kramer QC and his reasoned judgment for withdrawing the case from the jury, L.B. Islington initiated section 31 Children Act 1989 proceedings against the parents. Islington had a reasonable belief, based on the police case and the Crown's experts, that the circumstances of Jayden's death were suspicious. There was a young baby born to the couple that they feared might befall a similar fate. To social services, the criminal case had not concluded that Chana Al Alas and Rohan Wray were innocent, only that they could not be found guilty on the evidence submitted to the judge and jury. In the family court the standard of proof is lower than in crime, a judge hears all the evidence and determine fact and law (unlike in a criminal case where the jury determines the facts) and in family cases a wide canvass of evidence is called, including hearsay, to inform a judge's decision. The Crown's criminal prosecution experts were maintaining their opinion evidence that Jayden had died from injuries inflicted on him by one or both of his parents and the medics that had been called from UCLH and GOSH had not changed their minds as to the significance of what they had seen and treated. Non Accidental Injury (NAI) was very much a concern of the authorities. Islington thus took on the mantle of the Crown's case and sought to put forward, to the family court that Jayden had died at the hands of one or other of his parents.

Thus, in 2012, the parents again faced the self-same allegation that Jayden was a victim of baby shaking, demonstrated by the classic TRIAD of injuries (subdural haematoma, encephalopathy and retinal haemorrhages), to which fractures at multiple sites and of varying ages added additional evidence of violence to substantiate death through non accidental injury. With the Crown experts now forewarned as to the parent's defence of death due to the effects of Vitamin D deficiency and fractures caused by rickets, and the lower standard of proof in family proceedings, those acting for the parents faced a case made more complex by the medical and scientific evidence rather than simplifying it. It appeared that the experts had become polarized in their beliefs.

Jayda remained in foster care under a sequence of interim orders. The case was transferred from the lay magistrates through the county court to the High Court because of its complexity. In that time no contact took place between the parents and Jayda because of the level of risk that social services feared the parents posed to the baby. It took a decision by a High Court Judge to order that contact should happen. Supervised contact between Jayda and her parents commenced. It was, week by week, month by month seen to be exemplary.

Jayda waited 18 months for a final decision on whether she could be rehabilitated to her parents or would be adopted: the decision of the judge that would determine which of those two outcomes would follow hinged entirely on whether the LA could prove that Jayda had died an unnatural death, abused and killed by his parent/s.

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Had one or other of them beaten Jayden to break multiple bones in his body and then shaken or thrown him so as to cause his intra cranial and eye injuries? Had one parent done so and the other failed to protect Jayda from an avoidable death? Or had neither parent hurt him? If so, how did a non-ambulant baby come to sustain such catastrophic injuries to his brain, eyes, skull and bones?[6]

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Experts, the Triad and its Alternative, a Benign Cause of Collapse and Death [7]

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The Family Court had the assistance of many eminent experts covering many disciplines: paediatric pathology, ophthalmology, osteopathology, neuropathology, radiology, mechanical forces, midwifery, and paediatrics. Their opinions had to be based on the facts identified by the court in the course of Jayden's treatment in life by the parents and by the medical treatment he received.

It emerged that Jayden had been seen by health professionals on 30 occasion's right up to 5 days before they brought him to UCH, and at no stage did they see any signs of bruising or pain. The parents argued, through American experts Professor Barnes' and Miller, that as a result of rickets, it was impossible to conclude that any of Jayden's fractures could have been caused by anything other than normal handling.

In respect of the fractures, the Local Authority relied on the evidence of Professor Malcolm, an osteopathologist, who stated that whilst some of the fractures could have been due to rough handling/rickets, the skull fracture, the metaphyseal fractures and two other fractures were due to non-accidental injury. None of the fractures were dated by him as any having occurred within 5 days of death: the skull fracture was 7 - 14 days old i.e. not connected to Jayden's death. The description of Jayden's rickets as 'moderate to severe' by Dr Scheimberg was agreed by Professor Malcolm, who conceded that he had only had only ever come across a case of rickets as severe as Jayden's in the 1970's. However it emerged that the medical research he relied on lacked firm foundation for the conclusions he drew.

Professor Malcolm expressed the view that the recent haemorrhage around the site of the skull fracture and traumatised fissure took place within 24 hours of death, which was when Jayden was on intensive care at GOSH and denied contact with his family. This contradicted the prosecution case advanced at the criminal trial and adopted by the LA that this bleeding was evidence of inflicted trauma contemporaneous with Jayden's collapse. It was not suggested by anyone that Jayden had been injured whilst on the ward at GOSH but the fact he had sustained such bleeding whilst on the PICU did evidence the fact that he was a "very fragile child".

In respect of head injury and 'the triad', the parents' expert evidence suggested that the retinal haemorrhages could have been caused by raised intra-cranial pressure; the subdural bleeds through hypoxia, which had been caused through sustained seizures. It became apparent not only from the evidence of medical witnesses who saw Jayden before and shortly after his admission to UCH but from the CCTV of the bus journey that the parents took that morning (which had not been made available during the criminal trial but was obtained for the family trial) that Jayden was conscious when he arrived at UCH. There was consensus amongst the experts that had Jayden's injuries been caused by inflicted trauma, he would have been noticeably very unwell immediately. Dr Mark Peters had stated at the criminal trial that he would have expected the child to have collapsed immediately or 2 minutes after having been subjected to trauma. When Dr Peters learned that Jayden had been assessed as 'alert' soon after arriving at the hospital, he expressed surprise and sought to argue that the health professionals had been mistaken in believing Jayden was conscious and that they were using an outdated assessment chart. It was argued against the parents that Jayden was in fact exhibiting signs of "decerebrate posturing" on admission rather than seizures, a sign of profound neurological abnormality caused by irreversible brain injury.

