EDITORIAL NOTE: CHANGES MADE TO THIS JUDGMENT APPEAR IN [SQUARE BRACKETS].

NOTE: PURSUANT TO S 437A OF THE ORANGA TAMARIKI ACT 1989, ANY REPORT OF THIS PROCEEDING MUST COMPLY WITH SS 11B, 11C AND 11D OF THE FAMILY COURT ACT 1980. FOR FURTHER INFORMATION, PLEASE SEE https://www.justice.govt.nz/family/about/restriction-on-publishing-judgments/

IN THE FAMILY COURT
AT MANUKAU

I TE KŌTI WHĀNAU
KI MANUKAU

FAM-2019-092-000026
[2021] NZFC 7360

IN THE MATTER OF	THE CARE OF CHILDREN ACT 2004
BETWEEN	ORANGA TAMARIKI Applicant
AND	[MA] [SA] Respondents
AND	[VA] [LA] The children the application is about

Hearing:	6-8 July 2021
Appearances:	L Evile for Oranga Tamariki O Woodroffe for Mr and Mrs [A] R Fuata'i as Lawyer for the Children
Judgment:	27 July 2021

RESERVED JUDGMENT OF JUDGE J G ADAMS

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[1] The baby was hardly breathing. He became floppy and unresponsive. He turned pale. The parents panicked. The mother ran outside their motel room and yelled at a cleaning lady to ring the ambulance.

[2] The paramedics could tell the baby was in a dangerous situation despite no external sign of physical injury. Immediately after they loaded him into the ambulance, he had a seizure. His head went back, he went rigid and then started shaking. They gave him an injection, but it wasn't enough. He had another seizure. They injected him again.

[3] At [the first Hospital], his symptoms indicated pressure on his brain congruent with a serious brain bleed. A CT scan confirmed this. Blood and swelling was so serious it was squashing part of the right side of his brain across the midline. Because of the pressure, the pupil of his right eye was dilated and poorly responsive to light. All signs indicated an emergency. He was rushed to Starship where a neuro-surgeon cut a flap out of the right side of his skull to relieve the pressure and drain off the fresh blood. The surgery saved his life.

[4] In the course of medical examinations at Starship, the baby was discovered to have suffered three fractures to his right arm and hand. Observations of the healing process over a fortnight indicated those fractures probably occurred close in time to the emergency. In addition, the neuro-surgeon noticed some membranes in his brain, indicative of an earlier brain bleed. The medical team formed the view that the injuries were non-accidental. The baby was [LA], a boy then aged 16 weeks.

[5] Because this proceeding began before recent changes to Oranga Tamariki Act, I must deal with the application for a declaration as a preliminary threshold step. In this case I must decide:

(a) Is [LA] in need of care and protection?

(b) Is his older sister [VA] in need of care and protection?

(c) If so, what plans should be made for each child?

Is [LA] in need of care and protection?

[6] The dramatic events occurred on [date 1] 2018. Oranga Tamariki submits that [LA]'s injuries were caused violently by one or both of his parents. Oranga Tamariki submits there is no alternative likely scenario. It is known that only the parents and two-year-old [VA] were in the motel room in the hours before the ambulance was called. If Oranga Tamariki is right, at least one parent knows what happened and the other parent is choosing to shield the violent partner rather than expose the truth.

[7] Although Oranga Tamariki refers to s 14(1)(b), its case, that [LA] is in need of care or protection, principally relies on s 14(1)(a), namely that he is likely to be harmed (whether physically or emotionally …), ill-treated, abused, or seriously deprived. The submission is that, if the parents, at least one of whom has caused life-threatening injuries, collude to hide the truth, they cannot safely be entrusted with his care. Apart from my emphasis on s14(1)(a), I adopt all of Ms Evile's submissions as to the law and its application in this case.

[8] The parents have suggested several scenarios. According to the opinion of Dr Patrick Kelly, specialist paediatrician expert in non-accidental injuries, none of them are congruent with [LA]'s injuries. Can there be an innocent explanation?

