[2024] EWFC 378
Case No: MB23C50448

IN THE FAMILY COURT
SITTING AT MIDDLESBROUGH

Date: 18th October 2024

Before :

HHJ MURRAY

- -

Between :

MIDDLESBROUGH COUNCIL

Applicant

- and –

(1) M

(2) F

(3) MGA

(4) N
(a child represented through their Children's Guardian**)**

Respondents

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Miss Thomas KC and Miss Blackmore (instructed by **Miss Seymour**) for the **Applicant**
Miss Lee KC ad Miss Stokes-Herbst (instructed by **Watson Woodhouse Solicitors**) for **M**
Mr Spencer KC and Miss Price (instructed by **Cygnet Law**) for **F**
Mr Hill KC and Miss Hart (instructed by **BBNM Law**) for **MGA**
Miss Howe KC and Miss McKenzie (instructed by **BHP Law**) for **the child**

Hearing dates : 2nd-6th September, 9th-13th September, 16th-19th September, 23-25th September 2024, 2nd and 18th October 2024

JUDGMENT

HHJ MURRAY :

Introduction

1. This case is about a little boy called N. N is 1 year and 8 months old. On 6th July 2023, when N was 20 weeks old, he was taken to hospital because his parents, M and F, were concerned about marks that that they had seen to his body. That hospital admission and various investigations that followed, led to a number of injuries being discovered to N's body, including bruising, fractures to his lower legs, vertebra and ribs, soft tissue swelling to his scalp and bilateral subdural effusions. That brief description of those injuries will be expanded upon in due course.

2. Although this hearing was originally listed as a final hearing, I decided that it would instead be used as a fact-finding hearing, to determine whether the local authority was able to prove that the injuries were inflicted/caused through rough or inappropriate handling, and if so, by whom.

3. I say from the outset that this is a complicated and complex case. The case involves the usual complicated features of the different types of injury involved with different time frames for each injury, with some little overlap in respect of a few. In addition, whilst the experts agree that the majority of the injuries were caused at various points prior to the 8th July 2023 when N was in the sole care of his parents, the subdural collections are said to have been caused at some point after his admission on 7th July 2024. Following that hospital admission, N did not return to his parents care but, instead, was placed in the care of his maternal great aunt, MGA. Following the subdural collections being identified, he was then moved into local authority foster care. The parents' contact whilst on ward from the point of admission was supervised. The Local Authority case is therefore pleaded on the basis of a possibility that different care givers within the biological family, on different occasions, have caused N significant harm.

4. But what significantly further complicates this case, is that the first months of N's life were not medically straightforward. Far from it. He had developed significant health

complications from birth, including symptoms arising from his contraction of the cytomegalovirus ("CMV"), in utero.

5. It is important then, that the fact of the various marks and injuries to N which have been reported, is seen and considered in a wider context of the issues and complications that N was experiencing. Later in this judgment I will set out a full chronology of the various issues that N has encountered from birth up to his removal into local authority foster care following his re-admission to hospital on 4th August 2023. This case is a clear example of the over-arching principle that when a Court considers allegations made, it is imperative not to simply undertake an isolated analysis of the background circumstances, the lay evidence and then expert medical evidence. It is only by considering the entirety of the evidence as a whole, looking at the oft coined "wide canvass", that I have been able to make the determinations that follow.

Issues

6. Following the hearing of evidence in this case, the Local Authority has provided me with a perfected document, setting out the findings it invites me to make. That document has only been amended slightly from that which was produced prior to the hearing and is focussed upon N's injuries. The findings the Local Authority invite me to make are as follows:

Fractures

1) *N has suffered the following fractures:*
   a) *Vertebral wedge fractures at T8, T10 and T12 levels. These occurred on or between 26 May 2023 and 8 July 2023, from a single episode of trauma.*
   b) *Fractures of the anterior right 5th, 6th and 7th ribs and the anterior left 6th, 7th and 8th ribs. These were in the region of 5 to 11 days old on 16 June 2023 and are likely to have occurred in a single episode of trauma.*
   c) *Fracture of the anterior right 8th rib. This was no older than 11 days on 8 July 2023*

d) *Incomplete fracture of the distal left fibula. This was in the region of 2 to 4 weeks old on 8 July 2023.*

e) *Incomplete fracture of the distal right fibula meta diaphysis. This was no older than 11 days on 8 July 2023.*

2) *The fractures listed above were either:*

a) inflicted by the 1st or 2nd respondent (namely M or F) or;

b) were caused by rough handling by either the 1st or 2nd respondent, out with normal handling for a child of N's age.

Bruises / marks

3) *When examined on 6 July 2023, N had the following skin marks/ rashes and bruises:*

a) *Pinpoint non-blanching rash to left cheek extending to left side of the scalp*

b) Pinpoint non-blanching rash over the left axillary region

c) 0.5cm linear mark / bruise

d) Non-blanching rash in the left antecubital fossa

e) Pinpoint non-blanching rash across his torso

f) Linear mark 1cm in length above the umbilicus to the left

g) Oval mark above and right of the umbilicus

h) 2cm linear mark above to the right of mark G above

i) 1cm linear mark below and to the right of mark G above

j) Round mark about 1cm in diameter lateral to the right knee

k) Cluster of small marks below the left knee joint

l) Linear 1.5cm mark to the upper aspect of the back on the left side

m) 1cm linear mark to the right side of the upper back

n) 6cm mark in a wavy form to the right of the spine at the level of T11 – T12

o) Mark over the right buttock, 2.5cm by 3cm, oval

4) *Marks b, c, f, g, j, l, m, n and o highlighted above have been caused by pinching or gripping N. They are the result of either:*
   a) inflicted injury, or;
   b) rough handling out with normal handling for a child of N's age

5) *The marks and bruises listed above were caused by either the 1st or 2nd Respondent.*

Soft tissue swelling

6) *A CT brain scan of N on 7 July 2023 showed a mild soft tissue swelling along the right fronto-temporal region of the scalp, in keeping with a small area of traumatic scalp injury through impact. This impact occurred within 7 to 10 days of the scan.*

7) *The soft tissue swelling was caused by a blunt impact injury or gripping forcefully to the head, inflicted by either the 1st or 2nd Respondent.*

Bilateral subdural collections

8) *An MRI scan carried out on 27 July 2023 showed bilateral subdural effusions in the supratentorial compartment, located over each frontal lobe with the left sided collection being larger. These effusions occurred on or between 7 July and 27 July 2023.*

9) *The subdural collections arose from inflicted injury, likely to involve an episode of shaking. They were caused by either the 1st or 2nd Respondent or the Intervenor (namely MGA).*

7. As a result, the essential questions for me have been:

a) Has the local authority proved that the fractures, bruising and soft tissue swelling has been caused by either an assault perpetrated by one or both of the parents or by rough handling inappropriate to a child of N's age and known vulnerability
b) Has the local authority proved that the bilateral subdural collections were inflicted by either M, F or MGA, likely following an episode of shaking.

This hearing

8. Due to the complexities of this case, the documentation filed has been extensive. I have been provided with a number of different bundles. I have considered:
   a) A core bundle in excess of 2000 pages, which includes the social work evidence, the lay evidence, the majority of the expert medical reporting, police disclosure, phone interrogation evidence and disclosure of previous private law proceedings involving F's older children with a different mother ("EP").
   b) A supplemental bundle in excess of 580 pages which has provided updated evidence since the core bundle was closed. That bundle contains a variety of evidence including but not limited to, expert reporting and addendum, medical research papers, lay evidence and case notes.
   c) 3 separate medical bundles with a total of around 2000 pages
   d) A family time bundle of over 200 pages.

9. The live evidence in this case has taken 16 days. However, the majority of the evidence I have heard has come from various medics, whether they be treating clinicians or the large amount of Part 25 experts that I have previously allowed to report. As a result, I have heard live evidence from the following witnesses:

Medical evidence

a) Dr Johnson (consultant paediatric radiologist: Part 25)
b) Dr T (consultant paediatrician: treating clinician)
c) Dr L (consultant in Paediatric Bone Disease: treating clinician)
d) Dr Gupta (Haemato-Oncology consultant: Part 25)

e) Dr Williams (Neuroradiologist: Part 25)

f) Dr Allgrove (paediatric endocrinologist: Part 25)

g) Mr Jalloh (consultant paediatric neurosurgeon: Part 25)

h) Dr McKiernan (consultant paediatrician specialising in paediatric liver disease: Part 25)

i) Dr Morrell (Consultant paediatrician: Part 25)

Lay evidence

j) FW (Early Help Family Practitioner)

k) MGM (Maternal grandmother)

l) MGA (Maternal Great Aunt: intervenor)

m) M (Mother)

n) F (Father)

10. I have had the considerable benefit of a full written opening prepared by the local authority, amended immediately prior to the hearing for reasons I do not need to address in this judgment. I have also had the benefit of robust questioning of all of the witnesses, and especially the expert witnesses, by leading counsel. At the end of the evidence, I adjourned for the preparation of written submissions. Each of the parties written submissions have been detailed, clear and well prepared. I have already indicated the complexities of this case, and I have been well assisted by the impressive way that each party has attempted to assist me.