The key period in understanding Jayden's decline and death was identified as being a four hour period after Jayden's intubation when he moved between different imaging departments at UCH without effective management of his seizures or his CO2 levels. In this period, seizure medication was drawn but not administered until the retrieval team arrived at 6pm. On intubation the tube had been wrongly placed causing one of his lungs

to collapse but this was not identified for at least 20 minutes. After this Jayden's CO2 levels had risen to dangerous levels but by then he was probably en route to or at the radiology department and it was unclear when the tube had been correctly positioned. By the end of the afternoon when the retrieval team arrived, his condition had deteriorated to the extent that there were clear signs of raised ICP (intra cranial pressure) which the team struggled to control, even with very aggressive treatment. Expert evidence, (contradicted by Dr Peters) suggested the fluctuating CO2 levels and raised ICP could have contributed to his deterioration, as well as the hypoxic-ischemic injury he suffered. Both ophthalmologists agreed this could have been the cause of his retinal haemorrhages.

The Outcome in Crime and Care

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Acquittal in the criminal court does not always presage rejection of the self-same allegations in the family court.

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To recap:

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The parents had faced and been acquitted of a murder charge heard at the Central Criminal Court which had lasted for 6 weeks. Jayden had been dead for 2 years and 4 and half months by the time the Old Bailey Judge, on 9.12.11, directed the jury to acquit the parents due to conflicting expert evidence.

Jayden had not yet been buried.

The inquest into his death was awaiting the outcome of the criminal, and then the care proceedings.

The parents had never returned to the former home having been compelled to leave it as they left Jayden for the last time in hospital as it was 'the scene as the crime'.

Their names and faces had been all over local and national media.

They had had to ask one another if the police medical evidence was true: had the other hurt their son?

They stayed together and had another child as the investigations rolled on.

By the time the criminal trial collapsed Jayda was by then 14 months old. She had never lived with her parents and saw them only restricted times under close supervision. Her future was to be determined in the family division. The parents endured a 5 week trial in the High Court of the family Division to argue for her return to their care.

The case was heard by Mrs Justice Theis over 6 weeks. She heard from over 40 medical witnesses and specialist experts including:

Paediatric pathologists: Drs Shemberg, and Cary

Neuropathologist: Dr Colin Smith, Dr David Ramsay

Ophthalmologists: Professor Luthert and Dr Bonshek

Histopathologist: Professor Malcolm and Dr Cohen

Paediatric Neurologist: Dr Jansen

Endocrinologist: Professor Nussey

Paediatric Neuroradiologist: Dr Barnes

Paediatrics and Obstetrics: Professor Miller

Biomechanics: Dr Van Ee

Midwifery: Professor Page

Theis J also heard from the parents and was shown video and CCTV footage of the parents progress from GP surgery to UCH and into its corridors.

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The Court's enquiry into causation of injuries and death was in effect a consideration of whether or not the opinion clinicians formed when treating Jayden was valid. This was relevant to the adequacy of the treatment.

[which was in turn relevant to the issue of causation of encephalopathy.](#)

[The Court had the benefit of *all* of the evidence and could take an unfettered view in relation to the treatment given. In *Al/Alas*, this enquiry included not only detailed forensic examination of Jayden's treatment in life at both UCH and GOSH but his parents' evidence, the evidence of other witnesses, the chronology of his deterioration leading up to his admission to UCH and then after admission to UCH; CCTV of Jayden and his parents en route to and at UCH, which demonstrated to the surprise of treating clinicians at GOSH that he had been conscious on arrival at UCH.](#)

[As Mrs Justice Theis observed:](#)

['I am very aware that this court has had the opportunity, as did the Central Criminal Court to consider the events of the 22.7.09 - 25.7.09 in exhaustive detail, with the benefit of expert evidence over a number of weeks. I am acutely aware that the clinicians operating on the ground, dealing with such urgent situations as occurred in this case, simply don't have that luxury.'](#)

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[In this instance GOSH medics formed the clear and unequivocal view that the injuries they found were inflicted: they were, as the family court found, wrong in that belief: there is an important difference between a working diagnosis and an expert opinion formed independently after the crisis has passed.](#)

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[To unravel the circumstances leading up to, and the cause of Jayden's death the court had the advantage of hearing from experts who had reviewed the contemporaneous medical records \(a task some experts undertook more thoroughly than others\). The Judge was then able to put all the pieces of the medical and expert jigsaw together in the context of her view of the evidence of the parents. The CCTV footage and records of their care of Jayden before his decline and death. It wasn't simply what evidence she heard, but also what evidence she had read. It is this vast horizon of evidence that is referred to as '*the broad canvas*' of evidence in care proceedings.](#)

[The judgment is appended to this lecture in full by this link. A summary here cannot do the skill and diligence of the judge's examination of the facts justice:](#)

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<https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Judgments/london-borough-islington-al-alas-wray-judgment-19042012.pdf>

After the medical evidence of rickets was explored Theis J commented that:

'The court has had the benefit of hearing many experts who are experienced and have wide expertise in their field. What is of note is that despite their considerable expertise and experience there is very limited direct experience of dealing with babies of Jayden's age with congenital rickets similar in severity to the circumstances of this case. Most have not seen an example of this severity or if they have, it was many years ago.' (202)

.....

