A LOCAL AUTHORITY v A (NO 1) [2010] EWHC 28 (Fam)

Family Division

Ryder J

28 January 2010

Care proceedings – Fact finding – Recurring events – Judicial inferences

The mother's first child died at the age of 4 months; this was treated as a sudden infant death. The second child, by a different father, was born prematurely 12 1/2 months after the death of the first child. When the second child was just over a year old, she was hospitalised with an apparent respiratory illness. She seemed to recover well in hospital, but shortly before she was due to be discharged, she suffered a cardio-respiratory crisis while in the mother's care on the ward. Although the medical team arrived less than a minute after the child's apnoea alarm went off, the expert evidence was that the child had already suffered a critical collapse, and that when the team reached her she had not been breathing for at least 2 to 3 minutes. The crisis left the child severely neurologically impaired; she was likely to be severely disabled for the rest of her life and her life expectancy had been significantly reduced. The mother was arrested on suspicion of child cruelty; an emergency protection order was granted; and the child was thereafter cared for under interim care orders. The child required multi-disciplinary professional help with her care 24 hours a day. The local authority asked the court to make certain findings against the mother, including a finding that she was responsible for the respiratory problems that had originally led to the child's hospitalisation, and a finding that she had induced the child's cardio-respiratory crisis, first turning off the apnoea alarm, and then smothering the child, before turning the alarm on again. The authority accepted that no adverse inference could be drawn from the death of the first child, the cause of which remained unexplained, but did suggest that a recurrence of rare unexplained events raised a powerful inference as to cause. The local authority also expressed concern about the mother's attitude to the child, and to her care, and on her credibility, as demonstrated by previous fabrications. There was also evidence that the mother's relationship with the father had been an abusive one. The mother denied responsibility for any of the child's respiratory problems.

Held – finding that the mother had deliberately smothered the child in the hospital –

(1) A judicial inference as to cause was no more or less an evidential assessment than a determination of likelihood or risk, and was to be based on facts that could be found. If there was no direct evidence of the primary fact, there had to be secondary facts from which an inference as to the primary fact could be drawn. It was not an appropriate starting point in this case to draw an inference from the mere recurrence of alleged asphyxiation. Similarly, it would be too simplistic to ignore a penumbra of social work evidence that related to threshold in a case in which there were recurring but unexplained events; the penumbra of evidence might give rise to secondary facts that supported a proper judicial inference (see paras [18], [19]).

(2) Medically, the cause of the child's initial respiratory problem was unknown; it was most likely that this was a natural but unexplained event. However, it was most likely, given the medical and factual evidence, that the mother had intended to, and had, smothered the child in the hospital, although she had not intended to kill her (see paras [50], [94], [95]).

Statutory provisions considered
Children Act 1989, s 31

Cases referred to in judgment

B (Care Proceedings: Standard of Proof), Re [2008] UKHL 35, [2009] 1 AC 11, [2008] 3 WLR 1, [2008] 2 FLR 141, HL

R v Cannings [2004] EWCA Crim 1, [2004] 1 WLR 2607, [2004] 1 All ER 725, CA

S-B (Children) (Care Proceedings: Standard of Proof), Re [2009] UKSC 17, [2010] 1 AC 678, [2010] 2 WLR 238, [2010] 1 FLR 1161, [2010] 1 All ER 705, SC

U (Serious Injury: Standard of Proof), Re; Re B [2004] EWCA Civ 567, [2004] 3 WLR 753, [2004] 2 FLR 263, CA

Mary Lazarus for the local authority
David Hart QC and *Martin Downs* for the first respondent
Barbara Slomnicka for the second respondent
Frank Feehan for the third respondent

Cur adv vult

RYDER J:

[1] Baby X was born prematurely on 19 December 2007. Her mother is Ms A and her father is Mr B. Her parents are unmarried and have separated. Baby X was cared for by her mother until 1 August 2008 when she was hospitalised at Hospital C with an apparent respiratory illness. She appeared to be recovering in hospital when she experienced a cardio-respiratory crisis (referred to as the 'collapse') on 7 August 2008 while in the care of her mother but on a hospital ward. The consequence of the collapse is an extremely severe neurological impairment. Baby X is likely to be severely disabled for the rest of her life and has a significantly shortened life expectancy.

[2] On the same day Baby X's mother was arrested by the police on suspicion of child cruelty. Baby X was taken to the Evelina Children's Hospital at St Thomas's in London under the authority of police protection and an emergency protection order was granted on the following day. Baby X has thereafter been subject to the protection of interim care orders and such has been the nature and extent of her medical condition that the High Court's inherent jurisdiction has been exercised inter alia in relation to the key issue of whether she should be resuscitated.

[3] This is a fact-finding hearing in care proceedings instituted by A Local Authority. Baby X is represented through her children's guardian. I am very grateful to the advocates for all parties for the impeccable standards of research, preparation and advocacy which they have provided.

[4] Baby X remains a very poorly young child with complex needs requiring multi-disciplinary professional assistance with her care 24 hours a day. In particular, she needs health professional supervision with her gastro-intestinal motility and bowel function, her lung function and the high risk of aspiration, the control of her epilepsy, the management of her tone and pain and her evolving gross developmental delay. On more than one occasion, the court has been told and the parties know that her life has been in danger. A declaration as to the lawfulness of the withdrawal of treatment has been made and subsequently revoked. There is now an emergency treatment agreement in place.

[5] There is also a measure of agreement between the parties that Baby X will henceforth need a carefully constructed package of care which is presently being provided by Hospital Services D. For the purposes of this

hearing Baby X's welfare needs, ie her social and medical care, residence and contact are agreed but will need to be re-considered in light of the expert advice received at a subsequent hearing.

[6] As originally put by the local authority, there were a number of strands to the background of Baby X's collapse which needed to be investigated. They were:

(a) the cause of death of a previous child of the mother's (but not of this father), namely, Baby Y, born 19 June 2006, who died at the age of 4 months on 6 October 2006;
(b) the cause and/or significance of the admission of Baby X to hospital on 1 August 2008;
(c) the cause of the collapse suffered by Baby X on 7 August 2008;
(d) the significance of other facts arising out of the parties' background circumstances.

[7] Well before the beginning of this hearing the extensive inquiries of the parties had led the local authority to accept that the sad demise of Baby Y was accurately described as a 'Sudden Infant Death': a death where the cause is unknown and/or unexplained. On the facts of this case it is accepted that this is not an event from which in all the new circumstances known to this court an adverse inference should be drawn against anyone.

[8] The local authority pursue findings of fact against Baby X's mother which are set out in a detailed schedule. Although reference should be made to the schedule it can be summarised as follows:

(a) *the 1 August 2008 admission to hospital*: Baby X suffered an apparent life threatening event (ALTE) at or around 11.30 pm on 31 July 2008, her mother was her sole carer, the person who discovered her with a blanket at an angle over her face and the person who administered immediate resuscitation to help relieve her symptoms;
(b) the mother was responsible for the ALTE by some form of intentional asphyxiation;
(c) *the 7 August Collapse*: Baby X suffered a prolonged cardio-respiratory arrest at or around 6.44 am on 7 August 2008 when her mother was the only person with care of her on a hospital ward. The event which the local authority say caused the hypoxic changes observed in Baby X's brain was likely to have been minutes in duration rather than a brief moment. The apnoea alarm attached to Baby X would have sounded after 10 seconds of interrupted breathing. An alarm sounded for only a brief period before assistance was called and it is accordingly likely that mother interfered with the apnoea alarm;
(d) Baby X's cardio-respiratory arrest was likely to have been induced by the mother, probably by intentional asphyxiation;
(e) the risk of harm to Baby X arising out of the domestic violence which has been admitted by Mr B.

