



PUMP COURT

CHAMBERS

**NON ACCIDENTAL HEAD INJURIES
(AND ASSOCIATED FRACTURES)**

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INTRODUCTION

Why are these cases difficult?

- Reporting on scanning images is always a matter of interpretation
- Is there an injury there at all?
- Extent / location of any injury may be a matter of subjective opinion
- Expert evidence can rarely help as to the precise method of causation

INTRODUCTION

Why are these cases difficult?

- Timing is largely a matter of clinical experience and guesswork
- A starting point is likely to be the explanation given by the parent or carer
- Courts have recognised the importance of surveying the ‘wide canvas’
- NAHI has a number of potential meanings.
- There is no opportunity to ‘phone a friend’ in real witness box time.

INTRODUCTION

Seemingly credible experts may give different opinions on the same set of facts.

Need to instruct a full range of experts in these cases and a judicial approach which attempts to limit the necessary range or number of experts or to shoe-horn a case into a pre-ordained case management timescale risks inflicting a terrible miscarriage of justice.

Per Baker J *Re ED, JD and TD* [2013] EWHC 968

Equally it is essential that the expert evidence is fully tested in Court – Per Wall LJ in *Webster v Norfolk County Council* [2009] 1 FLR 1378.

INTRODUCTION

Medical evidence can rarely provide a complete answer. More often than not the expert will reach a conclusion that:

- (a) The injury is equally consistent with a medical / accidental or non-accidental cause.
- (b) The injury is more likely to have been caused non-accidentally but other alternatives are possible.
- (c) The overwhelming probability is that the injury was caused non-accidentally but it is impossible totally to exclude an innocent explanation.

It is not possible to 'diagnose' a non-accidental injury. Rarely is an injury pathognomic / pathognomonic of abuse.

Recently we have seen a tendency for experts to speak of 'balance of probability' conclusions. Cf Charles J in *A County Council v K, D & L* [2005] EWHC 144, [2005] 1 FLR 851

INTRODUCTION

The evidence of the parents is therefore of the utmost import and to this end, the court will make a clear assessment of their credibility and reliability.

The Court is likely to place considerable weight on the evidence and the impression it forms of the parents.

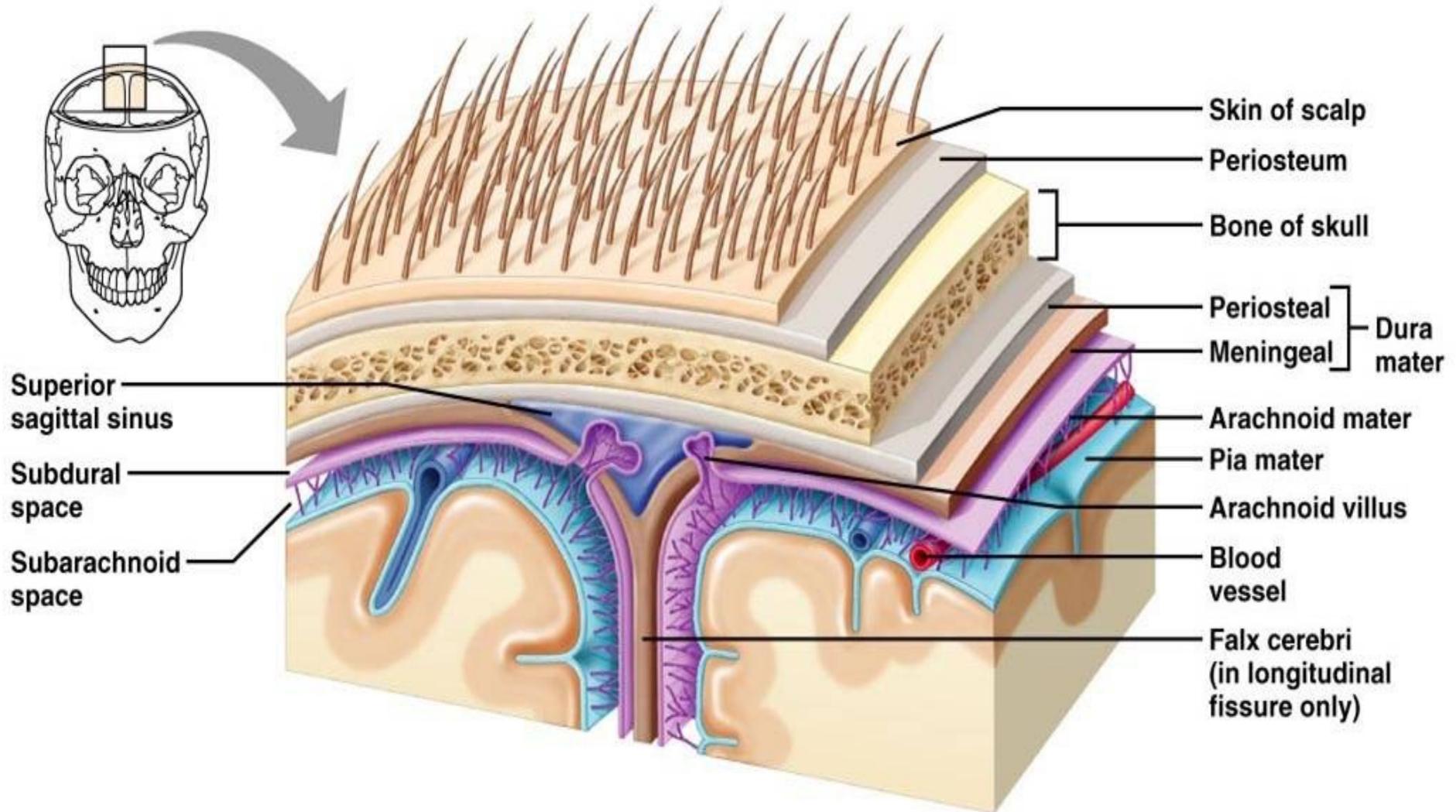
Courts can and do reject / accept parental explanations despite this being against the full weight of the expert evidence.