Another feature of this case, which makes it so unusual, is the severity of the deficiency and manifestations of that in the bones on a baby aged only 4 ½ months. It was effectively outside the clinical experience of any of the medical witnesses. (204)

Re. Fractures: Theis J concluded (212-213)

(1) There is no external evidence to support or indicate that Jayden was being assaulted by his parents; if anything the evidence all points the other way. That evidence is importantly not just self-reporting by the parents but was witnessed by a range of professionals with whom the family had contact with on a regular basis over the four and half months he was in their care. Whilst such behaviour can't be ruled out it is unusual with this degree of 'visibility' by the parents and Jayden for something not to be noticed.

(2) There was no evidence of marks or bruises that could indicate that such abusive actions have taken place. Within the timeframes indicated by Professor Malcolm the child was very 'visible' to the professionals through the appointments he attended.

(3) The relatively unusual nature of Jayden's condition in the experience of the relevant experts and the literature which did not give them any reliable comparison with other similar cases.

(4) Whilst not scientific Dr Scheimberg, who is experienced in conducting post mortems of children of Jayden's age considered the bones (the rib and the skull) to be very fragile, in her experience and she compared them to new-born baby bones.

(5) I acknowledge that Professor Malcolm is the only expert Histopathologist who specialises in bones but due to the particular circumstances of this case and for reasons outlined above I consider there are grounds upon which I can depart from his opinion.

(6) The evidence in relation to the traumatised fissure is now far from clear in the light of the timing of the fresh bleeding within 24 hours of Jayden's death. There is an issue about whether granulation was present which was not fully explored with Professor Malcolm. But in the light of the timing of the recent bleeding and my findings about the fractures I do not consider the traumatised fissure is more likely than not to be a result of inflicted injury.

I have therefore reached the conclusion for the reasons outlined above that I can't be satisfied, on the balance of probabilities that any of the fractures or the traumatised fissure were as a result of inflicted deliberate harm caused to Jayden by either of these parents. In my judgment, on the evidence, the fractures could have been caused by the day to day handling of a young baby due to the particular fragility of Jayden's bones as a result of the severity of his undetected rickets. It has been suggested that the skull fracture could have been caused at the time of Jayden's birth. On the evidence I have that is unlikely due to the passage of time and Jayden's presentation after birth, but it can't be ruled out. Although I am not asked specifically to find this by the LA I consider the other fractures that Professor Malcolm said could be due to rickets rather than any abusive act by the parents. I am satisfied on the balance of probability that that is correct.'

Seizures or not?

One of the first issues I need to determine is whether Jayden was seizing prior to his admission to hospital or whether he was to all intents and purposes unconscious and/or demonstrating decerebrate posture. (217)

I have reached the conclusion that it is more likely than not that Jayden was suffering from seizures prior to his admission to UCLH. (218)

Suboptimal medical care at UCHL:

The next matter I have to consider is the chronology of treatment received by Jayden whilst he was in UCLH. It is submitted on behalf of the parents that the treatment between about 2 – 6pm on 22.7.09 was 'sub-optimal'; I agree. (219)

.....

It is more likely than not, on the information I have, there was not proper management of Jayden's CO2 levels during this period and that both the high and low level are both likely to have contributed to his deteriorating condition'.

Re the TRIAD: This I observed with admirable under statement:

'This is an area of some controversy with strong feelings on both sides of the medical profession.' (221)

The role of the court in considering each component part is to consider, in particular, any differential diagnosis. As Dr Cary said, any break in the link, means the whole picture needs to be re-evaluated. (222)

Retinal Haemorrhages:

I have reached the conclusion that they are more likely than not to be secondary to the hypoxic ischemic injury, (224)

Encephalopathy

'This aspect has been the most troubling and difficult to unravel. However, having considered the evidence I have reached the clear conclusion that, on the evidence I have seen, I am not able to conclude that it is more likely than not that the hypoxic ischemic encephalopathy had a traumatic cause. In my judgment it is more likely to have been caused by a combination of different factors, some of which may be unknown, but not including inflicted trauma, either by way of impact or shake or any other mechanism. (225)

Sub Dural Haemorrhage

There was a bilateral thin film subdural haemorrhage over the frontal left hemisphere. The source of such bleeding is a matter of considerable debate (226)

232, on the evidence I have in this case I have reached the conclusion that the SDH is more likely to have been caused by trauma. However, that has to be looked at in the context of all the other evidence and, in particular, my findings about the other component parts of the triad and the 'wider canvas'

233. Having now considered all the evidence, and my analysis of each part as set out above, I have reached the conclusion that even though the presence of the SDH points towards Jayden's injuries being caused by trauma the balance of the evidence points the other way. As Dr Scheimberg said 'So, could it be torn bridging veins? Yes. But does it fit with the rest of the picture? No. That's the problem. When you tried to put it all together is when the thing starts crumbling all over the place. Each individual step, it's possible. But when you put it all together, it [trauma] stops being probable.' I agree.

In her concluding remarks she had this to say of the case:

'234. The complexity of this case is perhaps obvious by the length of this judgment and breadth of expert evidence the court has heard from. There are a few general observations I would like to make.

235. Despite the extent of the dispute between the various experts, the one aspect they were all agreed upon was the need for further research. In particular research in relation to the different aspects of the triad and the impact of Vitamin D deficiency and rickets on babies under 6 months. I wholly endorse that view.

237. The issues surrounding vitamin D deficiency have dominated this hearing. Evidence has been given that it is on the increase, leading possibly to an increase in congenital rickets. I am unclear as to the evidential foundation for that however it is a condition that if identified at an early stage can usually easily be resolved. The identification of it is not easily done, as this case has so graphically demonstrated. Dr Peters readily accepted it was not picked up by GOSH as even requiring further investigation. I echo the observations made by Professor Nussey and Professor Page of the need to understand this more and ensure that early identification of this takes place in those groups most at risk.