[9] The local authority also seek to rely on the mother's attitude to Baby X and to her care and on the mother's credibility as demonstrated by previous fabrications.

[10] The local authority pursue no findings against the father save in respect of the specific concessions made by him about his volatile and violent past which the local authority accept. He is only 18 years old and when the circumstances relating to his own child occurred it was in the context that he was already trying to deal with having found Baby Y dead on 6 October 2006, an event which had a profound effect upon him.

[11] The local authority have also expressed agreement with the position the father has maintained throughout these proceedings. That position is this: Mr B wants to know what happened to his daughter and why. He wants her to have the best possible treatment and care for the remainder of her short life. He wishes to continue to have contact with her wherever she is living and he supports the extensive contact also enjoyed by his parents. If Baby X were to be cared for again by her mother, he would wish to have the support of the local authority in maintaining his family's relationship with Baby X.

[12] The mother's position is that she denies being responsible for Baby X's ALTE on 1 August 2008 and her collapse on 7 August 2008. She denies interfering with the apnoea alarm. As to the 1 August 2008 admission she says that that was an event precipitated by natural causes. Adopting the opinion of Professor Morris, consultant pathologist, she says that the collapse on 7 August 2008 was the consequence of a medical, ie natural mechanism, the precise details of which are unknown, but that Baby X's breathing became shallower and less effective, causing hypoxia, then bradycardia, gasping and finally apnoea ie this was sadly a natural and explicable if not an explained event.

[13] There is no doubt (not least from father's concessions and the mother's assertions) that Baby X's parents had an abusive relationship. There were incidents of serious domestic violence perpetrated by Mr B in the presence of Baby X and pre-pregnancy domestic violence which included the father breaking the mother's nose in February 2008 and hitting the mother in the face in May 2008 for which he received a conviction for actual bodily harm. These matters will be relevant to the assessment of the parents and the father's concessions are a matter of record accepted by the court.

The law

[14] There is no disagreement between the parties as to the law which has most recently been reviewed in *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35, [2009] 1 AC 11, [2008] 3 WLR 1, [2008] 2 FLR 141 and *Re S-B (Children) (Care Proceedings: Standard of Proof)* [2009] UKSC 17, [2010] 1 AC 678, [2010] 2 WLR 238, [2010] 1 FLR 1161. Mere suspicion is neither sufficient to prove that a child is suffering harm nor is it a sufficient basis to give rise to a likelihood or risk of that harm. Findings of fact whether as to the harm alleged or the basis for concluding that there is a likelihood or risk of harm must be concluded to the civil standard of proof, namely on the balance of probabilities as to which there is no heightened standard referable to the gravity of the allegation or consequence.

[15] In these proceedings and because of the stark circumstances which are identified to be found, if the cause of harm is proved to be unnatural then

there will be no need to consider the more sophisticated propositions which are in play as to the identification of the perpetrator of that harm. The only relevant carer at any material time was Baby X's mother. Mr B was not present and had no part to play in any causative event on either 1 August or 7 August 2008. No-one suggests that the mother's friend, Ms G, who was present on 31 July and 1 August 2008, was in any way responsible.

[16] I have specifically been addressed on the mother's behalf about 'unexplained' or 'unascertained' causes of death and near death. Reliance is placed upon the dicta of Judge LJ, as he then was, in *R v Cannings* [2004] EWCA Crim 1, [2004] 1 WLR 2607 at paras [8] and [9] where three categories of death were identified: natural and explained (cause identified), natural and explicable (cause unidentified) and unnatural (whether accidental or deliberate). From the perspective of the criminal and the family courts the latter represents two distinct situations.

[17] As can be seen from the position the mother submitted in closing, as set out below, and having exhausted the detailed medical inquiries which were recommended, the circumstances of this case are now said to fall into either natural and explicable (cause unidentified) or unnatural (deliberate).

[18] Although the cause of Baby Y's death is not pursued, there are still two events which it could be said represent a recurrence of alleged asphyxiation. In that circumstance it is necessary to comment upon the submissions the court heard about the difficulty which arises from an approach to the evidence that the mere happening of more than one incident, by the very recurrence of the events, ie the rarity of unexplained events recurring, is said to raise a powerful inference as to cause. I do not propose to enter into the interesting and broader scientific debates which exist on this topic. A judicial inference as to cause is no more or less an evidential assessment than a determination of likelihood or risk. It has to be based on facts which can be found. If there is no direct evidence of the primary fact, there have to be secondary facts from which an inference as to the primary fact can be drawn.

[19] It is not an appropriate starting point in this case to draw an inference from mere recurrence just as it would be too simplistic to ignore a penumbra of social work evidence which relates to threshold in a case where there are recurring but unexplained events. The penumbra of evidence may give rise to secondary facts which support a proper judicial inference.

[20] It is in this context that the family law response to *R v Cannings* is important and I bear it in mind. That can be found in *Re U (Serious Injury: Standard of Proof); Re B* [2004] EWCA Civ 567, [2004] 3 WLR 753, [2004] 2 FLR 263 at paras [22] and [23]:

> '[22] In family proceedings the procedures and the rules of evidence are different from criminal trials. In the first place the material available to the court is likely to be much more extensive than would be admitted in a criminal trial. In the second place the standard of proof to be applied before reaching a conclusion adverse to the parent or carer is, as we have set out above, also different. Given a similar background to that in *R v Cannings* a judge would be required to ask himself which of two possible explanations, human agency or unascertained natural cause, is

the more probable. If persuaded by clear and cogent evidence that it was more likely to be the former the court is entitled to reach a conclusion adverse to the parent or carer.

[23] In the brief summary of the submissions set out above there is a broad measure of agreement as to some of the considerations emphasised by the judgment in *R v Cannings* that are of direct application in care proceedings. We adopt the following:

(i) The cause of an injury or an episode that cannot be explained scientifically remains equivocal.
(ii) Recurrence is not in itself probative.
(iii) Particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.
(iv) The court must always be on guard against the over dogmatic expert, the expert whose reputation or *amour propre* is at stake, or the expert who has developed a scientific prejudice.
(v) The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners that are at present dark.'

[21] In this case, it is the mother's position, very clearly set out in her closing submissions, that the court is asked to choose between the following:

(a) whether at some time before 6.44 am on 7 August 2008 the mother switched off the apnoea monitor which was attached to Baby X, attempted to smother her and then switched it back on again, waiting for an unspecified time for it to ring and then shouting for help to a nurse; or
(b) whether, as a consequence of a medical mechanism, the precise details of which are unknown (but which, I interpolate, can be hypothesised), Baby X's breathing became shallower and less effective, causing hypoxia, then bradycardia, gasping and finally apnoea.

[22] On either basis, it was only because of the skill and persistence of her treating clinicians, doctors and nurses that Baby X recovered at all.