WHAT IS A NON-ACCIDENTAL HEAD INJURY?

Common features in such cases tend to include:

- (a) Encephalopathy (impairment of the brain affecting brain function)
- (b) Subdural haematomas ('SDHs') often described as 'chronic' or 'acute'
- (c) Subarachnoid / intraventricular bleeding
- (d) Retinal haemorrhages ('RHs')
- (e) Brain contusion or axonal (shearing) injury
- (f) Hypoxic-ischaemic brain damage
- (g) Skull fractures
- (h) Fractures to other parts of the body, particularly ribs or metaphyseal limb fractures
- (i) Neck and / or spinal injury
- (j) Bruising
- (k) A collapse

WHAT IS A NON-ACCIDENTAL HEAD INJURY?



WHAT IS A NON-ACCIDENTAL HEAD INJURY?

The task of identifying NAHI in cases of SDH must be one of exclusion. They may have a number of potential causes, such as:

- a) A variety of medical and surgical interventions;
- b) A variety of pre-natal, peri-natal and pregnancy related conditions;
- c) Birth;
- d) A variety of metabolic diseases;
- e) A variety of congenital malformations;
- f) A variety of genetic diseases;
- g) A variety of conditions of malignancy;
- h) Auto immune disorders;
- i) A variety of blood coagulation disorders;
- j) A variety of infectious diseases;
- k) Arising from poisoning, toxins and drug effects;
- l) A variety of traumatic causes of which NAHI is but one.

WHAT IS A NON-ACCIDENTAL HEAD INJURY?

Conventional medical opinion focused on the existence of the 'triad' as 'diagnostic' of NAHI:

- (1) Encephalopathy;
- (2) SDHs;
- (3) RHs.

This approach was comprehensively rejected by the Criminal Court of Appeal in *R v Harris* [2005] EWCA Crim 1980 CA.

WHAT IS A NON-ACCIDENTAL HEAD INJURY?

There have been many changes in scientific thinking over the last 3 or 4 decades:

- (1) Medical perception of the degree and type of force required to cause SDHs and RHs has been subject to considerable debate;
- (2) The significance of the 'triad' has been challenged;
- (3) There is a debate as to which features are to be entered into the diagnosis as opposed to being secondary phenomenon;
- (4) The ability to time injuries with any accuracy has caused difficulties;
- (5) What was once identified as an 'acute' or 'chronic' bleed, indicating more than one episode of injury, is now seen as potentially explicable by a single event;
- (6) Birth injury is now more widely recognised as a potential cause of SDHs and RHs.

WHAT IS A NON-ACCIDENTAL HEAD INJURY?

The relevance of RHs – causes / relevance poorly understood

The potential for birth related SDHs – papers by Whitby, Looney and Rooks illustrating:

- (1) The dangers of too heavy a reliance on the prevailing orthodoxy;
- (2) The difficulty in explaining mechanism;
- (3) The potential for 'acute' SDHs to become chronic and thereby mimic findings normally associated with NAHI.

OTHER TRAUMATIC CAUSES

John Caffey – ‘The theory and Practice of Shaking Infants’ 1972

Accidental explanations will emerge and require the most careful analysis: heavy handed winding, low level falls, attempted resuscitation, throwing the baby in the air, bouncer chairs, car seats, supermarket trolleys, inadvertent ‘head butts’.

The experts’ dilemma:

- (a) Research is plainly unethical;
- (b) Experiments on animals or biomechanical data are extremely poor substitutes;
- (c) The limits of ‘clinical experience’ – “the ability to go on making the same mistakes with increasing confidence”
- (d) Published studies and ‘incorporation bias’.
- (e) Generalised data does not help with the specific case.