11. This is a case where I have previously determined that M ought to be assisted by an intermediary to ensure that she is able to fairly participate in this hearing. The combination of the professional assistance provided by the intermediary and the ground rules I have implemented, have meant that I am satisfied that all parties in this case have had the best opportunity of engaging in this hearing. This is a case where the medical evidence is far from straightforward, but I have been assured at each stage that the breaks we have taken have allowed consideration and reflection of the evidence, before moving on.

12. It is not my intention to set out all of the evidence I have heard. To do so would be disproportionate; my note of the evidence is over 270 pages of typed notes. I am grateful to counsel for assisting me in producing summaries of those parts of the medical evidence which they say is particularly relevant. I have checked those summaries against my own note, and I am satisfied that they accurately reflect the evidence referred to. I intend only to include those parts of the evidence I have read and heard which I consider are particularly relevant to the determinations I make. However, no party should think that I have not considered the evidence as a whole.

The Legal Framework

13. I have been greatly assisted by the parties producing a document titled "*The fact-finding exercise - general principles*". It is a comprehensive document which I have read carefully, and I have applied the principles set out within. However, whilst I attach that document as an annex ("A") to this judgment (to be removed for publication), there are some principles so fundamental and specifically relevant to this case, that I must set them out here.

Threshold

14. For the Court to contemplate the making of a public law Order, the local authority must first prove that the existing circumstances at the point that protective measures were taken, justifies the intervention of the State. That fundamental question of whether the threshold for that intervention has been reached, is set out in s.31(2) Children Act 1989:

(2) A court may only make a care order or supervision Order if it is satisfied-

a) that the child concerned is suffering, or is likely to suffer, significant harm;

and

b) that the harm, or likelihood of harm, is attributable to-

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

(ii) the child being beyond parental control.

15. In this case the Local Authority say that it is the various injuries identified on N that can satisfy the Court that the threshold for the making of a public law Order is met. It is those injuries, their causation and the potential for infliction by one or both of his parents and great aunt, that have been the focus of the evidence.

16. The relevant date is when the local authority took protective measures on 7th July 2023.

The burden and standard of proof

17. The threshold is established by facts being proved. The burden is on the party who seeks to prove those facts. In the majority of care proceedings, this one included, that means that the burden rests on the local authority. I must be careful that there is no reversal of that burden of proof, it is not for the respondents in this case to prove anything, including a negative.

18. I am specifically assisted by 9 key principles set out by Baker J (as he then was) in *Re L and M (Children)* [2013] EWHC 1569 (Fam) paragraphs 47-55, and later approved by the then President of the Family Division (Munby P) *in X (Children) (No 3)* [2015] EWHC 3651:

a) First, the burden of proof lies at all times with the local authority.
b) Secondly, the standard of proof is the balance of probabilities.
c) Third, findings of fact in these cases must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation.
d) Fourthly, when considering cases of suspected child abuse, the court must take into account all the evidence and furthermore consider each piece of evidence in

the context of all the other evidence. The court invariably surveys a wide canvas. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof.

e) Fifthly, whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. It is important to remember that the roles of the court and the expert are distinct, and it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision. I will consider this principle further below.

f) Sixth, cases involving an allegation of non-accidental injury often involve a multidisciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others

g) Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability.

h) Eighth, it is common for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (see R v Lucas [1981] QB 720). The impact of lies in this fact finding hearing will be further considered below.

i) Ninth, as observed by Dame Elizabeth Butler-Sloss in an earlier case “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 would throw a light into corners that are at present dark.” This principle, inter alia, was drawn from the decision of the Court of Appeal in the criminal case of R v Cannings [2004] EWCA 1 Crim. In that case a mother had been convicted of the murder of her two children who had simply stopped breathing. The mother’s two other

children had experienced apparent life-threatening events taking a similar form. The Court of Appeal Criminal Division quashed the convictions. There was no evidence other than repeated incidents of breathing having ceased. There was serious disagreement between experts as to the cause of death. There was fresh evidence as to hereditary factors pointing to a possible genetic cause. In those circumstances, the Court of Appeal held that it could not be said that a natural cause could be excluded as a reasonable possible explanation. In the course of his judgment, Judge LJ (as he then was) observed: "What may be unexplained today may be perfectly well understood tomorrow. Until then, any tendency to dogmatise should be met with an answering challenge."

Medical Evidence

19. That 9th point set out by Baker J in *Re L and M* above is of particular relevance in this case, where I have heard evidence from a number of different specialist medical experts who all describe the analysis of how N's various injuries were caused, as being complex. Given the extent of the medical evidence in this case, I have specifically reminded myself of the following guidance and observations summarized in *LB v G* [2024] EWHC 2200 Fam, in cases where the principle allegation is one of infliction of injuries:

a) Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have related to the relevance of each piece of evidence to other evidence, and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the Local Authority has been made out to the appropriate standard of proof (*Re T* [2004] 2 FLR 838 at paragraph 33 per Dame Elizabeth Butler-Sloss)
b) In *Re H; Re B* (A Child) [2004] EWCA 567 at paragraph 23 Dame Butler-Sloss adopted the following considerations:

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."

c) Expert medical evidence is an important and often valuable part of the puzzle that the Court must consider as it considers the facts of each individual case. But, whilst valuable, it is not determinative. As Peter Jackson LJ said in *Re R (Children: Findings of Fact*) [2024] EWCA Civ 153, at paragraph 34, "*of course [the judge] was right to say that the court's task was to determine whether the local authority had proved its case on threshold on the balance of probability. However, that involved grappling with and drawing conclusions from all of the evidence, medical and lay … Medical and non-medical evidence are both vital contributions in their own ways to these decisions and neither of them has precedence over the other*."

20. Inevitably, in a case such as this which has considered not only separate areas of medical speciality, but how each of those areas then interacts with other specialist disciplines, a number of research papers have been produced. Those papers have either been produced by the various experts instructed to report in these proceedings, or produced by counsel in their exchanges with the experts. I have been careful to remind myself that I am not a medical expert. My role should not be to scrutinise research papers so as to form my own medical opinion as to how injuries have been caused. Rather, research papers are a tool to be used by the court in its analysis of the evidence of the experts. Assistance has been provided by Baker

LJ in *D and A (Fact Finding: Research Literature)* [2024] EWCA Civ 663 as to how the Court ought to use research paper evidence as part of its overall analysis:

84. How should a judge approach research literature cited to the court? As Kerr LJ observed in Abadom, the reason for requiring an expert to refer to the research material on which they have relied in expressing their opinion is so that the cogency and probative value of their conclusion can be tested and evaluated by reference to it. The judge is therefore entitled and, where necessary, required to scrutinise the research cited when assessing the expert's opinion evidence. The reliability of an expert's opinion may be enhanced if it supported by research literature. On the other hand, it may be undermined if it is contrary to the research literature. This is all part of the overriding principle that the judge must reach her decision on the totality of the evidence.

85. In considering the research literature, however, the judge must exercise caution. First, she should not use analysis of research as a stand-alone method of trying to decide what happened. It can help to confirm the accuracy or reliability of the expert's opinion. It is not a tool for the judge to use herself independently when analysing the evidence. She is not the expert.

86. Secondly, in areas of scientific controversy and uncertainty (such as causation of intracranial bleeding in infants), there is a risk that the judge may be drawn into too extensive an analysis which will distract from the central issue in the case. There is a danger that the obligations on the expert in Practice Direction 25B to identify the literature and research material they have relied on in forming their opinion and to summarise the range of opinion on any question to be answered will lead the judge into an unnecessarily detailed analysis of the material.

87. Thirdly, there are particular difficulties with the research literature about the causation of intracranial bleeding in infants……

88. Fourthly, when a large volume of research is cited, there is a danger that it may obscure other important parts of the evidence. As Peter Jackson J observed in Re BR

(Proof of Facts) [2015] EWFC 41 at paragraph 8, (cited by the judge at paragraph 169 of her judgment) "the medical evidence is important, and the court must assess it carefully, but it is not the only evidence". In A County Council v K D & L [2005] EWHC 144 (Fam) at paragraph 39, Charles J observed "It is important to remember (1) that the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence."