Judgment was publicly handed down by Theis J on 19.4.2012 after the conclusion of a second hearing listed to determine if any of the clinicians, professionals or experts named within the judgment, or the institutions they were employed by, should be anonymised. Lawyers for Chana led the argument that there should be full publication of the judgment and that she should have total freedom to name those who had failed her and her son. Chana Al Alas wanted to be able to reclaim her daughter with pride, without the fear that suspicions surrounding the death of Jayden would haunt the family, blighting their future family life just as they had a chance to become parents again.

Chana Al Alas and Rohan Wray were reunited with the baby Jayda who, at 18 months old, had never lived with them. Their dead baby Jayden could at last be released to them for burial.

I, along with fellow barrister Kate Purkiss, and our solicitor Anne Thompson represented Chana Al Alas in her Family Division trial. We worked closely and collaboratively with her lawyers instructed in her criminal trial. We were and remain proud to be Legal Aid lawyers.

Was Al Alas a one off or do we have lessons still be to learnt about the ways in which benign injuries can masquerade as abusive acts of inflicted trauma?

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EDS: EHLER DANLOS SYNDROME

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You may have recently read in the media of a case concerning a family who had their children removed and adopted because of findings of abuse by the parents when they and the court were unaware that the mother had a genetic abnormality called Ehlers-Danlos Syndrome (EDS) [\[8\] which might have relevance to the injuries the child sustained\[9\]? Easy bruising can accompany EDS often as a result of minimal trauma: this implies increased fragility of dermal blood capillaries and poor structural integrity of the skin. When bruising presents in a child it may be incorrectly attributed to non-accidental injury.](#)

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[This is not the first time such a case has come before the family courts with injuries masquerading as abusive:](#)

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Devon County Council v EB & Ors (Minors) [2013] EWHC 968 (FAM)[10] :

This 2013 case concerned twins born to parents who suffered from a range of medical conditions including (for the mother) a genetic condition (Ehlers- Danlos syndrome) and (for the father) joint hypermobility. Save for the injuries, there were no concerns about their care of the children.

The twins, E and J were markedly different, with E suffering from feeding difficulties. Both children were seen very frequently by health professionals from birth until the start of the proceedings, which were triggered, when, following E's emergency admission to hospital in July 2011, both she and (on subsequent investigation) J were found to have bone fractures and subdural haematomas.

The children remained in the care of their parents (supervised by the maternal grandparents) throughout the proceedings, during the course of which, a further child "T" was born for whom the same arrangements pertained.

Whilst living under this arrangement, T suffered skull fractures, prompting the local authority to seek removal of all three children. The interim application was heard by Baker J who found that T's injuries had resulted from a low level fall and were accidental in nature. The familial care arrangement stayed in place and all parties accepted the court's finding as to the causation of T's injuries.

When the matter came back before Baker J for fact finding, he read and heard extensive evidence from a number of treating physicians and experts from different disciplines.

I'd like to give you a flavour of what a case such as this entails for the judge and lawyers

The judges Reading:

'Nine bundles of documents were put before me for this hearing comprising inter alia: statements from various witnesses, in particular the parents themselves; expert reports; supplementary letters and emails from a variety of specialists, namely: Dr Hart, the treating paediatrician; Professor Ian Hann, Paediatric Haematologist; Dr Maurice Salzmann, Consultant in Clinical Chemistry at the RDEH; Dr Robert Sunderland, Consultant Paediatrician instructed as an expert witness; Mr Peter Richards, Consultant Paediatric Neurosurgeon; Dr Katherine Halliday, Consultant Paediatric Radiologist; Dr Philip Anslow, Consultant Paediatric Neuroradiologist; Dr Paul Brogan, Consultant Paediatric Rheumatologist and Professor Pope, Consultant Geneticist; a schedule compiled after an experts' meeting attended by several of the above; Local Authority documents, including care plans; medical records for the children and parents; documents disclosed by the police, including various further statements taken during the course of their enquires; material identified by the mother in the course of very extensive searches on the internet and elsewhere; plus documents generated by counsel - position statements, skeleton arguments, chronologies, medical research papers, bundles of legal authorities and closing written submissions.'

In addition to the reading material he heard from the following witnesses:

Oral evidence: Professor Hann; Dr Pearson, Paediatric SPR who examined E on arrival at hospital on 5th July; Nurse Ahmed, Paediatric Nursing Sister at the RDEH; Professor Pope; Dr Sunderland; Dr Anslow; Dr Salzmann; Dr Griffiths, the GP for the twins; Dr Hart; Mr Richards; Mrs Still, the health visitor; the maternal grandmother; the maternal grandfather; Dr Halliday; the paternal grandmother; the paternal grandfather; Nurse Gray.

In a lengthy and detailed judgment, Baker J, having set out the factual background, examined the case law relevant to the standard of proof required, the role of expert evidence and the issue of identification of perpetrators. He noted (inter alia) the need to consider each piece of evidence (including that of an expert medical nature) in the context of all the evidence and that medical/scientific knowledge was of an ever evolving nature.

His review of the medical evidence was characteristically thorough: What is useful as well as the detail is the pragmatic comment that the role of the treating medic and independent experts are very different: as he explained

'137. At the outset of the investigation, Dr Hart and the social workers and the police were faced with two children who had suffered a multiple of bone fractures and subdural bleeding and in the case of E, an episode of encephalopathy. Not surprisingly, they considered that these factors pointed strongly towards a diagnosis of non-accidental injury. As a busy consultant paediatrician in a local hospital, Dr Hart was doing his job properly and conscientiously in investigating and instigating child protection procedures and in explaining to the parents in

frank terms his view, based on the available evidence and the established understanding of cases involving such injuries, that this was prima facie a case of child abuse.