OTHER TRAUMATIC CAUSES

The ‘wide canvas’: *“It must never be forgotten that expert evidence is relied upon to prove that the individual defendant is lying in the account he gives, either at the time or at trial”*
– *R v Henderson* [2011] 1 FLR 547.

It is for the LA to prove that the child sustained an NAHI not for the parents to prove otherwise

- *Lancashire CC v D,E* per Charles J.
- *Re M (Fact Finding Hearing: Burden of Proof)* [2013] 2 FLR 874

Timing may be of crucial importance in looking at potential explanations – but experts disagree about presentation and the potential for a ‘lucid interval’.

ASSOCIATED FRACTURES

Wide range of fractures may be seen in these cases, particularly rib and metaphyseal.

Unifying cause – NAI?

Questions to be asked:

- 1) Is there a fracture at all?
- 2) What can be said about timing?
- 3) Birth process?
- 4) Bone fragility issue?
- 5) Other genetic issue?
- 6) Same accidental explanation?
- 7) Different explanations?



UNKNOWN CAUSE

Professor Luthert in *R v Harris*: *“There are areas of ignorance. It is very easy to try and fill those areas of ignorance with what we know but I think that it is very important to accept that we do not necessarily have a sufficient understanding to explain every case.”*

Mr R in *Re JS*: *“We have enormous gaps in our knowledge. Anything anyone says is informed speculation, not scientifically proven fact, including what I say in the reports”.*

Peter Richards in *Lancashire CC v R, W and N*: *“the more you know the more you know you don’t know.”*



UNKNOWN CAUSE

In *Re LU and LB* [2004] 2 FLR 263 Butler-Sloss P sitting in the CA:

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

UNKNOWN CAUSE

The court should be very slow and loathe to find deliberate infliction if in fact the medical causation is “unknown” – which put simply, means that the LA will have failed to establish their case on the burden of proof.

See Re R (Care Proceedings Causation) [2011] EWCA 1715 per Hedley J at [10] and [19].

Having assessed the evidence of the parents, in that case Hedley J said:

“In all those circumstances, I am deeply unwilling to make a finding of culpable conduct against these parents, unless entirely compelled by the medical evidence to do so.”



UNKNOWN CAUSE

“In my judgment, a conclusion of unknown aetiology 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 all fearfully and wonderfully made.”



UNKNOWN CAUSE

See also now the decision in *Re B-T* [2017] EWCA Civ 265 per McFarlane LJ (as he then was):

“Equally, the judge needed to demonstrate in his judgment his willingness to entertain that medical science might not have a definitive answer to each and every case, but there are some “outlying” cases where the answer as to what has happened is simply unknown or, put more succinctly, not capable of proof on the balance of probabilities within care proceedings”.

CASE MANAGEMENT

Important case management issues:

- (1) Ensuring full disclosure of medical records;
- (2) Ensuring disclosure updated;
- (3) Checking to ensure the full range of tests has been undertaken by the clinical team;
- (4) Obtaining full and early police disclosure;
- (5) Resisting / analysing calls for reciprocal disclosure and giving clear advice to parents about e.g. s.98(2) CA 1989;

CASE MANAGEMENT

- (6) Instructing experts with the full range of necessary specialisms early in the process;
- (7) Resisting suggestions that treating clinicians can be experts to save time and cost and considering carefully the impact of involving criminal experts in the family court process;
- (8) The choice of experts is crucial;
- (9) Full and early parental participation is of obvious significance;
- (10) Careful thought will need to be given as to the necessity / desirability of an experts' meeting;

CASE MANAGEMENT

- (11) Early joinder of potential perpetrators;
- (12) Parties require expert representation;
- (13) Trial counsel should be involved at the earliest opportunity.

CASE MANAGEMENT

Single Joint Experts – *W v Oldham MBC* [2006] 1 FLR 543 – where the medical evidence is pivotal the court should be slow to decline an application for a second expert

Webster v Norfolk County Council [2009] 1 FLR 1378 – hypothesis in relation to causation of a child's injuries must not be dismissed only because such a causation would be highly unusual and where history contains a demonstrably rare feature, the possible nexus between that feature and his injuries must be subject to specialist appraisal at an early stage

CASE MANAGEMENT

Expert not decision maker – beware of the ‘balance of probability’ opinion – *Oldham MBC v GW* [2007] 2 FLR 597, *A County Council v K, D and L* [2005] 1 FLR 851, *R v Henderson* [2011] 1 FLR 547

Beware experts meetings: *“An overriding desire to promote agreement can lead to key issues being obscured and thereby not investigated by the court”* per Ryder J (as he then was) *Oldham MBC v GW*

“Agreements and disagreements have to be scrutinised for what they are; an exercise in skilled and pragmatic deductive reasoning not a substitute for the court’s duty to make its own decision”



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Thank you for watching!!!