[23] Baby Y was the child of Ms A and Mr E . Baby Y died aged 4 months and his body was discovered by Mr B in very distressing circumstances. There is uncontradicted paediatric and pathological evidence that Baby Y died a sudden death which is unexplained. There is insufficient evidence to re-open an investigation into his death by this court. That remains the agreed position of the parties after consideration of whether any facts capable of being found in relation to the collapse suffered by Baby X might lead to a proper judicial inference in respect of the cause of death of Baby Y. Accordingly, the possible causes of Baby Y's death have played no part in this court's consideration of the cause of Baby X's admission and collapse.

The medicine

[24] As to the potential medical causes of the collapse on 7 August 2008, the following possibilities were identified:

(a) a neurological disorder;
(b) a metabolic disorder;
(c) an infection, in particular an RSV infection;
(d) an underlying immune deficiency or predilection to infection;
(e) a mutant channelopathy gene or other genetic disorder;
(f) a susceptibility to cardiac arrhythmias;
(g) a bacterial toxaemia precipitating sudden cardio-respiratory arrest;
(h) an unknown medical mechanism.

[25] At the conclusion of the evidence, there are some propositions which are agreed or as to which no contrary proposition is advanced on the mother's behalf. These propositions are based upon clear examination and test results validated and analysed by experts in each specialist field. I accept them as being reasonable, mainstream opinions based upon peer-reviewed research and anchored in medical best practice and the medical records, history, tests and examinations which were performed. They are as follows:

(a) Dr Jayamohan, consultant neurosurgeon, has ruled out the existence of any neurological disorder;
(b) Dr Wilson, honorary consultant paediatrician and Dr Kanabar, consultant paediatrician, identify no metabolic disorders. This is supported by Professor Patton, who found that Baby X's organic acids tested in her urine were normal;
(c) Professor Klein, professor of infectious diseases and honorary consultant at Great Ormond Street Hospital, has also ruled out the likelihood of any infection, including RSV infection, causing the collapse;
(d) Professor Klein has excluded any underlying immune deficiency and has advised that the low immunoglobulin levels found on 8 August 2008 were likely to be a consequence of Baby X's recent acute illness not a predilection to infection;
(e) Dr Kanabar excludes RSV infection and recurrent infections and agrees it is unlikely that Baby X has an underlying immune deficiency;
(f) Professor Patton, consultant clinical geneticist, excludes the existence of any genetic chromosomal or mitochondrial abnormality or disorder and specifically two major autosomal disorders for which tests have been conducted namely: reduced respiratory drive and cardiac ion channelopathies (which could cause serious or fatal cardiac arrhythmia);
(g) there is no history to suggest cardiac arrhythmia either clinically or on ECG testing before or after the admission and collapse;
(h) other forms of cardiac disorder (eg myocardial damage or congenital heart block) have all been excluded by Dr Shinebourne, honorary consultant in congenital heart disease;

(i) Dr Stoodley, consultant neuroradiologist, identifies that the length of the causative insult which was the cessation of oxygen delivery to the brain, is likely to have been minutes rather than a brief event because of the hypoxic changes to the brain which can be observed.

[26] The following medical opinions were identified to be tested in evidence; that of:

(a) Dr Stoodley as to the nature of the changes observed in the brain;
(b) Dr Shinebourne, who is of the opinion that:
    (i) Baby X is not susceptible to cardiac arrhythmias and that in any event cardiac arrest as the result of arrhythmia would be shown by Baby X's heart being in ventricular fibrillation not asystole; and
    (ii) the blood gases taken at 7.14 am on 7 August 2008 are not indicative of primary cardiac failure as the heart would not have been able to pump around the system increasingly de-oxygenated blood which was taking up increasing amounts of CO2.
(c) Dr Kanabar who is of the opinion that
    (i) the most likely cause of both events is asphyxia secondary to accidental or deliberate smothering; and
    (ii) as respects the 1 August 2008 admission: the stridor and epistaxis are indicative of a sinister component to the condition in which Baby X was found.
(d) Dr Wilson who is of the opinion that for the collapse to be caused by bacterial toxins the mechanism would be cardiovascular which fails to explain the raised CO2 levels measured in the blood gases taken on 7 August 2008.
(e) Professor Klein who is of the opinion that the clinical picture does not support an infection related collapse and that transient bacteraemia is extremely unlikely.
(f) Professor Morris, who presents two hypothoses to explain Baby X's collapse, the first, his general hypothesis is that it is as likely to have been caused by an unknown medical mechanism as it is intentional airways obstruction and his second, specific hypothesis is that the mechanism could have been triggered by transient bacteraemia.

The evidence

[27] I have heard the mother and father give evidence, together with her parents, the social workers, a health visitor, a paediatric nurse in the health visitor team, Ms F and Ms G. I heard from the clinicians, ie the doctors and nurses in the hospital at the time of the events in question. The following forensic experts gave oral evidence: Dr Stoodley, Dr Kanabar, Professor Morris, Dr Wilson, Professor Klein, and Dr Shinebourne. The court has read

and considered all of the core bundles of evidence together with every medical record referred to in the oral and written evidence and the research papers detailed in the annexe to this judgment.

[28] Considering first the evidence of Mr B. There were moments in his evidence of genuine poignance, distress and abject hopelessness. At the age he was, Mr B had few enough resources to draw upon in the witnessing of the death of his partner's first child. He has almost nothing other than unconditional love for Baby X to sustain him in the face of this overwhelming tragedy. He is a very young man who desperately needs support and explanations as to why this has happened to him. His emotional reactions are very similar to someone diagnosed with post traumatic stress disorder. The court does not, of course, know whether this is other than a layman's superficial description of him but those assessing him in due course or seeking to help him with the consequences of what has occurred should bear in mind the seriousness of the effect the consequences have had upon him. None of this excuses his anger and violence which is serious.

[29] Mr B was a perfectly straightforward witness. I do not accept that he has not told the truth as to the extent of the concessions which he made to the court before the hearing began. He was appropriate, restrained and dignified in the stance he took before the court. As a credible witness, I take note of his evidence as to the mother's fabrications, which she by and large accepted in cross-examination. I accept his evidence.

[30] Ms A was not the witness the court expected. She has the benefit of a very professional and careful legal team and initially presents as a 'street wise' and sophisticated young woman. It was at least surprising to find that Ms A was patently superficial, demonstrably economical with the truth and lost in a performance which I regret to have to say was worthy of a soap opera and which, I suspect, only she believed. Her attitudes to others including the process of examination and cross-examination demonstrated a careless and self-justifying approach from a witness whose recollections were by and large unreliable and sometimes demonstrated a worrying emotional response to the allegations put to her and the circumstances which occurred, whatever their cause. She gave all the appearance of someone who thrives on attention but is very dependent upon it and who is emotionally detached from the events which have occurred.

[31] Although I remind myself that because some of what Ms A may say is unreliable that does not mean that all of her evidence is so tainted, there being many and different reasons for recollections being poor and inaccurate or untruthful evidence being given, I came to the clear conclusion that on almost every aspect of importance to the collapse of her daughter Ms A was an unreliable witness.