Lies

21. The Court has long approached the issue of lies using those principles established in the criminal jurisdiction in the case of *R v Lucas* [1981] QB 720. The ongoing application of *Lucas* in the family Court was considered by McFarlane LJ (as he then was) in *Re H-C* (Children) 2016 EWCA Civ 136. At paragraph 97 he observed:

97. … A family court, in common with a criminal court, can rely upon a finding that a witness has lied as evidence in support of a primary positive allegation. The well-known authority is the case of R v Lucas (R) [1981] QB 720 in which the Court of Appeal Criminal Division, after stressing that people sometimes tell lies for reasons other than a belief that the lie is necessary to conceal guilt, held that four conditions must be satisfied before a defendant's lie could be seen as supporting the prosecution case as explained in the judgment of the court given by Lord Lane CJ:

> *"To be capable of amounting to corroboration the lie told out of court must first of all be deliberate. Secondly it must relate to a material issue. Thirdly the motive for the lie must be a realisation of guilt and a fear of the truth. The jury should in appropriate cases be reminded that people sometimes lie, for example, in an attempt to bolster up a just cause, or out of shame or out of a wish to conceal disgraceful behaviour from their family. Fourthly the statement must be clearly shown to be a lie by evidence other than that of the accomplice who is to be corroborated, that is to say by admission or by evidence from an independent witness."*

98. The decision in R v Lucas has been the subject of a number of further decisions of the Court of Appeal Criminal Division over the years, however the core conditions set

out by Lord Lane remain authoritative. The approach in R v Lucas is not confined, as it was on the facts of Lucas itself, to a statement made out of court and can apply to a "lie" made in the course of the court proceedings and the approach is not limited solely to evidence concerning accomplices.

99. In the Family Court in an appropriate case a judge will not infrequently directly refer to the authority of R v Lucas in giving a judicial self-direction as to the approach to be taken to an apparent lie. Where the "lie" has a prominent or central relevance to the case such a self-direction is plainly sensible and good practice.

100. One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of R v Middleton [2001] Crim.L.R. 251. In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt.

22. I make it clear that whilst I have set out those legal principles above as being particularly relevant to the particular circumstances of this case, I have applied them alongside those principles set out at length in the annexed document. In my view, dogged repetition of those other principles is not necessary within the narrative of this judgment; what is important is that I go on to show that they have been applied in what follows.

Background

23. I intend on setting out a background to give a chronology to the evidence I have read and heard. Whilst not repeating verbatim the contents of the voluminous records, it

is my intention to set out, in broad terms, the issues and difficulties that N has been subjected to from birth through to his placement in foster care on 10th August 2023. In so doing, this chronology will look at the various hospital appointments and admissions which I consider to be relevant to my determination, along with what was being reported by family members at the relevant time. Even though it is a summary of the wider evidential picture, it is still a lengthy process. I make no apology for its length as it is important that a proper context is given for the relevant time period as I then go on to consider the medical evidence.

24. I therefore intend on splitting this section into 5 parts:
    a) Pre-birth
    b) birth to 5th July 2023
    c) 6th July,
    d) Admission on 6th July to placement in foster care
    e) Post placement in foster care.

25. In setting out this background I will be considering aspects of the clinical evidence from those who were treating N, as well as lay evidence. As I do, I will be considering aspects of the evidence which remain contested or has attracted an element of disagreement. Any findings I make as I proceed through this background, I do on a balance of probabilities and with reference to the case law that I have already rehearsed.

<u>Pre-birth</u>

26. M and F formed a relationship in/around September 2020. At that time M was 16 years old and F was around 29/30 years old. In his oral evidence to me F did not initially accept that M was 16 years old. He told me that she was 17 or 18 years old. He told me that he had only seen her a few times when she was 16 as she was a neighbour of one of his ex-partners.

27. It took counsel for the local authority reminding F that the medical records show that M had a termination in January 2020, when she was 16, for F to then accept that he had started a sexual relationship with her at that point.

28. Having accepted as much, he told me:

I knew she was of that age but I had forgot with time passing… I knew she had learning difficulties. I was aware of that from the time I met her.

29. When F entered a sexual relationship with M he was either in, or had just finished, a relationship with EP. F told me that he had ended his relationship with EP in 2020 and accepted that EP had then moved out of F's property around August 2020. M then moved into F's property around 4 weeks after EP had moved out.

30. When M moved into F's property, F's children to EP, then aged 4 and 7 years old, were also living there.

31. F's relationship with EP after they had separated was not without issue. F suggested in his evidence to me that he did not consider there was an ongoing dispute with EP post-separation. However, having been taken to the relevant records in cross examination he then went on to accept that issues between he and EP had in fact on occasion become heated, with swearing and name calling. He also accepted that matters had escalated in November 2020 to the point of police involvement. That police involvement was at a time when M had been living in F's property for some 3 months, herself only 17 years old. There was further police involvement in May 2021 when the police were called following EP dropping her children back to F. The situation escalated to the point that M was involved in a physical altercation with EP.

32. Although it seems that the intensity of the issues between EP and F lessened, they did not completely disappear. I have seen text messages into January 2023 indicating

that tensions remained between the two. This was at a time when M had fallen pregnant with unborn N.

33. F was working at the start of 2023, and it seems that M took on more responsibility for looking after EP's children. Again, F was willing to accept that M took on some responsibility, but was slow to accept that it would have been difficult for M, now pregnant with her first child, to also then often undertake caregiving for F's children.

34. The dynamic between F and M was also, in my view, an unhealthy one. The mother told me that there were issues with the father's jealousy and that he would react badly if he thought the mother was looking at other men. She told me that it became easier to stare at the ground if other men were around so that F would not accuse her of something. She told me that she and F would argue about it quite a lot and that it hurt her feelings that he did not trust her. In her oral evidence to me, I was satisfied that she was honestly describing a particularly difficult moment in her young life.

35. For F's part, he accepted that he would accuse M of seeing other men. He told me it was not frequent, but he had raised issues with her, probably once a week. Issues such as where she had been or who she had been speaking to. For F, those types of questions were reasonable. He told me:

There was a real reason to accuse her of being unfaithful. She didn't do nothing, but she told me once that she used to like the lad who lived next door to us. She told us that she didn't do anything with him but that she used to like him…. In the back of your mind I was thinking that if she liked him and told me, then she might like someone else… that's why I [was] asking"

36. When pressed, F accepted that the relationship with M was probably not in a healthy place before N was born.

Birth to 5th July 2023

37. N was born on 15 February 2023 by way of emergency C-section. He was born with complex health needs, including congenital CMV (Cytomegalovirus). I have heard expert evidence during this case that indicates that CMV is the most common congenital infection for newborns, with around 1 out of every 200 newborns being infected with the virus[1]. However, of that only around 10% of babies with CMV then develop symptoms. Of those who display symptoms, there is a spectrum of symptomology. Whilst I was told that N's symptomology was not right at the top of the spectrum, that there will be babies who are more negatively impacted by CMV, I was told by one Court appointed expert that of those babies with symptomatic CMV, it is unusual to have the range of symptoms that N presented with[2].

38. At the time of his birth, N had CMV induced hepatitis and neutropenia. He had and continues to have, abnormal liver function and partial hearing loss in both ears. Whilst in the NICU, he developed neutropenic sepsis which was treated with two weeks of medication. He has a periventricular cyst in the brain, putting him at risk of developmental issues.

39. The first weeks of life for N were very difficult and required intensive care. M told me that she recalls being told by medical professionals to brace herself for the worst outcome, that N may not survive. Following birth, he received various methods of assistance in breathing, from the less intrusive CPAP, to ventilation for 6 days at a point when he became particularly unwell with sepsis, and additional oxygen provided by way of nasal prongs until day 58 of life. During that period of time, he received no less than 18 medications and vitamins supplements. His medical picture was complicated and complex. As I will go on to consider, whilst there have been significant improvements in N's health, there remain uncertainties in respect of the cause of some of his ongoing health issues.

[1] Although the infection percentage varies considerably amongst different study populations.
[2] Dr Morrell in cross examination

40. He was discharged following birth on 24 April 2023. Whilst I could set out at great length the medical issues identified within the medical records relating to his time from birth to discharge, it is not proportionate to do so. It is enough in my view to set out the bullet point neonatal discharge summary identifying the principal problems/diagnosis during stay:

- Prematurity (28-31 weeks)
- Oxygen requirement- after 1st week in preterm
- Very low birth weight
- Congenital cytomegalovirus infection
- Retinopathy of prematurity Grade 1 and 2
- Jaundice- cholestasis
- Jaundice – conjugated
- Hepatosplenomegaly
- Congenital viral hepatitis
- Anaemia
- Thrombocytopaenia
- Neutropoenia
- Sepsis/septicaemia
- Subependymal/Germinal Layer Haemorrhage

41. On the same day that he was discharged, he was presented back at A&E by his parents. They were concerned that N appeared to have a low temperature and was unable to settle. Following discharge, he was monitored by the neonatal outreach team and had weekly hospital appointments. Whilst N has a lead clinician, Consultant paediatrician Dr A, there were a number of medical professionals involved in N's ongoing treatment and medical care because of the complexity of his presentation. They included:

a) Neonatal team (up to May 2023)
b) Paediatric infectious disease consultants
c) Paediatric liver team

d) Paediatric dieticians
e) Consultant clinical geneticist
f) Consultant in paediatric metabolic bone disease
g) Other various consultants and nursing staff who had interactions with N on appointments and admissions.