[9] The parents submit that Dr Kelly's evidence is unreliable even to the point that they doubt that medical evidence, such as X-rays upon which his opinion relied, related to their son. Ms Woodroffe submits I should reject much of that sort of evidence. Dr Kelly was the consultant during [LA]'s Starship admission. Dr Basu, who met with the parents, is no longer employed by Auckland District Health Board. She worked in this case under the direction and oversight of Dr Kelly. Dr Kelly impressed me as well-briefed on the case. He was not challenged during cross-examination that the X-rays and other produced images were not those of [LA]. He would have no motive for passing unrelated images off as those of this child. This is not a criminal case where the chain of documentation is put in issue, it is a case where the court process operates to discern matters upon which the welfare and safety of a child rests. There is no balanced basis for suggesting that, because he used teaching images (for example, illustrations of brain structure) to contextualise and

background certain remarks, the images of [LA] could have been confused with such teaching tools.

[10] Almost two and a half years have elapsed since this case began, yet the parents have offered no alternative medical opinion. The Family Court is not bound by strict rules of evidence. I found Dr Kelly's evidence to be probative and professionally dispassionate. He produced material about [LA] appropriately as the consultant in charge of the boy's admission and treatment at Starship. Dr Kelly offered additional context and detail but the essentials of his evidence are detailed in the Multi-Agency Safety Plan[1] which has been available to the parents since January 2019.[2] I decline to strike out the evidentiary documents.

What does [LA] say?

[11] Although [LA], at 16 weeks of age, had no ability to give a verbal report, his body is a truthful witness. Dr Kelly is able to interpret a great deal of [LA]'s bodily evidence. The following passage of this judgment (paras [12] – [26]) relies on his expert opinion which, although not accepted by the parents, was not challenged by any alternative specialist opinion.

[12] A life-threatening brain bleed requires significant force. Examples include automobile accidents, falling from a height above two metres onto a hard surface like concrete, being hit forcibly or being slammed into a hard surface. Although a child's body appears fragile, a child's body can cope with vigorous handling. A simple fall from a modest height such as a fall from a bed will not result in this sort of brain injury. In addition to the successive shields of skin (scalp), skull bone, dura mater, and arachnoid, all of which contribute to protect, the brain has a couple of additional internal cushions. The brain is protected as its owner moves, changes direction, jumps and so on. Ventricles, filled with fluid, provide internal cushioning. There is also some space available below the dura where the brain has room to move within the cranial cavern.

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[1] Bundle, 28.
[2] Exhibited to affidavit of Ms [L] 11 January 2019.

[13] A brain bleed such as that suffered by [LA] requires tearing of a bridging vein, one of the many veins below the dura that drain blood back to the heart. It takes a great deal of force to achieve such a tear.

[14] The brain bleed suffered by [LA] caused rapid deterioration in his vital signs. I can rule out the possibility that the injury may have been caused hours before the emergency. The dramatic signs in this case will have followed soon after the event that caused tearing of one bridging vein or more. The relatively rapid build-up of blood and the associated swelling of the right side of his brain are clear evidence of this. We can infer from [LA]'s bodily evidence that he suffered the precipitating forceful incident within a very short time before [MA] called for an ambulance. I find this timing a high probability.

[15] [LA]'s bony injuries were tracked by skeletal surveys at Starship Hospital on [dates deleted – 4 days and 18 days respectively after date 1 2018]. Distinctive healing changes observable between those dates (such as new bone formation and sclerosis) suggest that all of those bony injuries were proximate in time, if not concurrent with, the brain bleed injury.

[16] The bony injuries situated near the top of his right humerus (upper arm), near the wrist (right distal radius, the bone that leads towards the thumb), and his right third metacarpal (the bone in the palm of his hand, near his wrist, that would lead towards his middle finger). The sites, and configurations of these bony injuries are congruent with a twisting action, for example, as if an adult grasped [LA] strongly by his right wrist and swung his body, using the right arm as a lever. If such a forceful action, sufficient to cause these injuries, resulted in the right side of his head striking a hard surface (a floor or wall, say), all the injuries would be accounted for.

[17] I cannot know, on the evidence in this case, what action caused any of the injuries. What [LA]'s body tells is that the force applied was severe. Dr Kelly explained that, contrary to common lay conjecture, it takes a lot of force to fracture a young child's bones.

[18] Tests were undertaken to check whether [LA] had brittle bones but he seems to have had no pre-existing condition that made his bones prone to breaking. Born at full term (caesarean birth), he was reported to have been in good health until [date 1] 2018. The only item requiring attention at first examination was utterly minor, a clicky hip which seems not to have been noted further so presumably was not problematic. Despite his life-threatening injuries on admission to Starship, [LA] healed well. His eye problems resolved rapidly. Nonetheless, because of the possibility of long-lasting brain damage, he may display behavioural or cognitive deficits later in his childhood. But, on a short-term basis, he has healed well, indicating robust underlying health.