[32] The local authority relied in opening on various facets of mother's background which they say are relevant in the sense that the evidence shows Ms A to be detached from Baby X. Insofar as it might be suggested that this evidence is relevant to her propensity to smother her child as alleged by the local authority I have ignored it on the basis that such propensity evidence may be inadmissible on any question of fact concerning causation. I have, however, recorded the concessions made by the mother and the court's findings on these issues at the end of this judgment as these are very relevant to any welfare decisions which the court has yet to make.

[33] The local authority also rely on a series of significant fabrications prior to the events in question in these proceedings to demonstrate the mother's inherent lack of credibility. Having heard Ms A in oral evidence this court did not need to have recourse to this material to come to the very firm conclusion that Ms A is an habitual liar. Again, for the purposes of further assessment of her, I record her concessions and my findings about the most relevant of these issues.

The 1 August 2008 event

[34] The local authority's case is that the mother was responsible for the symptoms experienced by Baby X and that she caused them by some form of asphyxiation. They say in support of their case that the mother's accounts were inconsistent and that having regard to those inconsistencies and the symptoms, in particular the stridor and epistaxis commented upon by Dr Kanabar, there was a sinister component to the collapse. The symptoms involved pallor/cyanosis, limpness, some epistaxis and fluctuating levels of consciousness for a few hours afterwards. It is said to be likely that Baby X suffered an apnoea. The symptoms are not in issue, their significance and cause is.

[35] There is medical evidence which supports both the mother and the local authority in their different positions. That supporting the mother comes from those who provided the most clear and cogent medical evidence in relation to the 8 August 2008 collapse, including that which is agreed. Dr Wilson concludes that Baby X's admission on 1 August 2008 was an instance of unexplained ALTE. Professor Klein thought that RSV may have been responsible for the admission 'taking into account the clinical signs and symptoms as revealed by the clinicians in the early hours of that morning and thereafter …'. That is an opinion relied upon by the mother in her evidence. Whereas Dr Kanabar is of the opinion that infection can be excluded and the presence of epistaxis and stridor may be indicative of an unnatural mechanism.

[36] It is certainly the case that the admission on 1 August 2008 has a cause which is not fully explained. It was a collapse, albeit not as severe as that 6 days later. As Dr Wilson reported in his written evidence, apnoeas and convulsions usually occur in infants of less than 6 months with the majority occurring in infants of less than 3 months. This was also the position of Professor Klein who added that RSV is rare in the summer. Dr Wilson commented in some detail about the lack of severity of the RSV symptoms which Baby X was subsequently identified to have. Again it was Professor Klein who said that Baby X had some features associated with RSV infection but her presentation was much more severe than would have been suggested by the history.

[37] Although Dr Wilson has said in written evidence that RSV infection was unlikely to have caused the 1 August 2008 symptoms, both he and Professor Klein very fairly agreed in oral evidence that these symptoms may have been due to that infection.

[38] The clear evidence to the contrary is that of Dr Kanabar. He relied upon the negative test results of 12 and 14 August 2008 for RSV bronchiolitis and an overall and very careful clinical review of the whole sequence of events from 28 July 2008 when the mother took Baby X to the GP without

any complaint of respiratory symptoms (and within which there was a normal ENT/chest examination). In simple terms he says with some force that Baby X did not have a severe RSV infection, nor was the RSV so severe as to have caused a collapse/apnoea.

[39] What other medical evidence was of relevance? Baby X had a nose bleed. The significance of epistaxis is dependent on the weight to be given to research conclusions on the facts of the case. There is accepted, published opinion to the effect that epistaxis is strongly associated with upper airways obstruction. That does not, of course, mean that every nose bleed will likely be the consequence of a suspicious act. Neither Professor Morris's hypothesis nor any natural mechanism associated with a collapse accounts for its presence in this case. So does it add anything? Dr Wilson advised caution. Unless the court accepts that the mother has dissembled about her evidence on this point and I do not, then the existence of a blood stained nasal discharge (which is the evidence of the paramedics which I accept is most likely to be accurate on the point) is insufficiently indicative of an unnatural act to change the balance of medical opinion which I have described.

[40] As respects the presence of stridor, the problem with this description is that it is a precise medical term which is also used loosely in the sense that it can be intended by the user to mean local or general floppiness. Dr Wilson again advised caution about reliance on this description and was in all the circumstances unconcerned about its presence. The real issue is what caused the floppiness and medically that remains unknown.

[41] The evidence of these three experts is powerful and careful. Having accepted it as I do, it would be impossible to say that it is likely that an RSV infection caused the symptoms that led to the 1 August 2008 admission. That is only a possibility. In balancing the careful opinions they preferred, which in each case I hold to be reasonable, I have come to the conclusion that I agree with Dr Wilson: medically the cause of Baby X's symptoms which led to the 1 August 2008 admission is unexplained ALTE and hence unknown.

[42] Turning then to the evidence of fact.

[43] Dealing first with the assertion that Baby X was in the sole care of her mother on the night in question. The evidence of the mother and her friend, Ms G, is consistent: they were together in the mother's flat at all material times. It should be recollected that it was part of the general tenor and content of the evidence about Baby X's care, which I accept, that Ms G spends a great deal of her time, arguably a disproportionate time, looking after Baby X to the extent, as she said in evidence, that she had a tendency to take over. I accept the mother's submission that on that night Baby X was in the shared care of herself and her friend.

[44] I also find that Ms G had an evident affection for Baby X. Her account of the night of 1 August 2008 was straightforward. She appeared to be a truthful and reliable historian. She gave a clear account of events in her statement to the police only one week later which is consistent with her oral evidence and the core of the mother's account. The mother's account to the police is likewise cogent. She gave them circumstantial recollections which are important because they were provided at the earliest opportunity, eg the fairy lights in the bedroom which allowed her to check on Baby X from the door of the bedroom and an account of holding Baby X's nose.

[45] The mother said that she found Baby X at 11 pm with a 'breathable' blanket at a slant over her face. The mother's evidence as to that and Baby X's habit of pulling her blanket over her face seemed to me to be genuine. It was corroborated by Nurse H who found Baby X with a blanket over her head while in hospital and at a time when the mother was not present and Baby X was being cared for by nurses. I came to the conclusion that on this aspect of the evidence the mother was reliable. There was a quality about her evidence concerning the night of 1 August 2008 which was quite different and missing from her account of the events of 7 August 2008.

[46] I accept that mother made two visits to the bathroom in the flat, one at around 9 pm and one between 9 and 11 pm. Nothing of concern was noted and the mother was able to see Baby X from the bedroom door. It is certainly correct that on going to the bathroom and/or the bedroom mother would have been out of the direct line of sight of her friend, who was lying on the sofa in the lounge. I also accept that Ms G was watching television and making telephone calls. Having heard the mother and Ms G in oral evidence and having regard to Ms G's near obsession with the care of Baby X, I do not accept that Ms G would have been so distracted as to have failed to notice anything unusual about the mother's behaviour or the length of time she was away from the lounge.

[47] I accept that the visits were short and that a creaking floorboard would have alerted Ms G to where mother was in the flat. Likewise I accept that on the occasion the mother found Baby X at 11 pm it was only a moment between the creaking of the floorboard and her call for help. In my judgment, it is unlikely that she used one of the earlier opportunities to smother her child and then raise the alarm only on her third visit to the bedroom. Had the mother's evidence about this evening been of the same poor quality as that relating to 7 August 2008, a very different conclusion would have to have been seriously considered. In any event, the mother's evidence was corroborated by Ms G who I find to be reliable.