42. In March 2023, M saw her GP. She viewed herself at that time as suffering with post-natal depression. She requested medication to help her stay calm and help with sleep. At the time she was having counselling organised through the hospital. She was described as obviously exhausted and stressed and was started on mirtazapine.

43. On 28 April 2023, a request for Early Help was completed by the Health Visitor. At that time, the family were reporting financial difficulties. F was an HGV driver whose income was based around shift work. F was indicating that he was unable to take the usual number of shifts and that it was having a negative impact on the money coming into the home. Living at the home was not just M, F and N but also F's other two children. The Health Visitor reported being concerned about overcrowding in the home as N got older, and the financial impact of his care needs on the family. However, the health visitor also observed that N was clean, dressed appropriately and that M was meeting his needs with confidence and interacting with him appropriately.

44. On 30th April 2023 N was taken to A&E by his parents. The parents had taken him to hospital following a reported choking episode. From the transcript of the 111 call, I can see that the mother was indicating that N had been sick, had started to choke on his own sick and had then started to turn blue. They had managed to get him to start breathing but he was described as struggling. A first responder attended and had observed some wheeziness and advised that they attend at A&E. On assessment there were no concerns raised about N's welfare and he was discharged home

45. A week later, on 7th May 2023, N was again taken to A&E by his parents. They were concerned that his feeding had been poor and that he seemed sleepier than usual. N was examined at hospital, but no concerns were raised. He was started on Omeprazole and discharged home.

46. On 11 May 2023, N presented at James Cook hospital. The parents informed medical professionals that they were concerned that N had been injured by F. The history provided by the parents in respect of that admission reads as follows:

Was at home with parents.
Dad F was in room with N.
N had had a feed as usual approx 30 minutes previous.
N laying in the cot and then appeared to get unsettled.
F reports N looked as though he was choking. Appeared to be trying to swallow and breathe at the same time and was struggling. Appeared to be changing colour.
Has done this before but this was worse than usual.
Dad therefore picked N up.
Demonstrated how he did this - put both hands around N's chest and then turned him over so that he was resting face down over dad's palm. Dad showed that he then started rubbing on N's back. Dad stated several times "and I squeezed him too hard when I was doing this". I clarified on several occasions what he meant by this and he means that he himself was panicked and that he was holding N quite firmly in his hand as he turned him over. He did state very clear that he was not intending to hurt N but is concerned that he may have.

47. In his evidence to me from the witness box, F did not seem to accept that the history given at that time was accurate. Instead, demonstrating from the witness box, he told me that he had not put his hands around N's chest. Instead, he told me that he had put one hand over N's chest and one hand under his back. He told me that N was so small that he could put a single hand across his entire chest. He told me that when he described having "squeezed him too hard", he meant with the little finger and

thumb that were placed across N's chest. F seemed to draw back from any suggestion that he may have hurt N, even unintentionally and in a moment of panic. I will take a closer look at this incident within my analysis.

48. Both M ad F told me, as they had reported to medical staff at the time, that following that handling by F, N began high pitched screaming and was difficult to settle. I was told by the parents that the screaming was not usual screaming and they thought it was a cry of pain.

49. At hospital, the medical records indicate that N was extremely distressed and was not holding himself in a way nursing staff would have expected. He was described by nursing staff as having squealed on handling and appeared distressed. N remained on ward until 15th May 2023. Despite the description give around F's handling, medical professionals were unable to identify any mark, bruising or injury arising from the incident. On presentation, the referral states that staff could not find evidence of bruising or physical injury, although F said that he had grabbed him and patted his back. F had asked staff if he could have caused an injury through winding. A chest x-ray was carried out and no fractures were identified.

50. The admission summary from 15th May 2023 reads:

Brought into the hospital with background of recurrent reflux episodes and history of child might have choked on milk 30 minutes post feed. Dad reported he may have squeezed the baby too hard on first response to choking episode. Therefore, leading to him remained unsettled and screaming since then. Unremarkable physical examination with no physical injury or bruises observed.
He has ongoing congenital cytomegalovirus infection on valganciclovir and neutropenia from valganciclovir.

51. As I will set out later, both those representing the Children's Guardian and the Local Authority draw my attention to this incident as an important indicator as to what level of either bony or vascular fragility was present in N at this time.

52. The staff are described as concerned about the high level of stress at home focussed around housing, finances, N's health concerns and conflict with EP. In discussions between the ward staff and social care on 15 May 2023, it was shared that the mother had described feeling anxious about N's coughing episodes which led to the choking.

53. There was also concern being raised at that admission around the way N arrived in parents' car. The records indicate that the health practitioner observed that N was slumped in his car seat sleeping, that he had no clothes on except for a nappy and a blanket wrapped around him and he had not been strapped into the seat. In their evidence to me, both parents denied that he was dressed inappropriately. They told me that they had rushed to get to hospital and were concerned that N was showing some pain in his arm. They told me that N was strapped into the car seat but not over his arm, as that is where they thought the pain was coming from. The mother told me that she sat in the back seat with N, to make sure he was safe on the trip into hospital.

54. In a follow up call to social care on 16 May 2023, the parents informed the social worker that F was working nights and also helping with childcare during the day. The mother said that she felt she was managing ok. The maternal grandparents were involved on a daily basis.

55. On 17th May 2023 N seems to have been re-admitted to hospital, again following concerns raised by the parents around choking episodes. I am not entirely clear about the circumstances of that admission as the medical records do not appear to provide a significant amount of detail and the admission summary seems to refer to the concerns being raised at the admission on 11th May 2023. However, it seems that N remained on ward until 19th May 2023.

56. Upon discharge on 19th May 2023, M went to stay with MGM. M seems to have stayed at MGM's property for a period of approximately 2 weeks. Whilst staying at MGM's:

    a) MGM told me that there were no hospital admissions during M and N's stay with her during that period (it is of relevance that there was a hospital stay on 1st June 2023, referred to below)
    b) There were no reported episodes of choking
    c) MGM told me that she had no concerns at all in respect of any issues arising in respect of N and did not see any unusual marking or bruising.
    d) A GP visit took place on 23rd May 2023 for immunisations and there is no record of any concerns being raised by the GP.
    e) On 30th May 2023 the parents were visited by their Health visitor:

        i. N was seen and no issues raised.
        ii. M was still staying over at MGM's property with N but intended on returning to the family home the next Saturday (3rd June 2023)
        iii. Both M ad F were observed to handle N with care and speak to him in a loving tome. M observed to kiss N on his nose.
        iv. HV discussed with M the need to ensure N's head is properly supported at all times.

57. That last discussion reflects the lay evidence, accepted by M, that at times she did not support N's head properly. MGM told me in her evidence that she would regularly remind M of the need to support N's head. It also reflects the observations of contact workers from various later supervised sessions and concerns being expressed about M's lack of confidence on holding N and properly supporting him.

58. At the point of discharge on 19th May 2023 a referral was also made to the local authority and an Early Help assessment was then carried out. That assessment started on 19th May and covered a period of time when M was living with MGM, as

well as when she returned back to the family home on/around 1st -3rd June 2023. Within that assessment the following is noted:

a) M described that she is adjusting well to being a new mum and is gaining confidence
b) M described an improvement in her mental health
c) There is a lot of emotional warmth between M and N; M talks very gently/baby talks to N and sings to him. She is very affectionate
d) N has been observed within the family home and it appears there is a lot of emotional warmth between him and his mother, and also him and his father
e) F described that he is becoming more affectionate with N however has found this difficult due to how much N has been in hospital.
f) There was ongoing financial strain because of the time that N has spent in hospital
g) M and F describe feeling heavily criticised by maternal grandparents.
h) MGM felt that F was controlling of M.
i) M described that her interactions with various professionals has made her feel inadequate as a mother.
j) Apart from assistance around housing, the parents do not really want support ad "feel like this has been forced upon us". In his evidence F denied that they didn't want support.

59. I am mindful that the assessment took place over a period when M was living with MGM as well as having returned back to the family home. However, having referenced the M's report within the assessment that her mental health was improving, it is important for balance to highlight that during her stay with MGM, M visited her GP on 22nd May 2023. M told the GP that she was struggling, was getting worse and was struggling with sleep and mood. MGM was assisting with the night feeds. Indicated that she was still struggling to sleep, but when she did sleep, it was too deep to wake. The issue with M waking from sleep, even in the context of N crying, is a thread throughout the chronology. M accepts that there were issues of

her sleeping through without waking. I formed the impression from M's oral evidence that it was something that she felt she could not change, but about which she felt a level of criticism. Within the GP notes it is said that M had been living with F and his children but that it was overwhelming, and she had moved in with MGM for support.

60. On 1 June 2023, the parents took N to the GP due to concerns around constipation. It is recorded in the GP note that the parents are reporting that N is screaming when evacuating his bowels, that they are unsure of what to do now and that they cannot tolerate seeing him screaming regularly. The GP referred N that day for a paediatric assessment and the parents then attended A&E.