[19] I am unsure what to make of the evidence that indicated an earlier brain bleed or bleeds. There is no report of earlier symptoms of distress. There is no evidence of earlier forcible or colliding actions that would cause such an injury. This lack of evidence about any prior brain bleed does not complicate my finding about the more recent incident. It may suggest there has been an earlier violent incident which, while tearing a vein, did not cause injury to the dramatic, life-threatening extent of the [date 1] 2018 incident.

[20] Dr Kelly says that ordinary handling of a healthy baby like [LA] will not result in broken bones or brain injury. The parents said that [VA] would play roughly with [LA], jumping on him in the bassinette, weeks earlier throwing an iPad at him and, on the day of his injuries, bouncing on his ribs. Dr Kelly commented that none of those behaviours could have resulted in [LA]'s injuries. The exhaustive tests undertaken at Starship during [LA]'s 18-day admission indicated no rib injuries. Had any of those treatments caused a brain bleed, the symptoms would have occurred promptly. None were reported.

[21] In Dr Kelly's opinion, a fall of 60 centimetres from a bed onto a carpeted floor, even though the carpet was laid over concrete, and even if precipitated by [VA] pulling him so that he fell, could not have produced the brain injury he suffered. In his opinion, no rough play by [VA] could have produced the severe injuries suffered by [LA].

[22] Specialist paediatric retinal examination disclosed extensive retinal bleeding widespread throughout the retina, pervading to all layers. The number, extent and pattern of the haemorrhages "in the absence of severe accidental trauma, and in the context of intracranial haemorrhage, are highly suggestive of abusive head trauma" in the view of Dr Carroll, paediatric ophthalmologist. Ms Woodroffe complains in her final submissions that Dr Carroll was not available for cross-examination. In this case, that submission has no force because the relevant opinion appeared in summary form in the Multi-Agency Safety Plan[3] and no issue had been taken with it before the hearing. The attempt to bring it centre-stage via final submissions is too late.

[23] The bony injuries attest to an extreme application of force in a combination that could break all three bones. I discount the possibility that these three bony injuries occurred in separate forceful incidents, within short succession. In my view, their configuration strongly suggests they occurred in combination from one violent event. Although I cannot rule out two violent events in short succession (say, within a day or two), it seems most likely that whatever incident caused the arm injuries occurred at the time the brain bleed injury occurred.

[24] I find that the forceful incident most likely occurred within a very short space of time before [MA] called for the ambulance.

[25] I accept Dr Kelly's evidence that a two-year old, even if a strong two-year-old, would not have sufficient strength or dexterity and therefore [VA] could not possibly have caused the injuries suffered by [LA].

[26] I find that only one logical possibility remains, namely that one of the parents caused the injuries, probably by swinging or wrenching [LA] by his arm so that the right side of his head hit something hard.

What do the parents say?

[27] Initially, the parents described a quiet domestic morning. [MA] breast-fed [LA] and laid him on the bed. She went to the toilet. [SA] says he fell back asleep. He awoke

[3] Bundle, 28, available to the parents since at least January 2019.

to discover [LA] on the floor lying on his right side, straddled by [VA] who was bouncing up and down on [LA].

[28] Later, [MA] recalled an occasion when she had picked up a child's car seat in which [LA] was seated, unstrapped in. He fell out onto concrete. No physical distress was noted at the time and Dr Kelly discounts this as a potential cause of the injuries. Similarly, Dr Kelly rejected, as medically incredible, incidents such as [VA] throwing an iPad or rough handling by [VA].

[29] Police examined the motel room scene. Their pertinent observations were recorded in the Multi-Agency Safety Plan document.[4] In particular: "The bed is about 60cm. The carpet is in good condition with concrete underneath." Without prior indication of challenge, Ms Woodroffe led evidence from Mr [A] about these matters. He stood up to demonstrate the height of the bed. On his evidence in Court, the bed was as high as his chest. In my estimation, that height, perhaps one and a half meters, for a motel bed, was unacceptably incredible. I prefer the, albeit hearsay but previously unchallenged, evidence from the Police investigation. I anticipate my findings to comment that I do not accept that [LA] came by his injuries in any of the ways described by the parents. That is, I do not find his injuries consistent with falling or being pulled off a bed, nor by rough handling by his two-year-old sister.