[48] I agree that it is unlikely that it was the blanket or its loose positioning across the face of Baby X which caused anything subsequently reported.

[49] The plans, photographs and measurements put before the court do not tend to diminish the quality of the evidence of the mother and Ms G; if anything those materials support the impression that the flat is small, the kitchen is open to the front/lounge area and although the mother would be out of sight if she went to check on Baby X in the bedroom, it would be plainly obvious to Ms G that that was what she was doing. The inconsistencies relied upon by the local authority are real but do not dissuade me from the quite powerful impression I gained from the oral evidence.

[50] On balance and having heard the evidence of the witnesses of fact I have come to the conclusion that although there is certainly a sound theoretical proposition that this was an unnatural event, it is more likely that this was a natural but unexplained event: an unexplained ALTE. That is not inconsistent with the medical evidence of Baby X having a raised respiratory rate until 3 August 2008, requiring supplementary O2 on the night of 3 to 4 August 2008 and experiencing a transient dip in her O2 saturations in her grandfather's presence on 6 August 2008. It is likely she had a mild RSV from which she was recovering well. Accordingly, the cause of Baby X's

presentations is not known. I have, of course, borne this in mind in relation to my analysis of what thereafter occurred.

[51] Having considered the events together as well as separately, nothing I have concluded about the later collapse has caused me to reconsider the findings I make about the earlier admission to hospital.

The 7 August 2008 collapse

[52] The local authority's case is that Baby X suffered an hypoxic ischaemic encephalopathy which occurred as a result of a prolonged cardio-respiratory arrest on 7 August 2008. The mother was the only person with Baby X and there was nothing covering Baby X's face at the time. They say that the aponoea alarm attached to Baby X would have sounded if breathing had stopped for more than 10 seconds and that an alarm did sound but only for a very short period before medical staff were summoned. Baby X's condition was such that the local authority say she had not been breathing for more than 10 seconds and the time it would have taken for staff to respond to a call. The implication is that the apnoea alarm was interfered with by someone and the local authority invite the court to say that was mother.

[53] The local authority seek to prove that Baby X's collapse was induced by the mother, probably by an intentional asphyxiation. In support of their case, they rely upon the medical evidence including that which has excluded all known clinical presentations other than the hypothesis relied upon by the mother. They adopt the conclusion of Dr Kanabar that the most likely cause is asphyxia secondary to accidental or deliberate smothering and say that having regard to all the factual circumstances, including the background, the circumstances of the collapse were not consistent with a natural disease process.

[54] The mother conceded that her parents and Ms G each played a part in the care of Baby X but asserted that she loved and was able to cope with the care of her. Interestingly Ms F said that the mother told her that she could not cope without the babysitting. I accept that evidence. Contrary to what other observations record, the mother recollected that Baby X had been 'grizzly' on 6 August into the 7th. She was with Baby X all that night and fed and winded her at 4 am. She said Baby X snoozed through the feed. The mother then dozed off while listening to her I-Pod. At that time, she said, the bay doors were closed. She said she heard Baby X's alarm and picked her up and then put her back down. Her head flopped back and the mother says that she shouted for the nurse and pressed the alarm call. She attempted one resuscitation breath while holding Baby X's nose.

[55] It is from the point where the mother purports to recollect being awoken by the alarm that her recollection becomes unreliable. She denies switching off the apnoea alarm and says that she does not know why the maternal grandfather should say that she told him that she had silenced it. She does not recollect Baby X being cold. She says that she was definitely not blue. As to the most important parts of the medical evidence she dissembled or deliberately lied.

[56] The medical proposition which the mother's representatives ask the court to consider is this:

> 'If Baby X was hypoxaemic and as a consequence … had a slow heart rate before she stopped breathing, it is far from necessary that there was a long interval between the apnoea alarm first sounding and the nurses being called by mother. She (Baby X) would have been ill anyway and Dr Shinebourne thought that 2 to 3 minutes of not breathing might be required to get her into the state she was in at 0645.'

[57] That, they say, is consistent with the medical evidence of de-oxygenation and with the factual evidence available to the court. The former proposition is no more than the conclusion of a theory which all experts save Professor Morris regarded in the final analysis as being unlikely. They take it seriously, as did the court: it is a respectable hypothesis from a highly experienced professional which may be proved to be the mechanism which operates in more SIDS and ALTEs than is presently thought to be the case. But at the end of the day, even Dr Wilson who suggested it should be seriously considered by the court, demurs from its adoption on the facts known.

[58] The hypothesis put forward by Professor Morris (and it must be noted he made it very clear it was an hypothesis as respects what happened to Baby X) is that in the decline of SIDS and ALTE babies, when observed, the apnoea comes at the end of a sequence which is hypoxia, bradycardia, gasping and apnoea. There is research which identifies that sequence and the conclusion of one paper is that 'at least seven out of the nine infants in this study were already severely hypoxaemic around the time of their first monitor alarm'.

[59] This line of medical opinion leads to the submission that there are natural causes as well as deliberate harm which may lead to the clinical picture presented by Baby X's collapse. Absent other evidence of fact, no one can know how the hypoxia/hypoxaemia arises and the possibilities must at least include upper airway apnoea, lower airway obstruction, re-breathing or intrapulmonary shunting.

[60] This is Professor Morris key point:

> 'What I wanted to say was that I think it could be natural disease that has caused the collapse. My postulate, my speculation, my hypothesis about bacterial toxins is one specific example of how it could occur … in many ways the simplest thing for somebody like me to say is that this could be natural disease but I don't know what it is. What we do know is that infants die and we don't find anything and we don't know what it is, but we all think it is natural disease. I could stop at that point. I think that it is helpful to explore a specific example of what it could be for which there is evidence and that is bacterial toxins.'

[61] It has indeed been postulated by Professor Klein in his published work that there is an association between certain bacteria and sudden infant death. In oral evidence Professor Klein said that a 'typical' death of a 2-month-old baby with RSV detected after death would be categorised in his paper as an explained death, leaving a significant category of unexplained deaths with a bacterial association.

[62] Whether or not bacterial toxins is a speculative cause in Baby X's case or even a speculative cause generally does not undermine Professor Morris's general hypothesis which is reasonable. Medical science does not yet explain all sudden infant deaths and ALTEs and within the spectrum of unexplained events there may be both natural and unnatural causes. With that proposition and on the basis of the scientific evidence available to the court, it is difficult to argue. Any court beginning an inquiry of this kind would be well advised to start from the position that the event is unexplained and at the end of the inquiry may still be unexplained. That reflects the experience of both the courts and clinicians that in some sudden infant death and ALTE cases, despite exhaustive investigation including, where relevant, at post mortem, no organism or medical mechanism is identified as the cause.

[63] Dealing with the specific hypothesis that bacterial toxaemia may be the cause of the collapse, Professor Morris says that his specific hypothesis has not been excluded and that on all the facts it is one of two possibilities, the other being upper airways obstruction. In his experience (which is primarily histo-pathological rather than as a clinical paediatrician) he fairly says that 'it is not possible to say which of the two possibilities is more likely'. There are two theoretical routes to collapse using Professor Morris's hypothesis: sudden cardiac failure or gradual hypoxaemia due to falling respiratory rate leading to bradycardia and the subsequent collapse of both breathing and circulation. Sudden cardiac failure can safely be excluded having regard to the fact that Baby X was found in asystole and with such high levels of CO2 in her blood.