61. N was examined and assessed. No concerns are raised in respect of any examination of N, or more generally in respect of his presentation. Advice is given in respect of the high energy feeds that N is consuming and N is discharged home.

62. By 5th June 2023, M had stopped taking her prescribed Sertraline. M told me that she had stopped taking the medication because she felt that it made her "snappy". The F also told me that he felt M had become irritable and snappy.

63. On 6 June 2023, N was once again admitted into hospital. The initial reason for the admission was because the parents had noticed blood in N's stool. M had contacted the hospital and was advised to bring him in. He was admitted for a number of days. By 9th June 2023, M was being told that N could be discharged as he was medically fit. M wanted to remain with him in hospital to ensure that he tolerated his feeds. It seems that shortly after 9th June 2023, N's condition worsened. His oxygen saturations decreased with assistance required to increase his oxygen levels with the use of nasal prongs. The ongoing concerns in respect of his oxygen requirement, meant that N remained on ward from 6th June to 22nd June 2023. The admission diagnosis is set out within the records as:

    1) *Feeding issues with poor weight gain*

2) *PR bleeding[3] secondary to coagulopathy*
3) *Resolved parainfluenza viral infection.*

64. There are some entries in respect of that admission which are relevant to my determination of the issues in this case. They are as follows:

a) Concerns were being raised by the hospital in respect of the messy state of N's room on ward.
b) Concerns were raised in respect of F being aggressive with staff on several occasions. That same confrontational/defensive presentation was later recorded in a health visitor record from 4th July 2023. It seems to have been associated with F indicating that he was already a father of 2 other children and was aware of how to meet a child's needs.
c) 14th June 2023, 9.06pm: Petechiae noted on N after bloods taken. Nursing staff note:
"I was called to the room earlier around 16.30pm by [a health care assistant] to inform me of some red spots on N's right hand (he had bloods here a couple of hour prior) which appears like peticia…"
d) 15th June 2023, 9.43pm: Petechia observed. Nursing staff note:
"*Reported during handover few non blanching petechial spots to arm – felt it was from holding during cannulation attempts on 14th June. However, reported by [student nurse] some non-blanching spots to head, neck and other arm. I have been to review… several non-blanching spots under ear lobes both sides couple to head*".

65. There is a message during this period of N's admission, which is relevant. On the evening of 11th June 2023, in reaction it seems to N being sick on her clothes, the mother sends a friend a message which reads:

"I'm gonna fling my child across this room in a minute"

[3] Rectal bleeding

66. In her evidence M accepted having sent the message. She told me that she had met another mother who was also at hospital during that time. She told me that they had struck up a friendship. In respect of that message she told me:

> *"That was just N not settling, It was just a joke. It was a figure of speech sort of thing… I was not cross with N".*

67. I am invited to view that message in the context of M having stopped taking her prescribed Sertraline by 5th June 2023.

68. Having been discharged on 22nd June 2023, the family were the visited on 26th June 2023 by a family worker ("FW") and on 28th June 2023 by the health visitor. On both of those visits N was seen with no concerns being raised in respect of his well-being. During the latter visit M was described as handing N "*with confidence*", and positive interactions were observed in respect of both M and F towards N. It was during FW's visit on 26th June that MGM indicated that she felt that F was controlling of M and that financial pressures continued to strain the couples' relationship.

69. N was seen in a dietetic clinic on 29th June 2023, with no issues or concerns being noted in respect of N's presentation. N stayed overnight with MGM on 30th June 2024. She told me in her evidence that she had no concerns about N. Although he seemed a little "crabby", it was nothing unusual. She told me that she bathed him that night and did not see any marks or bruises. In essence, she told me that she had no concerns, at all, about his presentation.

70. A second relevant text message around this time relates to the previous suggestion from staff members that F had been confrontational and aggressive. On 29th June 2023 M was again in communication with her friend in respect of her complaint that hospital staff had been making referrals to children's services in respect of issues around M's basic care. At one point, the friend asks M how F had reacted. M replies:

"Oh he booted of[f] *had to get taken out be security lol"*

71. When she was challenged about where she had lied about that incident, M told me:

"He was angry. He didn't boot off like screaming. He wasn't screaming and shouting. He was talking to security, to me I thought he was getting escorted out, but then found out that he had just been talking to them".

72. On 4th July 2023 a different health visitor attended at the family home as part of a planned appointment. As part of that appointment N was stripped and weighed, necessitating some close up examination by the HV of N. No issues are recorded or raised in respect of N's presentation. There are positive interactions noted, particularly between M and N. It is recorded that M handled N with care and confidence, gently undressing him to be weighed.

73. At 11.18am on 5th July 2023, M and F took N to A&E. It is important to set out why the parents did so. In the medical notes, the following is set out:

Seen first with dad – dad mentioned that the reason coming here is his breathing he breath faster when he take his bottle. Still feeding fine and taking his normal feeds within 24 hours. Also, he felt that N warm to touch in the morning checked his temp and was 38cc. checked again and was normal (dad mentioned that N was covered with blanket and possibly that the reason of his high temp)…

Mother came after – history from mother that he is not himself, feeding longer time with problem with his breathing as he was sounds like recession after feeds"

74. N was examined and found to be alert with good colour and no respiratory distress and well perfused. He was handling well in the examinations. No concerns were raised and the parents returned from A&E that afternoon.

75. Both of the parents tell me that there were no issues with N following that hospital visit. F told me that as far as he could remember, N was his usual self.

6th July

76. For the most part, I am reliant upon M and F as to the circumstances which led to marks/bruises being discovered on N. As a result, as I go through their accounts, I will be considering how the evidence given to me from the witness box is corroborated or not by the other accounts they have given.

77. From the mother's description of her routine prior to 6th July 2023, she suggested that she undertook the majority of care giving for N, as well as supporting the care of F's children when he was at work.

78. In terms of night feeds, there seemed to be an ongoing issue as between M and F. F accepted that on occasion he would get up and do a night feed. That would happen when he wasn't on a night shift at work. To that end he accepted it might be 1-3 times a week. However, when he would get up to feed N at night, F told me that there were times when he would try and wake M up to help with the routine.

79. That was explored with F in cross examination as to why he felt the need to wake M up, when she had provided care throughout the day, it then being his turn to provide some care. He told me that he did sometimes wake her up because he wanted her to get into the routine of doing it herself. He told me that he made a point of waking her up, not because he needed to, but because he felt he was helping her establish a routine. As I have already touched upon, there have been issues raised by professionals and family members previously about the M often sleeping through,

even when N has been crying and it might have been expected that M would have woken.

80. From F's description, I formed the impression that he felt that it was helpful to wake M up in the middle of the night, even though her sleep did not, in fact, require disruption.

81. In any event, both M and F told me that on the evening of 5th July 2023, it was M who got N ready for bed. She told me that N was fed, changed and then put down in the "Next-to Me" crib which was positioned on F's side of the bed.

82. For reasons I will come onto in due course, neither M nor F suggested in their written evidence that there were any issues with the crib when N was placed into it on the night of 5th July 2023.

83. Both parents told me that it was F who did the night feed, at around 2am. Neither M nor F have suggested that M woke that night when F got up to do the feed. I make the reasonable inference that M presumes F did the night feed because that was what had been agreed.

84. F told me that there was nothing eventful about the feed he gave N, at around 2am on 6th July 2023. He tells me that it was just a routine and normal feed. He told me:

"I cannot help. There was nothing on him that I saw. I had not been rough with him over night".

85. The lack of detail from F is striking, particularly as this is the night before marks were discovered on N, which in turn then led to N's removal from the parents care. Despite an invitation to think carefully as to how he might be able to assist the Court, he simply told me that it was just like any other feed and he could not help further.

86. Both M ad F agree that it was M who got up at around 7am on the morning of 6th July 2023 to change and feed N.

87. M told me that she got N out of his cot to get him ready for the day. Although M has difficulty with precise timing, she told me that it would have been between 6am and 7am on the morning of 6th July 2023. M told me that she recalls that as she was feeding N, his bib had become wet which had, in turn, caused his clothes to become wet. As a result, she changed his clothes.

88. It is at that point that M told me that she first saw the marks to N's back. That is not what is recorded in the account provided to nursing staff later that day. The initial nursing assessment reads:

> *"Mum says she first noticed the rash on the morning of the 6th July whilst changing on waking, noticed rash to* ***face and chest*** *then throughout day the rash spread to other parts which the mum felt she needed to get checked out"* [my emphasis]

89. M tells me that the history in the medical records in incorrect.

90. She tells me that when F woke up, he had his usual "fag and a drink". She was clear in telling me that she mentioned the marks to F immediately after he had done so, who told her that it was not an issue. She told me:

"Once he had a fag and a drink, I told him about the marks. He didn't look straightaway. I was surprised that he didn't look. Sometimes he didn't believe what I was saying, He sometimes thought I was exaggerating. He just went not to worry, sort of thing".