[30] Because the parents agree that [MA] was out of the room before symptoms appeared, and because her actions in calling for an ambulance seem child protective, I tend to think that [SA] was more likely to have been the perpetrator of the incident. This could be consistent with his evidence that after [MA] ran out with [LA], [VA] slapped him on the face and scratched his face.[5] However, the parents have maintained their common stance of innocence which, on my finding, amounts to one of joint complicity in keeping the facts hidden. I cannot conscientiously find either one to have been primarily responsible rather than the other.

[31] I find the most probable cause of all [LA]'s injuries was an assault by one of his parents. I find it highly probable that the other parent will know of the

[4] Bundle, 29.
[5] NoE 122, lines 7 – 8.

circumstances and has chosen to protect the assaultive parent. I cannot imagine any other reasonable alternative. In this stance, both parents are, in my finding, complicit in keeping the information hidden. I find that prioritises adult needs over the needs of their children.

[32] Parents who combine together to take such a stance cannot be trusted to care for a child. To place [LA] back with his parents, one of whom has assaulted him to the point of life-threatening injuries, and the other, who has covered it up, is insupportable, the risks to the child are too great, even after the passage of time since the incident.

[33] There are no other practicable means to protect [LA] and therefore I declare that [LA] is in need of care and protection under s 14(1)(a) Oranga Tamariki Act.

Is [VA] in need of care and protection?

[34] Although there is no evidence that [VA] suffered harsh physical treatment from her parents, they were willing to advance her as the agent of [LA]'s injuries. In short, they offer her for the court to blame. I do not accept Ms Woodroffe's submission that it is unfair to describe their action as blaming. In my view, that is a plain and fair descriptor.

[35] There is evidence that their parenting was lax, allowing [VA] to treat her young brother roughly without sufficient supervision.

[36] That they are unprotective of her brother indicates their general lack of child focus. I am not prepared to run the risk to [VA] of placing her back in their day to day care. I find that there is, for [VA], a risk of serious harm both physically and psychologically. Because at least one parent has seriously harmed [LA] and the other has hidden the fact, neither can be trusted to be child-protective. Their willingness to blame [VA] for the damage done to her brother is psychologically abusive and bodes badly for the welfare of [VA] in future if in the care of her parents or either of them. I find the case made out for [VA] under s 14(1)(a) and (b). As with [LA], there is no practicable alternative to protect her other than making a declaration. I make a declaration that she is in need of care and protection.

What plans should be made for the children?

[37] The children are currently subject to s 78 interim custody orders in favour of the Chief Executive.

[38] It follows from my findings (above) that I do not favour a return of day to day care to the parents. The current presenting picture is that family members are peeling away from any form of support for the children other than return to their parents. The Chief Executive ultimately seeks custody and additional guardianship orders but, because of the provisions of s 128, I cannot make those orders until a plan has been prepared.

[39] Ms Woodroffe took the irregular step of annexing to her final submissions an affidavit by a maternal uncle and aunt of the mother, [MA]. That affidavit attempted to introduce into the record several references and statements, for example, letters from aunt [TA] who had been an Oranga Tamariki approved caregiver for the children. I do not accept the affidavit and attached documents for the purpose of the hearing on declarations. I permit the affidavit to remain on the file for the next step which is the consideration of a post-declaration plan. I note that aunt [TA] supports returning the children to the parents, a step I cannot countenance.

[40] The s 78 interim custody order in favour of the Chief Executive shall remain in force for both children pending consideration of plans.

What plans should be made for each child?

[41] I adjourn this matter for 6 weeks to consider a plan, to be prepared by Oranga Tamariki. The case should be set down for one hour (submissions on the papers), preferably before me. [This has been set for 12 October 2021.]

[42] I direct that a courtesy copy of this decision shall be sent to Dr Kelly.

[43] I direct that a copy of this decision be sent to NZ Police who are still in the process of assessing this matter. I believe it is in the interests of the children that this decision be shared with Police.

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Judge JG Adams
Family Court Judge | Kaiwhakawā o te Kōti Whānau
Date of authentication | Rā motuhēhēnga: 27/08/2021