[64] That leaves gradual hypoxaemia which is theoretically consistent with the blood gas levels found. Reduced respiratory drive without any underlying medical condition leaves the mechanism unexplained. Professor Morris postulates the action of transient bacterial toxins. Despite this being only a hypothesis, as an alternative possible cause of the collapse it needs to be carefully considered even if by that consideration the court concludes, as it began, that the mechanism of collapse is unexplained.

[65] The research study relied upon by Professor Morris, which along with all other research papers considered by the court is detailed in an annexe to this judgment, concerned only nine infants: a very small and arguably anomalous statistical sample. Impedence monitors were used to detect breathing. I accept the evidence of Dr Shinebourne that this would now be regarded as giving rise to the possibility of a methodological fault in that when the heart rate slows it gives a slight electrical charge which can prevent the apnoea alarm on the monitor. Likewise, the timing of the recordings was set in such a way that the possibility of suffocation before recordings began may have been unintentionally ignored with the deduction that intentional airways obstruction was unlikely being open to question.

[66] I record these reservations not to question the research itself, which would require an even more careful and wide ranging inquiry than that conducted by the parties in this case, but to give an example of the difficulties of applying a developing medical hypothesis to the facts of a particular case. The authors of the paper warn against its use to extrapolate the conclusions to other children rather than for the purpose of developing hypotheses. The local authority say that as a consequence the assumptions made by Professor Morris to develop his specific hypothesis should not be applied to Baby X and that in her case there is nothing to sustain the notion that transient bacterial

toxins caused the initial hypoxaemia. If they are right that must lead to the conclusion that the cause of the initial hypoxaemia is unknown and hence the best that Professor Morris can do is to say that the cause of the collapse is unknown.

[67] Professor Morris is a careful expert. He does not seek to develop his specific hypothesis inappropriately. All other medical evidence before the court is to the effect that the specific hypothesis cannot be applied to Baby X. Dr Wilson, who has a gift for the global but careful summary of detail and who suggested the investigation which led to the instruction of Professor Morris, says that the hypothesis on all the known facts of Baby X's collapse is no more than a speculation and that he is unable to find any evidential markers for the theory.

[68] The markers of transient bacteraemia flagged up by Professor Morris were all demonstrated to be inapplicable in Baby X's case. They were the low IgG levels excluded by Professor Klein, raised white blood cells which were conceded not to be diagnostic in any way and CSF protein figures which in the event were discovered to be normal. None of the toxigenic organisms which have possible associations with sudden infant death or ALTEs were found in any tests (eg staphylococcus aureas and E-coli). A non-toxigenic common contaminant was found (coagulase negative micrococcus type – E509) but Professor Klein discounted its relevance and Professor Morris agreed that there is no evidence to suggest it could contribute to the mechanism he was postulating.

[69] In my judgment, Professor Klein's evidence which was from a clinical perspective effectively ruled out Professor Morris's specific hypothesis. I accept that evidence. In summary Professor Klein said:

(a) you have to have evidence of a toxin or toxin disease and there is no evidence of toxin or bacteria;
(b) there is no evidence that whatever weapon the bacteria may have been using has left its mark;
(c) I cannot see a mechanism whereby you could insert a toxin into a membrane, it happens to work for about a second and then it has completely gone without any further evidence;
(d) you cannot have organ failure without seeing evidence that the bacteria or virus has caused that damage;
(e) there is an absence of any footprint demonstrating a huge host inflammatory response necessary to cause Baby X's body to shut down, and in fact there were low C-reactive protein levels which contraindicate a response to a severe bacteraemia.

[70] Professor Morris highlighted the problem which his specific hypothesis raised when he very fairly commented:

> 'I do accept that it would be extremely unlikely to get an established definite bacteraemia with bacteria growing in the blood and ill in that short of time. But to get transient bacteraemia which are cleared in less than 20 minutes, I am not sure there is any evidence at all on that.'

I hold that there is no evidence to support the application of Professor Morris's specific hypothesis to the circumstances of Baby X's collapse on 7 August 2008 and accordingly, the court is left with two possibilities: natural but unexplained cause (cause unknown) or unnatural (accidental or deliberate).

[71] One of the medical elements of Baby X's collapse which has withstood all scrutiny by the mother's team is that her presentation on being discovered by the nursing and medical staff was of a child who had not been breathing for considerably longer than the 10 seconds it took the apnoea alarm to sound and such further moments as I accept it took the clinicians to reach her. Her unusual colour variously described as blue, purple and grey, a difference which Dr Wilson advised and I accept is not important on the facts of this case, suggests to them that Baby X had suffered from the circulation of increasingly de-oxygenated blood over a significant period of time. If breathing had stopped for only a short time Baby X would have been both pink and warm.

[72] The expert paediatric evidence is that for a child to be found cold or cool she must have suffered a critical collapse much longer than the timescale provided by the mother's account. Dr Kanabar thought several minutes to reach that colour and at least 60 seconds to cool down. Dr Shinebourne thought it would have taken longer than a minute or two and that the presentation was not consistent with 30 seconds to a minute. He added that the blood gases as subsequently analysed could only be explained if breathing had stopped completely for 5 minutes. Dr Wilson thought 5 to 10 minutes. From his separate expert perspective, Dr Stoodley supported this evidence by opining that the length of the causative insult, ie the cessation of oxygen delivery to the brain was likely to have been minutes rather than a brief event having regard to the hypoxic changes demonstrated in Baby X's brain.

[73] This evidence is highly persuasive and not contradicted. Accordingly, I find that Baby X had suffered a critical collapse which involved her not breathing for at least 2 or 3 minutes and likely 5 minutes or more.

[74] There is no contradictory evidence to that of Dr Kanabar, Dr Wilson and Professor Klein which firmly concludes that no identified infection including RSV caused the collapse. There is no history of persistent or recurrent infections and no basis for any suggestion that Baby X has an underlying immune deficiency. Baby X had a low IgG level after her collapse on 7 August 2008 rising to normal by December 2008. Professor Klein's opinion, which I accept, is that this is more likely than not to have been provoked by her illness around 1 August 2008 than by any immune problems which have not otherwise been demonstrated. Professor Morris accepted that no significance should be given to this reading.

[75] The evidence which exists is consistent with Baby X recovering well after the 1 August 2008 admission. Save for one cough on 6 August 2008 and the brief drop in her saturations on the same day (which according to Dr Wilson may be accounted for by the sensor) she appeared by then to be free of signs of infection or any serious illness. She was ready for discharge and the mother knew that. Ms G confirmed that Baby X was back to her normal giggly self. Baby X took a whole bottle of milk at 4 am on 7 August 2008, only a couple of hours before her collapse. This is not thought to be consistent with any medical cause of a collapse so soon afterwards.