138. Had this case been decided on the basis simply of the information then available, it is likely that the court would have reached a similar conclusion but, as has been made clear many times in many reported cases, not least by Dame Elizabeth Butler-Sloss President in *Re T* and in *Re U, Re B*, as cited above and repeated by counsel in this case, the court surveys a wider canvas. A court hearing application for care orders based on cases of suspected physical abuse of children must follow the evidence and pursue the enquiry in whatever detail and for however long is necessary to arrive at the truth. In this case, it was decided, rightly as it turned out, to seek expert opinion from a range of experts and to explore the family medical history in much greater depth than normally occurs in care proceedings.

139. My impression is that the longer this process has gone on, the greater the degree of uncertainty. Gradually the inquiry unearthed a number of unusual features.

140. The first, and to me particularly striking, is the fact that there were hardly any external signs of any of the injuries sustained by either of the children. Until the MRI, CT scans and x-rays were carried out, nobody had any idea that these two little children had sustained the large number of injuries that were subsequently discovered. It is remarkable and in my view highly significant that these children were seen very frequently by a range of health professionals, including being regularly examined naked by a very experienced and highly competent health visitor, and yet not a single bruise or mark or other sign was ever seen on either child that might have suggested that either of them had sustained a fracture. Furthermore, neither child exhibited any signs of pain and discomfort that might have been attributable to such an injury

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He then dealt with the evidence he had heard on the nature and causation of the injuries; the detail of the parents' conditions (some aspects of which were found to be present - in varying ways - in both children) and the issue of whether or not the parents' conditions could have led to inherited characteristics in the children, such that they were more vulnerable to injury at a lower level of force than that normally required. He also set out his assessment of the parents, both of whom he found to be honest witnesses.

In drawing his conclusions, Baker J emphasized again the need for the court to survey a "*wider canvas*" than that of the medical information in isolation and stressed that in cases of suspected physical abuse the court must "follow the evidence and pursue the enquiry in whatever detail and for however long is necessary to arrive at the truth."

In considering the causation of the injuries, he noted the high level of health care scrutiny before the proceedings and the absence of any signs of injury having been noted by any professionals; the complex family medical history; the lack of understanding of some aspects of the mother's syndrome (EDS); the earlier finding in respect of T (which was another "*pointer*" to the possibility that the children were more than usually susceptible to fractures); the evidence that the subdural haematomas in both twins could have been chronic, arising from their birth, rather than acute and the evidence that at least one injury was sustained (and another could have been) in hospital.

He also commented that in the 19 months since the start of proceedings, there had not been "*one scintilla*" of criticism of the parents' care of the children.

Accordingly, he could not find that the local authority case (that one or both of the parents had inflicted the injuries in a momentary loss of control) was made out to the requisite standard. The threshold was not crossed and the application was therefore dismissed.

Baker J observed that in cases of suspected child abuse it is important that:

There is a full and thorough forensic examination; this requires judicial continuity before a judge of sufficient experience.

That, although judges will be rigorous to resist the unnecessary use of experts, equally, they will not hesitate to endorse expert instruction where they are satisfied this is **necessary** to determine the relevant issues

Finally, Baker J commented that this case demonstrated again the crucial role played by specialist family practitioners and that not enough recognition is given to the contribution of family lawyers.

What of the other Deformities or Genetic Abnormalities that might Mimic Abuse?

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[More and more of these cases are being explored at court as science evolves in its understanding of how the body works.](#)

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[The court can only make the decision it is asked to make on the basis of the best evidence available to it at the time.](#)

[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.](#)

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[In A County Council v KD & L \[2005\] EWHC 144 Fam.](#) At paragraphs 39 to 44, Mr Justice Charles observed:

"It is important to remember that (1) the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision."

He added at paragraph 49:

"In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non-accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof ... The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury or human agency and the clinical observations of the child, although consistent with non-accidental injury or human agency, are the type asserted is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that, on the balance of probability there has been a non-accidental injury or human agency as asserted and the threshold is established."

As Mr Justice Ryder observed in **[A County Council v A Mother and others \[2005\] EWHC Fam. 31:](#)**

"A factual decision must be based on all available materials, i.e. be judged in context and not just upon medical or scientific materials, no matter how cogent they may in isolation seem to be".

Unknown Cause?

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The Family Court is not a place where this Sherlock Holme's dictum applies: 'when you have eliminated the impossible, whatever remains, however improbable, must be the truth'.

The Child Protection Judge, lawyer and expert must be aware that the conclusion that a child has sustained injuries through an 'unknown cause' is not a declaration of failure to find the cause and effect of the truth.

The simple fact is that the working of the human body is a miraculous and unique thing and, much as we know through the evolution of science and medicine, we are still learning about its capacity for surprise and uniqueness

Declaration: I acted for the father in the Family Trial before Hedley J that I describe below

In a case **[Re A and B \(Children\) \[2013\] EWHC B22 \(Fam\)](#)** Hedley J was asked to consider whether the Local Authority should have leave to withdraw a case involving a dead child whose death had been considered suspicious by both police and social services in the first instance.

The court was concerned with a family of three children, A, B and C. Previously (in 2010), the mother had been found responsible for three fractures sustained by B. After an extensive residential assessment, B was placed with the paternal grandmother while A returned home to the mother and B's father (F). At around this time, C was born but died at age 10 weeks. The "triad" was present at death. As a result of extensive enquiries, two medical opinions emerged - one which diagnosed that non-accidental injury remained the "leading possibility" for cause of death; the other that C's skull was of a particularly unusual nature such that it was not possible to say how it would react to any level of force applied.