91. F's evidence is very different to M's in that respect. According to F, he knew nothing about any marks at that stage. He denied that M had raised any concern with him at

all. In his written evidence dated 2nd February 2024, F tells me that the first time he knew about any marks to N was later that day when FW arrived for a visit:

> *"N woke up an everything seemed fine. I was outside cutting the grass when the Health Visitor arrived, I had a brief conversation with her when I asked if she was alright and we both then went into the house. The Health Visitor asked how things were going. This is when* ***M mentioned*** *N has some rashes,* ***this was the first time I knew about them****"* [my emphasis].

92. I have had trouble reconciling that account with what he then told me in evidence. As that morning was explored with F, he told me that he had spent a lot of his time outside in the garden. He told me that the first thing he knew about any rash was when M came out into the garden to tell him. On his oral account, he does not go back inside the house, he does not go and check the rash that M is raising. Instead, he remains in the garden until FW arrives a short while later. He then told me that he then went inside with FW and sees the marks for the first time.

93. His written account is clearly inconsistent with his oral account, both of which are inconsistent with M's account.

94. Nor is his first account above at paragraph 91 consistent with his second account given on 30th August 2024:

I spoke to her [FW] and said hello and she came into the house. I walked in with FW ***and asked*** *if she could look at N as M had noticed "faint purple lines" on him. I had not seen these myself. I got my phone out to see if I could see them the faint lines but there wasn't any there".*

95. F's oral evidence was confusing and contradictory in respect of when, or even if, he saw any marks to N. Despite his written evidence indicating that he had not seen anything of note on N during FW's visit, he would later say that he had seen faint red

lines only when FW was there. Under cross examination by the Local Authority he even seemed to be suggesting at one point that he had seen those “faint red lines” before FW arrived and he had agreed to raise the issue with FW when she arrived.

96. There is an issue about when FW attends at the property on 6th July 2023. FW tells me that she had an appointment booked to see the family at 3.30pm. She tells me that she might have been a little earlier but did not think it was as early as 11am. She told me that when she arrived at the property, she had knocked. The door was opened by M, who was leaving the property. She went into the lounge area where she saw F with N. The most contemporaneous account of that visit comes from a Strategy Meeting minute dated 10th July 2023, 4 days after the event. Within the minute of that meeting, at which FW was present, she is recorded as saying:

> *“I visited last Thursday 6th July and during the visit dad was checking over the baby, he said he noticed purple lines on N’s body. F was using his phone flashlight to look, he was using his phone flashlight to look, he was covering baby’s eyes and was being gentle in moving him around, F is always gentle when observed changing nappies”*

97. Both the M and F tell me that FW visited around 11am and that both M and F were present when discussion took place. Although some of M’s recollection of that day, specifically around timings, was poor, she remained adamant that she was there when the marks were raised with FW. FW was robustly but properly cross-examined on her recollection of those details. Although FW accepted that it was possible her recollection was wrong, overall she maintained that the account she was giving was accurate.

98. It is right that FW had visited the property on a number of occasions prior to that visit on 6th July 2023. It is also right that FW’s statement dated 12.10.24 does not include any details about that visit. In her statement dated 21.11.23 FW gives additional detail about her observation of F checking N over, but does not say that M

was not there. In fact, the penultimate sentence reads: "*I do not remember M or F presenting differently during this visit*".

99. I have formed the view that on balance, FW is honestly mistaken about the time that she arrived at the family home. I cannot say what time it was, but I accept it was prior to 3.30pm. I am also of the view that FW is honestly mistaken about whether M was at the property or not. However, in so far as the evidence between her recorded account in the strategy meeting minutes conflicts with that of the parents, I prefer FWs. She has a clear recollection in respect of what she saw in that property on 6th July 2023, as opposed to the inconsistent accounts of the parents, in particular those of F. That means, on balance, that I consider F was checking N over as described. I accept the evidence of FW that she had been reassured as F had indicated that they would seek medical advice. F told me in his oral evidence that he may well have.

100. It is not clear to me why medical advice was not then sought for N. I am particularly perplexed given the parents had the day before attended at A&E for N because he didn't seem to be himself. Afterall, these marks to N were, as M told me in her evidence, "*something different*".

101. M tells in oral evidence me that as the day progressed the marks became more evident. In particular, she noticed marks to both N's front torso and his back. There is a question as to why M did not seek medical attention, as the parents had only the day before. It seems that previously decisions had been made and agreed between the parents in respect of taking N to hospital to get checked out. However, if I accept M's account, she has raised the issue with F but he has not expressed the level of concern that M expected he would.

102. Regardless as to what marks were first noticed by M, the progression of the appearance of marks reached a point, M tells me, where she decided to call MGM and raise concern about them. There appears to be agreement that the call to MGM was made just before 3pm. The reason why there is a degree of accuracy to that timing is because having been told about the concerns, MGM was then immediately

sent two photographs of N; one of his front and one of his back. The photographs were sent at 2.56pm. MGM decided to go around to the family home a little while later.

103. Those photographs again raise a troubling inconsistency in F's evidence. In his oral evidence, F told me that he only seen the one mark to N's front, although I am not clear in his evidence when he says he saw that. However, he was clear to me that he had not seen any other marks before MGM arrived at the house. That seems incredible to me, given the photographs taken of N and sent to MGM, were of both N's front and back, with marks clearly visible. I specifically asked F why he then thought that M was taking a photograph of N's back to send to MGM. He told me he didn't know. By the end of his oral evidence he seemed to be accepting that he had seen additional marks, at some point, but I was unable to understand where his position finally lay.

104. MGM attends at the family home with another relative. MGM told me that when she attended she looked at N and could see the marks that had been sent to her in the photographs. She also thought she could see additional marking. Both M and MGM accept that having looked at the marks, MGM's response was "*What the hell are those marks*". MGM told me that her initial reaction reflected her belief that she was looking at bruising. M told me that the look that MGM gave her as she said those words led to M responding, "*I haven't done anything to him*".

105. It is not entirely clear to me where F was at the point that MGM was looking at N. MGM said he wasn't in the room and had been told that he had been in the garden all day. When I asked F directly, he seemed to suggest that he was hovering in the periphery but did not want to get directly involved. When I asked him why not, he was unable to adequately explain.

106. As MGM was describing to me the circumstances of her attendance at the property, in her free-flowing narrative, she told me that she had seen a broken cot at the property.

107. I pause here to consider the cot. Both parents have described the "cot" in question as a "Next to Me" crib. At no point in the parents written evidence did the cot feature as relevant within their narratives. During the parents' police interviews references were made to the cot, both in terms of where the cot was or whether N had ever trapped his leg in the cot. Any real focus in respect of the cot only arose during the evidence I heard from MGM. As she was describing to me the conversations that were taking place once she had seen the marks to N, she told me that she had been asking M whether N had fallen out of the broken cot. She told me that she was referring to the "Next to Me" crib. MGM said:

> *"M was adamant that N had not fallen from the cot. She later said that it had not broken. It is a space saver "next to me" crib. The cot was broken but she said that he was not in the cot".*

108. Given neither parent had mentioned the broken cot in any of their previous statements or interactions with professionals or police, they were asked about it in oral evidence. M told me:

> *"The "Next to Me" crib is what I would call a cot. At that time the cot was broken. I had leaned onto it and I think it had snapped a little bit. N was not in the cot when it happened, he was on the bed. It happened in the middle of that daytime. I had reached in to get a blanket and the base of the cot broke as I was leaning on it… I did tell F about the broken cot but I don't recall showing it to him…* "

109. M told me that she could not recall how heavily she had leant on the cot but confirmed that it was broken by the time FW came to the house.

110. F told me:

"I recall M telling me that the crib had broken. I had a look but it wasn't broken. M had thought she had broken the bit underneath, where the baby lies".

111. F told me that it had broken when N was still in the parents care but could not say when M had raised the issue, except to say that it had happened before N went to hospital with the marks, i.e. 6th July 2023. He told me that N did not sleep in the crib again and that, even though the crib was not broken, and he did not see any damage, he thinks social services bought them a new one. I have looked through the papers and have been unable to identify a time when a new cot was bought for the family.

112. Whilst MGM was at the property, it was agreed that N would be taken to A&E.

Admission on 6th July to discharge on 17th July 2023

113. N was admitted to hospital at 5.10pm on 07.07.23. An initial nursing assessment was undertaken, to which I have already referred.

114. When N was seen at 7.18pm, a clinician identified a number of bruises across N's abdomen, back, left leg and buttocks. Medical photography was undertaken and I have had the opportunity, as have the other medical experts in this case, to consider those photographs. N was kept on ward and a number of investigations undertaken.

115. A CT scan was undertaken on 7th July 2023. The CT scan revealed soft tissue swelling over N's right temple. There is no suggestion on any of the medical evidence before me that there was any associated redness or bruising in respect of that soft tissue swelling. One thing which was absent from that CT scan, which is important for what will follow, is any suggestion of subdural effusion.