[76] The medical evidence of upper airways obstruction comes from Dr Kanabar, Dr Wilson and Dr Shinebourne. They all regard it as the only likely explanation on the known medical facts, ie Baby X's clinical presentation. In the course of a basic medical analysis relating to Baby X Dr Wilson advanced a number of propositions with which these doctors agreed, to which can be added the factual markers relied upon by them in coming to their opinion, all of which I accept:

(a) cardiovascular causes (asystole, VF or shock) leading to death produce acidosis but not raised CO2 levels;
(b) raised CO2 levels are due to reduced respiratory drive, airways obstruction (internal or imposed) or lung disease;
(c) the normal capillary O2 reading (obtained from the blood gases results) confirms that resuscitation had provided effective ventilation and circulation. Bag and mask ventilation has been shown to be as effective as via a tube;
(d) Baby X had no cardiac abnormality;
(e) her blood glucose levels were appropriate;
(f) no breathing movement during sleep for 30 seconds is not rare and can be self correcting;
(g) Baby X was found in asystole;
(h) the blood gases were tested at 7.14 am on 7 August 2008, the blood being taken by Dr I when she found a pulse which was probably shortly after 7.05 am. The CO2 was so high as to be 'off the scale' despite the opportunity for some of it to have been dissipated during resuscitation and the pH was extremely low at 6.8. The lactate levels support this overall picture albeit that the O2 levels had returned to normal;
(i) the levels of blood gases tested are not indicative of primary cardiac arrest but are indicative of airway obstruction: the profound respiratory acidosis demonstrated by the high CO2 levels is consistent with airway obstruction and the heart continuing to pump while O2 is deprived so that the heart efficiently circulates blood around a metabolising body, which means that the blood becomes increasingly low in O2 and high in CO2;
(j) the severe degree of acidosis and raised CO2 are not explained by a period of anoxia of 30 to 60 seconds. The blood gases as tested would have taken longer than a minute or two of not breathing to develop. They are only explicable by the complete cessation of breathing for 5 to 10 minutes and at least 2 to 3 minutes if Baby X was already hypoxaemic. One would regard the chances of reviving a newborn with a pH of 6.8 as remote;
(k) Baby X's presentation, ie cold and changed colour are consistent with upper airways obstruction but inconsistent with the reduced respiratory drive theory.

[77] A significant question arose as to whether the high levels of CO2 and/or the extent of Baby X's brain damage might be due to poor resuscitation. It is stressed that this is not an assertion as to poor care but, it is

said, a reflection of the risks inherent in the bag and mask ventilation mechanism used. However, Dr J gave clear evidence of the difficult but effective way in which this was performed and I accept his evidence. There is no evidence to support the proposition that ventilation was ineffective; indeed there is evidence to the contrary namely the normal level of O2 by the time the blood gases were taken which suggests that Baby X had been adequately oxygenated and the compressions had been sufficient to circulate the oxygenated blood to a capillary. Dr Wilson confirmed that bag and mask ventilation is now regarded as being as effective as intubation and Drs Wilson, Kanabar and Shinebourne were of the opinion that it was unlikely that the resuscitation contributed to Baby X's brain damage. Dr Shinebourne was also of the opinion that it would have been most unlikely that Baby X's heart would have re-started at around 7.05 am if resuscitation was ineffective as O2 is required for either or both of the nervous system and the heart to achieve this. I accept their evidence.

[78] I recollect that it is said on the mother's behalf that Professor Morris's hypothesis is consistent with the factual evidence available to the court. Having heard the mother in oral evidence, I have to disagree. Even if Professor Morris's theory is applicable and this court and all other medical experts are wrong, the court's factual conclusions are fatal to the mother's case.

[79] I accept that the mother voluntarily gave an account to the police which is apparently complete. She likewise chose to give evidence to this court which one might expect to be a genuine attempt to be helpful. However, I remind myself of the unfortunate and quite forceful impression she gave in oral evidence on any matter concerning 7 August 2008. She has convinced herself of her own beliefs which are not an accurate recollection of events.

[80] I accept that on the night in question the curtains were drawn around the bed area available to Baby X and her mother on what was a bay in a public ward. I draw no adverse inference from that. The curtains are designed for the privacy of patients and their resident carers and that was how they were being used. I also bear in mind the fact that this was a public ward and that there were both adults and children who could hear and see what went on when they were awake.

[81] Likewise I accept that the mother would go to sleep and be able to sleep with her I-Pod running, ie with the sound of music overlaying what she could hear through the earphones which she used. There is no inconsistency with the events of the night for the mother's evidence to be true that she awoke during a break between tracks when she was able to hear the apnoea alarm sounding and I find as a fact that that is what occurred.

[82] Having regard to the fact that the apnoea alarm which was attached to Baby X had previously been faulty and repaired prior to 7 August 2008, there have been tests as to its functioning and the evidence of the engineer is that it was likely to have been operating effectively at the relevant time. It was last checked on the night in question by Nurse K at 3 am when it was functioning appropriately. The apnoea alarm has been produced and demonstrated for the court's benefit. The mother rightly concedes that the court is likely to find that the alarm was working on the night in question and I do.

[83] The mother's evidence was that she only heard the apnoea alarm between tracks on her I-Pod and then there was a short delay (the impression

given was of only a second or two) when she thought that the monitor might relate to another child on the ward. I remind myself that the monitor might have been covered by a comfort blanket around Baby X's body when it first sounded. I accept that evidence. What I do not accept is that she immediately initiated the nurse call or emergency call alarms to alert the nurses on duty to what was happening. That flies in the face of the medical evidence and of the evidence of fact which I have heard. I have come to the conclusion having heard the mother and the nursing staff that there was a delay of at least a couple of minutes from the first sounding of the apnoea alarm until the sounding of the apnoea alarm which alerted Nurse L.

[84] Such a delay could be accounted for either by the mother switching off and then re-activating the alarm or by any of the nursing staff, in particular Nurse L, failing to hear it for a couple of minutes.

[85] No-one knows directly what happened and the court, therefore, has to look at what is otherwise known to decide whether it can and should make any findings. Dealing firstly with the alarm again. Nurse L was the first on the scene. She had been responsible for setting the apnoea alarm to the 10 second setting the night before (a fact confirmed by Nurse K). Her evidence was clear, she heard the apnoea alarm sounding and she entered the room. She recalled that the mother of another patient, Ms F, said that she heard it too. Nurse M did not hear the alarm but was aware of the fact that it was flashing red which would be consistent with it having alarmed and still being on. Other staff including Dr N first heard the nurse call alarm from the nursing station which is just outside the doors to the bay of the ward in which Baby X was placed.

[86] I accept that the apnoea alarm was on and working effectively until removed from Baby X by Dr I during the resuscitation. That at least raises the question whether Professor Morris's hypothesis can apply because for the alarm not to sound before it was heard by Nurse L and Ms F, it would have to be stimulated at least every 10 seconds throughout the whole process of progressive failure and gasping which is postulated.

[87] If the court finds that it was working effectively and alarmed and also that the child's condition was such that some minutes had passed between the commencement of the crisis and before medical assistance was obtained, then it follows that one of the possibilities is that the alarm sounded and was then disabled so that no one heard or responded to it until later when it was re-activated. Another possibility is that it was sounding and Ms F did not hear it until she awoke and Nurse L did not hear it until after she entered the room. The final possibility is that Baby X suffered a progressive decline which did not trigger the alarm until the final apnoea.

[88] The professionalism which was so overtly demonstrated by the clinicians who gave evidence to this court should be noted. It reflected their extraordinary professionalism and dedication on the night in question. I accept the nursing and medical evidence and where there are differences of any significance between them I have considered what the reasons for that may be.