He gave judgment in open court for this reason:

“In my view, this judgment should be treated as being given in open court, because in my judgment it is essential that such serious matters as the withdrawal of a hearing in to the causation of death of a child where there is conflicting medical evidence is something that should be dealt with in public and should be available to public scrutiny and comment.”

The commentary that followed is worth repeating in full as it sets out the court’s functions, the legal framework it works within and what its task is:

13. In my judgment, a valuable warning note was sounded by the Court of Appeal Criminal Division in the case of *Henderson & Others* [2010] EWCA Crim 1269, and particularly in the words of Lord Justice Moses which introduce the judgment of the court in those cases, and he said this:

There are few types of case which arouse greater anxiety and controversy than those in which it is alleged that a baby has died as a result of being shaken. It is of note that when the Attorney General undertook a review of 297 cases over a 10-year period, following the case of *Cannings*, 97 were cases of what was known as 'Shaken Baby Syndrome'.

The controversy to which such cases give rise should come as no surprise. A young baby dies whilst under the sole care of a parent or child minder. That child can give no clue to clinicians as to what has happened. Experts, prosecuting authorities and juries must reconstruct, as best they can, what has happened. 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 cause, it is tempting to conclude that the prosecution has proved its case. Such a 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. As *Cannings* teaches, even where on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown.'

14. Those words apply with equal force in family proceedings, and it is equally important within family proceedings that the court should keep an open mind, should not fall into the temptation of deducing non-accidental injury from the absence of any other identifiable causation but recognise that there may be areas that we do not understand.

15. I venture with all becoming diffidence to quote a passage of my judgment in [Re R \(Care Proceedings: Causation\) \[2011\] 2 FLR 1384](#), and I do so, not because of its inherent merit, but because it has recently been approved by the President giving the lead judgment in the Court of Appeal in [Re M \(Children\) \[2012\] EWCA Civ 1710](#). I expressed these views:

'I have been impressed over the years by the willingness of the best paediatricians, and those who practise in the specialties of paediatric medicine, to recognise how much we do not know about the growth patterns and what goes wrong in them, particularly in infants.

Since they grow at a remarkable speed and cannot themselves give any clue as to what is happening inside them, and since research using controlled samples is self-evidently impossible in many areas, perhaps we should not be surprised. In my judgment, a conclusion of unknown etiology in respect of an infant represents neither professional nor forensic failure. It simply recognises that we still have much to learn, and it also recognises that it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism. Maybe it simply represents a general acknowledgement that we are fearfully and wonderfully made.'

17.....if we confine ourselves just for the moment to the medical issues, the relevant background is this: all the evidence is that Child C was a loved and well-cared-for child; there is the evidence of his urgent admission and sad and sudden death; there is the discovery at death of the presence of what is often referred to as the 'triad', that is to say, subdural haematoma, hypoxic-ischemic injury and retinal haemorrhage.

18. It is pretty well inevitable, in the current climate, that when that is found, the inquiries will initially focus on non-accidental injury causation and that is precisely what happened in this case, and why, of course, these proceedings were launched. However, as the medical evidence developed, it became apparent that something was not quite right, and very extensive enquiries amongst many disciplines were undertaken. What seems to have emerged in the end was a view on the one side that, notwithstanding the various abnormalities, a diagnosis of non-accidental injury remained the leading possibility, whereas on the other, and in particular in the pathology evidence of Dr Cary, Professor Risdon, Professor Freemont and Professor Scheimberg (which I am told spoke

with an unusual expression of unity) that Child C's skull was of a particularly unusual nature, indeed for Dr Cary and Professor Risdon it was unique to their experience, though one pathologist claims to have seen it on other occasions.

19. What made the case difficult was their observation that crucially it was not possible to say how such a skull would react to force at any level applied to it, and, of course, some forces are pretty well inevitable in the course of life. And thus it would not be possible confidently to discern the mechanism of fatal injury, much less to ascribe it to parental culpability, and so the Local Authority and the parties, and, of course, the court were confronted by distinguished, competent, impartial evidence of many disciplines that strongly tended in different directions. Now that clearly raises difficulties.

21. So those were the matters that were put before the court for its consideration, in the context of the legal framework that I had endeavored to set out, as to whether the Local Authority should have permission to withdraw these proceedings, in which, of course, they were supported by the parties, and indeed by the guardian.

22. In my judgment, after anxious and careful consideration, I am wholly satisfied that the Local Authority were correct to take the view that they have. There is, of course, clearly an issue between the Local Authority on the one hand, and the parents on the other, as to the actual strength of evidence that would have been available to the court. Since I am giving permission to withdraw, it would not be right for me to express a view about that, save to say this: first, my reading of this case merely suggested to me that it may well have all the hallmarks of that kind of case in which the Court of Appeal in Henderson urged the greatest caution; and secondly, there are strong welfare reasons, which I have identified, as to why it may be undesirable or unnecessary to continue with a fact-finding hearing.

23. I am satisfied that when all these matters are viewed together in the round, the Local Authority should, without doubt, have the permission it seeks to withdraw this fact-finding hearing. I appreciate that the granting of such leave, even though unopposed, is a very serious step for the court to take, where what is in issue is the causation of death of a tiny child, **but it is important to remember that the function of the court is not to inquire into the death for the purposes of discovering the cause of it, but is more limited:** it is an inquiry into whether that death was caused in some part by the parents, or either of them, in terms that would be relevant to Section 31(2) of the Act., **that is to say, whether the death is attributable to the care given to the child not being what it would be reasonable to expect a parent to give.** That is the inquiry which the statute requires of the court, and it is in those circumstances that I grant the permission that has been sought.