116. A skeletal survey was also undertaken on 8th July 2023 which immediately identified a buckle fracture to the left distal fibula. That skeletal survey was reviewed by Alder Hey Hospital, whilst N was still on ward, which revealed:

a) Healing fractures to the left 6th, 7th and 8th ribs
b) Healing fractures to the right 5th, 6th and 7th ribs
c) Vertebral fractures at T8, T10 and T12
d) Confirmation of the healing fracture to the left distal fibula.

117. A Child Protection Medical was undertaken by Dr T on 7th July 2023, but seemingly updated post admission. From that safeguarding report I take the following:

"N's bruising remains unexplained. He has bruised both at home as well as in hospital. In hospital, his bruising was observed to be in areas where he was held for obtaining bloods…

I would not expect a baby to bruise with routine holding.

In the meantime, I have concluded that N's bruising at presentation remains unexplained, but he has a tendency to bruise easily.

Considering literature evidence, opinions from various other professionals and my own observations I have concluded that:

a) N has a complex medical history and therefore abnormal findings will have to be interpreted in light of this. It has to be borne in mind that so far, his extensive investigations have not pointed towards any abnormal bone structure or fragility.
b) In the meantime, it is not possible to disregard physical abuse as an explanation to N's significant fractures as he is a non mobile baby and could not have caused the fractures himself. No clear explanation of any accidents that would explain his injury has been given so far from his carers. Mum has suggested that she may have sat on his leg for a few seconds although further details about this incident and timeline have not been provided.

c) *it is also important to consider that even children with poor bone health can sustain fractures as a result of abuse. The presence of multiple fractures in multiple areas of at least two separate ages is extremely concerning to me.*

d) *Based on the information at present, my opinion is that N's fractures are likely to be non-accidental in origin and he has suffered significant home*

e) *N does require further extensive investigation as outlined below and is likely that this process will take time. Should any specialist offer a potential medical explanation for N's fractures, it is paramount that this information is shared with me so that I can review my opinion accordingly. I reserve the right to alter my opinion in light of any new information that becomes available, however, i conclude that, at the present time, the fractures are most likely to be non-accidental in origin"*

118. N was discharged from hospital on 17th July 2023. During the period of time that N spent on ward a number of different tests were undertaken in respect of N. I do not intend on repeating them here as they formed part of the overall medical picture upon which the medical experts provided their opinion and which I will set out in due course.

119. However, there are some aspects of N's observations which do require some reference:

a) 8th July 2023: a further new "bruise" observed on the back of N's left calf

b) 12th July 2023: Bruising noticed to N's wrist and had after bloods had been taken. I have been provided copies of photographs that were taken in respect of that bruising. They show extensive bruising to the wrist and hand as well as, unusually the medical evidence tells me, to the palm of the hand. Dr T told me in oral evidence that she had never seen that type of bruising to the palm caused by taking blood.

c) 12th July 2023: Further petechiae bruising observed on N's neck and chin area. A photograph has been produced of N's neck, taken that day.

d) 15th July 2023: further bruising noted after bloods having been taken. It is recorded:

> *"Note has had blood done this morning. Initial attempt in right hand. He now has multiple petechiae and bruising on his hand which are new and have appeared since the blood tests were done. There is a line of petechiae on the palmar aspect of his right wrist. There are also multiple petechiae and bruising over the dorsal aspect of right hand My impression is that these marks are consistent with the routine hold (and squeezing) that would occur during routine attempted venepuncture at this age"*

120. Whilst N remained on ward, MGA took over some responsibility for supervising N's contact on ward with M and F. There is only positive evidence in the papers in respect of how seriously MGA took her responsibility and her proven ability to supervise effectively. For example, I have considered a nursing note on 12th July 2023 to read:

"MGA is well aware of the responsibility of supervising N and M and I do not feel she would jeopardise this given how she sticks meticulously to the arrangements at present. She has said that she feels fine about M staying".

121. When N was discharged on 17th July 2023, he was discharged into the care of MGA and went to live with her and her partner.

122. An incident occurred on 19th July 2023 whilst N was in the care of MGA. There is a significant amount of evidence in the papers in respect of that incident. I have heard directly from the MGA that on that day there had been a planned fostering assessment session taking place. In anticipation, MGA had relatives at her property,

including a lady who is a social worker. The fostering assessment took place without issue, lasting around 45 minutes.

123. Shortly after the fostering assessor had left, and whilst the family members remained at the property, MGA went to fit a hearing aid to N's head, who was asleep. As she started to do so, N opened his eyes. MGA describes N's eyes having then "rolled back into his head". She described to me how it seemed that N was struggling to breath and was changing to a blue colour. MGA told me that she was in a panic as she had never seen N like that before. She told me that she handed N to a family member. She denied that in doing so she had been overly rough with N. An emergency call was made to 999, the transcript being contained in the papers, and MGA left the property to obtain a local defibrillator. When she returned to the address, emergency services had already arrived at her address.

124. As a result, N was admitted to hospital on 19th July 2023 and remained on ward overnight. It is of note that when N was reviewed on 20th July 2023, prior to discharge, the papers record:

- N has been very well through the day
- Feeding normally
- No vomiting
- No abnormal episodes
- Normal breathing
- Chest is clear
- Alert and smiling

125. The admission summary reads:

"N was brought in due to a choking episode. He was seen by a consultant and its most likely reflux that caused the episode. He had been stopped from omeprazole previously. Omeprazole has been restarted. He's otherwise well".

126. There are statements from some of those family members who were in attendance during that incident. Their accounts corroborate MGA's account of what happened. No party has sought to challenge their evidence

127. Like the earlier period of admission where MGA was supervising parental contact, no concerns are raised in respect of MGA's care for N. In fact, there are no concerns raised by any of the professionals in respect of MGA's commitment and good care of N whilst he was residing with her.

128. A follow up skeletal survey was undertaken on 21st July 2023. When that skeletal survey was reviewed by Alder Hey Children's Hospital, they additionally identified:

a) Healing fracture to 8th right rib
b) Healing fracture to right distal fibular

129. An MRI brain scan of N was performed on 27th July 2023 was also reviewed by Alder Hey Children's Hospital on 28th July 2023, who concluded:

> *"Bilateral subdural fluid collections with the larger collection along the left cerebral hemisphere. Could either be related to haemorrhage or proteinaceous fluid. Cannot be differentiated on the available sequences… Proteinaceous fluid can be related to infection and haemorrhage could be related to trauma, In absence of a medical reason or fluid collections such as intracranial infection, bilateral subdural haemorrhages need to be considered"*

130. Given the CT scan on 7th July 2023 did not indicate the presence of subdural collections, concern was raised that, other than being on ward, the only person who had care of N from 7th July to 27th July 2023, was MGA. On that basis agreement was reached that N would be placed in Local Authority foster care.

131. The LA the issued care proceedings on 7th September 2023.

Post removal to foster care

132. Before I leave the chronology, there are a few other parts of the evidence which require recital.

133. On 28th August 2023, a search was undertaken using M's phone. We know from the phone interrogation in this case that the search was:
"How do medical professionals recognise when a patient is lying about abuse not being the cause of the injury"

134. The fact of and exploration of that internet search was only touched upon briefly in M's oral evidence. She told me that she had lent her phone to one of her neighbours. M told me that it was her neighbour who made the search using her telephone. She was adamant that she had not made the search herself.

135. Both parents have been interviewed by the police on 8th August 2023. They both denied having caused any of the injuries to N. Whilst I do not intend on repeating the contents of those police interviews within this judgment, it is relevant that the mother told the police about an incident, date unknown, when she had accidentally sat on N's leg. Her description of that incident was in the context of a concern that she was raising that F *"is going to try and pin it on me"*. She told the police:

"I realised there was an incident where I sat on his leg… F had tried to deny it, that he was there, and say that he was in the kitchen, when he wasn't, because obviously N cant sit on the sofa by himself, he can't sit up… But he tried to stand there and say that it wasn't, that he wasn't there. He even said that he was in the garden all day, on the day we went to the hospital about the rashes, and he's even trying to use the working nights as an excuse".

136. Given the injuries seen to N in the context of his complex medical conditions, a professionals meeting was arranged on 9th October 2023. That professionals meeting

involved 8 specialist consultants who were engaged in N's medical care. From that professionals meeting I have noted:

a) Dr L was reporting that that the progression of the fractures could be due to repeated episodes of trauma or a gradual progression in the presence of weakened bones.
b) Dr B did not feel that further tests needed to be done to look for rare genetic conditions give the unusual presentations.
c) Dr S felt that the high-level persistent abnormalities of N's liver function tests are not something that she typically sees in congenital CMV outside of the neonatal period (older than 4 weeks of age).
d) There was agreement that there is no biochemical or radiological (bloods or X-rays) evidence that N has metabolic bone disease.
e) A specialist in haematology had been spoken to. They indicated that whilst blood tests undertaken did not show any evidence of abnormality on N's blood clotting, N did develop bruising and petechiae as an inpatient in hospital undergoing routine investigations that in a normal child, they would not expect that degree of bruising or changes in the skin. Therefore, he must have had some increased skin fragility and tendency for easy bruising during this time.