[89] One conflict is as to whether the ward doors were open or closed. The nursing staff are all clear that the doors were ajar – either one or both. Others were surprised that they had not heard the apnoea alarm. All the mother can say is that the doors were closed at 4 am. Ms F said that the doors would be

closed to prevent undue noise. Having listened to the witnesses carefully, I tend to the conclusion that one door was open at an angle and the other was closed. That was the evidence of Nurse K which I accept. That meant that there would be some obstruction to audibility but not much. Nurse L heard the apnoea alarm. She was the most proximate person on duty and it is not surprising she was acute as to her realisation and subsequent recollection. Ms F was woken by the alarm and then heard the mother call out and the staff start to come in.

[90] In my judgment, the apnoea alarm was effective and started to alarm moments before the mother pressed the nurse call button. Nurse L heard the apnoea alarm before the nurse call was heard by others as did Ms F. I prefer the evidence of the nursing staff to the mother and have come to the conclusion that the apnoea alarm had been activated for only seconds before Nurse L heard it.

[91] When Nurse L heard the apnoea alarm she saw the mother leaning over Baby X. Even if the mother's evidence had otherwise been reliable, that at least casts doubt on the mother's assertions that she cancelled the alarm immediately or that she had picked up Baby X (which would have had the effect of cancelling the alarm). In any event, the mother did not tell the police that she had switched off the alarm; she apparently only told her own father. Had she done this the red light would not have remained flashing. as observed by Nurse M. One possibility is that the mother told her father the truth but that she was recounting to him the fact that she had cancelled the alarm some minutes before she summoned assistance, the other is that her evidence on the point is wholly unreliable.

[92] I have come to the view that she mentioned it to her father because it had happened in the way that people do when they are worried about what they have done or even if they might have been seen or be discovered. Her subsequent rationalisations about doing this at the moment she called for assistance are no more than rationalisations. They are not an accurate recollection.

[93] It was only in oral evidence that the mother for the first time suggested that the apnoea alarm must have been sounding for as many minutes as it would have taken for Baby X to have become cold and changed in colour. She sought to suggest that she might not have heard it because of the I-Pod music. I do not think it likely that this mother would have put herself in a position where she could not hear her own child. I note that to the police she said she had even been able to hear the girl in the bay visiting the bathroom. I regret to have to find that her explanation in oral evidence, whether it departs from the medical hypothesis or not, was merely a last desperate attempt by the mother to explain herself. I reject it.

[94] Having regard to the extent to which I have rejected the evidence given by the mother, there has to be a purpose to her switching off the apnoea machine and then, as I find she did, switching it back on some minutes later at a time which is coincident with the dramatic decline in her child's condition. It is a reasonable inference in all the circumstances that the mother caused the cardio-respiratory arrest which followed and switched off the machine to avoid detection while she was doing it. That is consistent with the most likely medical explanation, ie intentional upper airways obstruction. There are no circumstances advanced of accidental asphyxiation and I have concluded in

all the circumstances that the most likely mechanism consistent with the medical and factual evidence is that the mother intended to and did smother her own child.

[95] In submission the question is asked, why would the mother go to these lengths when at 4 am in the morning she could have done what is alleged with so much less possibility of detection. That argument assumes that the mother intended to smother her child to death. In my judgment, no such intention has been evinced by the mother. It can only be an hypothesis for subsequent assessment, but it must at least be a possibility that this deeply flawed mother wanted to prevent her child being discharged from hospital. Whether that be for the attention and care it provided for Baby X or the attention it provided for herself or even for other reasons as yet unexplored must be a question for those who seek to assess the needs, risks and capabilities which remain to be decided.

[96] I do not doubt that the mother was distressed or even that her distress as reported by a number of observers was genuine. What she had done to her child was becoming clear and would have been distressing to anyone other than the most calculating and cold blooded. Whatever psychological, psychiatric or other characteristics the mother may have which account for her actions, she does not present as a calculating and cold blooded person who intended to kill her child.

[97] The facts found by the court satisfy the requirements of s 31 of the 1989 Act.

[98] The background circumstances which will be relevant to the further assessment of the mother are as follows. The mother concedes that she told a social worker that Baby X was not a planned child. She was concerned that the pregnancy was so soon after the death of Baby Y and she wanted a baby for the right reasons not just as a replacement for Baby Y. She communicated her worries about whether she should continue with the pregnancy. In that context the mother spoke about her confused feelings for Baby X. She was grieving for the death of Baby Y. She also said that she felt low when she wanted to feel happy. The balance of reported information makes it highly likely that she told more than one person that she felt differently about Baby X in the sense that something was missing and she did not feel as close to her as she would have wanted to.

[99] I am less clear that the mother took a very limited part in the care of Baby X. I accept that Ms G had a tendency to take over and having heard Ms A's mother in evidence I can easily imagine that that situation would have been the same in the grandparental home. What is objectively correct is that Baby X was regularly cared for by her grandparents and Ms G every week to the extent of 2 or 3 evenings and nights. Furthermore, for some of the time Baby X was cared for by her grandparents and once by Ms G while in hospital. In both respects the care of Baby X by others was of an extent that I do not accept to be normal.

[100] Balanced against that there are positive records relating to the bond between Baby X and her mother and the affection displayed by the mother to her. Those who have to assess the mother will have to take into account the findings of the court and both the positives and the negatives which exist from the background history.

[101] As to the mother's credibility, the following findings and concessions may be relevant to any future assessment of her:

(a) she admits to making things up when younger: she said as much to her treating psychiatrist in 2003;
(b) none of the injuries the mother claims to have sustained after the pregnancy with Baby X (a broken jaw, broken ribs and a broken nose on two occasions) are supported by GP or hospital notes. Insofar as she sustained any of these injuries they were either not reported or have been so highly exaggerated as to have attracted no appropriate record. The claim to have sustained a severely swollen and displaced nose for which she sought no medical assistance is highly unlikely given her obvious concern about her own appearance. Her evidence about these matters was wholly unreliable;
(c) she admits to lying to Mr B in the terms he describes: having 12 brothers, being in care, living in Brixton, having a father in the Mexican mafia and her mother being killed by her throat being slashed. She concedes that all of these fabrications were said seriously with the intention they be relied upon;
(d) she accepts that she misled social services that she had been in foster care as a child;
(e) she admits that she misled a housing officer so that he believed that her mother was dead;
(f) she has not given a reliable account of the counselling she says she has attended.

[102] The implications of the findings made by this court for the long-term welfare of Baby X are serious. Mr B concedes that Baby X's care needs are beyond him as a sole carer. Ms A will have to think long and hard about how it is she says she can meet those needs and the protections which will be necessary for her to do so. The findings the court has made relate not only to the significant harm caused to Baby X but are so serious that they demonstrably give rise to an obvious risk of harm in the foreseeable future. There is as yet no acknowledgement by mother of what she has done.

[103] I shall adjourn the welfare questions to a fixed date and invite the parties to agree directions for the future assessment of the welfare issues.

Order accordingly.

Solicitors: *A local authority solicitor*
B & Co for the first respondent
R for the second respondent
H for the third respondent

PHILIPPA JOHNSON
Law Reporter

APPENDIX OF RESEARCH MATERIAL

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