- **Miscarriage of Justice?**

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- Science is constantly evolving and miscarriages of justice have happened with parents wrongly accused of shaking their child to death based on scientific research and hypothesis, genuinely held, but discarded or refined as science develops.

How many cases had already been decided and babies adopted on the basis that a child had sustain non accidental fractures which could actually have been benign because of Vitamin D deficiency and weak bones caused by Vitamin D induced rickets? A breast fed baby at home become a formula fed baby in foster care: it suffers none of the broken bones it sustained at home leading to the confirmation that the parents had harmed the child as it hasn't shown the same inherent physical weakness in care, but what if the baby is removed from the breast by virtue of being in care and given Vitamin fortified formula milk that changes the strength of formerly breast fed Vitamin D deprived bones?

Adoption is a final step for the child:

- "with the state's abandonment of the right to impose capital sentences, orders of the kind which family judges are typically invited to make in public law proceedings are amongst the most drastic that any judge in any jurisdiction is ever empowered to make. When a judge makes placement order or an adoption order in relation to a twenty year old mother's baby, the mother will have to live with the consequences of that decision for what may be upwards of 60 or even 70 years, and the baby may be upwards of 80 or even 90 years'.
- **Re J (A Child) [2013] EWHC 2894 (Fam)**
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- The case examples I have given above simply dip into the world of child protection I inhabit. Vitamin D deficiency, EDS, wafer thin skulls: these are but examples of physical frailty that may or may not explain why a child has come to suffer injury.
- Throughout our family justice system judges are faced with injured children unable to give an account of what has happened to them- they may be too young to speak or they may have died.
- Moreover, it is a sad fact of life that babies and children are hurt, and sometimes killed, by those who ought

to have protected them from harm. Guilty parents lie to conceal their actions. Not every claim to have been a victim of an injustice is valid. The judge of the family court has a hugely difficult task to perform because the stakes cannot be any higher, for the surviving child, the parents and society at large. That burden is shouldered by the family judge alone: there is no jury to share the load between its members.

- **Miscarriages of Justice and the Role of the Media**

Human justice is inevitably fallible. However hard we struggle to avoid them, and however rigorous the procedural and other safeguards we strive to erect against them, there will always be miscarriages of justice. In the investigation of possible miscarriages of justice and in righting judicially inflicted wrongs, campaigning and investigative journalists and the media in general have an absolutely vital role to play.

As the President of the Family Division has said:

"... We must be vigilant to guard against the risks. And we must have the humility to recognize - and to acknowledge - that public debate, and the jealous vigilance of an informed media, have an important role to play in exposing past miscarriages of justice and in preventing possible future miscarriages of justice ... We cannot afford to proceed on the blinkered assumption that there have been no miscarriages of justice in the family justice system ... Open and public debate in the media is essential."

Re B (A Child) (Disclosure) [2004] EWHC 411 (FAM), [2004] 2 FLR 142

Concluding Remarks

- As I have said before: child abuse is the stuff of nightmares, but so too is being falsely accused of harming your child.
- Babies die at home in parental care and the Family Court has to determine if death came about by violence or from a benign cause mimicking abuse.
- In cases where a child dies, and the Local Authority alleges that a carer caused the death medical evidence plays a pivotal role in informing the court as to how a child came to die.

From the point of its birth, the child has rights of its own to live a life without being subjected to significant harm and abuse within its family. That 'right' matters more than the 'right' of his or her parents to care for their child, if by so doing the child has or may suffer serious harm which has or may blight its healthy development .

In cases like Al Alas there is a small pool of available experts. The science on which their opinions depend is complex and sometimes controversial. The acceptance or rejection of those opinions by the court has a pivotal effect on the outcome for the family at the heart of the case. But for the vigilance of Dr Irene Scheimberg, the paediatric pathologist who conducted the post mortem, Jayden's Vitamin D deficiency and rickets may have gone undetected in death as it had been in life and the outcome of the criminal and care case for the parents and Jayda may have been very different. The importance of open minded experts in cases such as this cannot be under estimated.

Science will not develop unless its orthodoxy is rigorously challenged by the experts who practice within it.

In alleged Non Accidental Injury cases the significance of Vitamin D deficiency, rickets, genetic abnormalities and rare syndromes affecting bone density are emerging as areas that have to be put into the equation when the alternative is that a carer has hurt, maimed and /or killed their child.

Science does not stand still.

We still do not have all the answers and there is no shame in saying that publicly.

Society needs a rational debate about how to balance the rights of a child, when there is a conflict between a children's right to grow up in its family of origin and at the same time offer protection against parental abuse or neglect within that family. For the time being, the criminal justice system offers a remedy *ex post facto* and the family justice system attempts intervention at an earlier stage before such abuse has occurred, if not to protect the child who has already been harmed or killed, then at least to protect any vulnerable siblings who might also be at risk.

- Cases in which a baby dies and parents face allegations of shaking it to death are amongst some of the most emotive and difficult cases the courts have to decide.
- The outcome for the families involved cannot be starker.

The debate about the use of experts in court proceedings conducted in the media reflects the conflicted stance

society takes on the emotive issue of child protection when a particular story breaks in the national media. It can be, with hindsight, a gross injustice to child and parent alike for social workers, backed by medical opinion to wrongly remove children from their families accusing the parents of abuse, but it is equally unacceptable for vulnerable children to be left at home to suffer abuse at the hands of those who should protect them.

The responsibility placed on the advocate acting for the parent who stands before the expert seeking to challenge their opinion is immense. We trespass into specialist fields of neuropathology, ophthalmology, neurosurgery, radiology etc. Yet we are not doctors or medics. We, as lawyers, are required in the family court to question the specialists. We have no expert sitting beside us to prompt or guide our challenge, yet it is we who have to navigate the medical notes and research materials so as to cross examine the expert in their own field of specialism. It is not a straight forward task.

As the legal profession struggles to keep up with the evolving science in relation to the alleged inflicted trauma, the Court in care proceedings is enjoined to:

‘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’.

***R v Cannings* [2004] EWCA Crim 1; [2004] 1 WLR 2607**

The link between science, emerging medical research and the welfare of a child has never been so intertwined and important.

- Next lecture 12th April: **‘Expert Witnesses: A Zero Sum Game’**
- The use of experts in the family courts can make a significant difference to outcomes. The debate about the use of experts in court cases reflects the conflicted stance society takes on the emotive issue of child protection. It is a gross injustice to the child and parent for social workers, backed by ‘expert’ opinion, to wrongly remove children but it is equally unacceptable for vulnerable children to be left at home to suffer abuse.

Professor Jo Delahunty QC, 2017

[\[1\] https://www.evensi.uk/crime-and-punishment-when-legal-worlds-collide-gresham/179133278](https://www.evensi.uk/crime-and-punishment-when-legal-worlds-collide-gresham/179133278)

In which I explored the difference in outcomes between cases in the Criminal and Civil Courts, considered the framework of ‘Beyond reasonable doubt’ versus ‘the balance of probabilities’ and the concept of the judge’s role to determine the law and the jury the facts, as against the idea that the judge determines all

[\[2\] **1 Welfare of the child Children Act 1989**](#)

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[\(1\) When a court determines any question with respect to –](#)

[\(a\) the upbringing of a child; or](#)

[\(b\) the administration of a child’s property or the application of any income arising from it.](#)

[The child’s welfare shall be the court’s paramount consideration.](#)

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[\[3\] s31 \(2\) Children Act 1989: A court may only make a care order or supervision order if it is satisfied—](#)

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[\(a\) That the child concerned is suffering, or is likely to suffer, significant harm; and](#)

[\(b\) That the harm, or likelihood of harm, is attributable to—](#)

(i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or

(ii) The child's being beyond parental control

[4] The statutory definition in the Children Act 1989 states that 'harm' means ill-treatment or impairment of health and development. Ill-treatment includes sexual abuse and forms of ill-treatment which are not physical, thus including emotional abuse. Physical abuse itself is not explicitly included, but this is taken as read. 'Health' includes both physical and mental health, and 'development' includes physical, intellectual, emotional, social and behavioural development. To assess whether health or development are being significantly impaired the Act tells us to compare the health or development of the child in question 'with that which could reasonably be expected of a similar child'. The definition of significant harm also includes 'impairment suffered from seeing or hearing the ill-treatment of another'.

[6] At the post mortem on August 3rd 2009 the following findings were made:

External Examination

(i) Various marks consistent with therapy

(ii) No old or recent marks of injury

Internal Examination

Sub-scalp bruising on the right parietal/occipital region over an area of 5cm x 5cm. Associated sub-periosteal bleeding from the midline to the right over the occipital bone over 3cm x 1cm area. A thin film of subdural haemorrhage over both hemispheres [more on the left] adherent to the dura. Some thin film subdural haemorrhage involving the skull on the left side. A suspected underlying fracture on the right occipital bone.

Radiological Findings confirmed by later bone histopathology-

1. Left hand: 1st left metatarsal: Incomplete mid-shaft fracture. 2nd left metatarsal: Incomplete mid-shaft fracture and crack fracture towards the end of the bone. 3rd left metatarsal: Complete mid-shaft fracture. 4th left metacarpal: Double complete shaft fractures.

2. 2 left ribs, costochondral area: Abnormal growth plates attributable to established rickets.

3. Left proximal humerus: Fracture of the proximal humerus between the growth plate and the bone (a metaphyseal fracture).

4. Left proximal femur: Fracture of the proximal femur at the interface between the growth plate and the bone (a metaphyseal fracture).

5. Right distal humerus in two places (old fracture).

6. Proximal humerus: Fracture of the proximal humerus at the interface between the growth plate and bone (a metaphyseal fracture).

7. Right mid-tibia: Old healed greenstick fracture and a complete fracture of the shaft.

8. Right parietal bone: A displaced fracture of the skull bone.

9. Right occipital bone: A traumatised fissure.

10. Left radius: Incomplete crack fracture of the shaft with rickets affecting the growth plate.

11. Left ulna: Rickets in the growth plate.

12. Right radius: Rickets affecting the growth plate.

The Brain

Subdural haemorrhage, global ischemic injury, ischemic axonal injury and axonal injury to the pyramids and spinal nerve root axonal injury.

The Eye

Fresh retinal haemorrhages in both eyes with bilateral papilloedema (optic nerve head swelling). There was also subdural bleeding associated with the optic nerve...

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[7] **Abusive head trauma (AHT)**, which used to be referred to as **shaken baby syndrome** (a term no longer used), is a constellation of medical findings (often referred to as a "triad"): subdural hematoma, retinal bleeding, and brain swelling which some physicians have used to infer child abuse caused by violent shaking

[8] Ehlers-Danlos syndrome (EDS) is a heterogeneous group of heritable disorders of connective tissue, characterised by skin extensibility, joint hypermobility and tissue fragility.

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[9] <http://www.nhs.uk/Conditions/ehlers-danlos-syndrome/Pages/Introduction.aspx>

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[10] <http://www.bailii.org/ew/cases/EWHC/Fam/2013/968.html>