137. Since N has been in foster care there has been an update in respect of his ongoing medical issues, dated 24th July 2024. Within a letter authored by Dr A, I am told:

a) N's liver function continues to improve. I am told separately that N had a liver biopsy in January 2024 in order to understand the cause of his liver dysfunction. The persistence of liver dysfunction alongside the liver biopsy appearance and early severe jaundice, suggests that the major factor accounting for the liver disease has been the congenital CMV infection.

b) It is considered that previous incidents involving colour change and eye rolling have been caused by gastro-oesophageal reflux, rather than seizure activity, and N is being treated as such.
c) Genetic investigations are ongoing
d) His current medications are Omeprazole and pepti junior milk.

138. Whilst in foster care, there have been incidents of further petechiae bruising being observed on N:

a) On 22nd January 2024 during a hospital visit the foster carers gave a history that they "*noticed some non blanching spots on face from coughing*". When N was examined, he was considered to look well but it is recorded as part of those observations:
"*petechial spots on upper back, on front of abdomen (finer here) and around face*".

Impressions of the lay witnesses

139. As I have set out the background, I have touched upon the evidence given by the various lay witnesses. For completeness, I set out here what my general impressions were of the evidence gave. As I do so, I remind myself of the care that I must take in placing weight upon demeanour or impressions of witnesses from the witness box. These are emotionally charged proceedings and I bear in mind that individuals will respond differently when placed in the unenviable task of giving evidence before the Court. However, what follows is not just a summary of demeanour, but an overall summary of the evidence they gave as a whole.

M

140. Earlier in the proceedings I approved an assessment of M's cognitive functioning. That assessment identified specific issues in respect of M's ability in retaining information and manipulating complex information. She has also been assessed as having traits of an autistic spectrum condition, which specifiically include challenges in social communication repetitive behaviours. I had also approved the preparation

of an intermediary assessment and, on the basis of that assessment, the assistance during this hearing of an intermediary. I have been greatly assisted by the assistance of the intermediary who has assisted in the construction of questions to allow M to better understand, but also in highlighting the difficulties that M has around the use of time and timeframes.

141. Despite her own vulnerabilities, I am satisfied that M was able to participate fairly within the hearing and that she was able to give me the best evidence she could.

142. Whilst there were clearly issues in respect of timing which created obstacles in her recollection, my impression of M was that she was genuinely trying her best to assist the Court. I did not gain the impression that she was trying to evade or avoid questioning. I formed the view that when she understood the question and was given the opportunity to give a free-reign narrative, that she did so honestly.

143. However, I have been careful about the reliance that I have put on her evidence when she has responded to closed questions. As the intermediary reminded me on several occasions, M has a tendency to try to please. If she is asked a leading and closed question, her natural instinct is to agree to the assertion. That is not to mean that she is dishonest. Rather, it is an aspect of her individual makeup which I have been alive to as I have considered the way she has given her evidence.

144. In respect of the specific events surrounding 6th July 2023, as opposed to events that had arisen in the preceding weeks during a period of high stress and trauma, I found the mother particularly clear and willing to assist. I formed the impression that whilst issues of time and chronology were difficult for M, she was able to give me clear and credible evidence in respect of 6th July 2023 as that was a significantly memorable event in M's life, which had led to the current proceedings.

F

145. Unfortunately, right from the start of F's evidence, I found him to be evasive with a tendency to minimise. Those aspects appeared to be associated with any suggestion that might paint him in a negative light. For example, I do not accept that F did not know when initially questioned by the LA that he had forgotten that M was 16 when they started a relationship. The fact of the difference in their age has been a feature of the various assessments and documentation produced by professionals during and before these proceedings. In my view, that was a clear example of F trying to avoid criticism.

146. That tendency to downplay and minimise was seen elsewhere in his general evidence, for example when it was suggested that there was an ongoing dispute between he and EP when they separated. His immediate response was:

"I wouldn't say a dispute. She walked out on the children. There were no arguments with her, she could see them whenever she wanted".

147. It took counsel on behalf of the local authority to then go through the various social care and police records, before F would accept that there had been ongoing issues between he and EP.

148. Likewise, when F was asked about his tendency to accuse M of being unfaithful or looking at other men, he attempted to downplay that behaviour as reasonable by suggesting that she had told him she used to like her neighbour. I formed the impression that F was unable to recognise that his own behaviour might be unreasonable.

149. Later in this judgment I will consider evidence given by Dr L in respect of a conversation he had with the parents on 26th September 2023. During that conversation Dr L clearly describes a description being given to him, he thinks by the father, which may provide a mechanism consistent with how vertebral fractures

might be caused. Dr L told me just how clear his recollection was of that conversation, because it was such a striking and relevant account. Yet, when asked about the account, the father denied that he had ever winded N in the manner he was said to have described to Dr L. I considered Dr L's evidence on this issue to be compelling. He was clear and credible as to why he recalled the conversation so clearly. I am afraid F's continuing denial of the content of that conversation is yet another example of the F trying to avoid being framed in a negative light. The irony is that Dr L's evidence in fact assists his and M's case that those particular injuries may have occurred through normal handling.

150. I found F to be vague in respect of some of his recollections where I would have expected a sharper recollection, for example the care he provided to N on the night of 5th-6th July 2023. Yet where he gave detailed account in respect of the circumstances of the day of 6th July 2023, I found his evidence to be confusing and inconsistent.

151. I did not consider F to be a credible witness or consistent in his evidence.

MGM

152. I found MGM to be a credible and compelling witness. I found her to be forth right in her views but also reflective on the circumstances which led to N being accommodated in foster care. She was clear to me that N had regularly spent time with her, my understanding is on a weekly basis, and she had not been concerned with his presentation. I formed the view from the way she gave her evidence, that if there had of been an issue she would have raised it.

153. Her evidence came across as natural and clear. I consider that she was doing her best to assist the Court and that she was honest and genuine in the accounts she gave.

MGA

154. It was clear that MGA was nervous in the witness box. I am alive to the stress that these proceedings have brought to bear, especially in the context that she has been included as a potential perpetrator in respect of the subdural effusions. As a result, I am also alive to the fact that any stress already felt likely reached a climax when she stepped into the witness box.

155. Although MGA's evidence was not as free flowing as the MGMs evidence, I did not form the view that her short answers were an attempt to evade or avoid questioning. On those parts of her evidence which went directly to the issues, she was clear. She described how terrible the 19th July 2023 incident was and I formed the impression that what had happened that day, affected her still.

156. There was nothing in her evidence, either written or oral, which drew me away from the positive descriptions given by others in respect of her understanding of the serious task of supervision of contact. Whilst properly challenged by the Local Authority, I formed the impression that MGA really did understand what a responsibility it was.

157. Likewise, although she was properly challenged in respect of the possibility that her actions might have resulted in the subdural effusions, at some point in time, she was clear and firm in her response to me that nothing untoward had happened.

FW

158. I have dealt with my impressions of FW as part of my analysis of the evidence. I consider that FW was attempting to honestly and genuinely assist the Court. Where I have considered that aspects of her account are incorrect, it is not because I consider her to be dishonest or attempting to deceive. Rather, it is a reflection that the passage of time can cause even an honest witness to make mistakes.

The medical expert evidence

159. It is accepted by all parties that the fact of the injuries is made out on the medical evidence. There is no suggestion that the injuries observed on N, and pleaded by the Local Authority, are anything other than that identified by that evidence. That is a very straightforward starting point for me, as I can confirm that I am satisfied to the requisite standard on all I have heard, that N did suffer those individual pleaded injuries. Instead, the issue in this case and the focus of the evidence, has been around how those injuries have been caused.

160. It is not my intention to set out all of the detail provided by the expert medical witnesses, either in their written reporting or within their lengthy oral evidence. Instead, I intend on providing a summary of those aspects of their evidence which I consider relevant to the decisions I must make.

161. In the course of expert reporting and during the hearing itself, I was provided with a number of different medical research papers, dealing with different aspects associated with potential causes of the injuries seen to N. I am not a medic. The research papers are produced by medics for, in the main, use by the medical profession. This is a case where the medical evidence is already complicated and complex. It would be entirely wrong for me to attempt to use those medical research papers to try to identify an answer to N's various presentations. In fact I see a danger in the Court doing so and deflecting away from the evidence provided. In any event, it is not my function to find an answer to a complicated medical picture. My function is to establish whether the Local Authority has satisfied me to the requisite standard, that the findings sought are made out.

162. As a result, I will not in this section be delving into the minutia of the medical research papers, except in so far as it is relevant to weight that I attach to the expert medical evidence itself.

163. At the end of the evidence, I invited the parties to consider whether an agreed summary could be produced of the relevant medical positions. That was a task which could not be achieved. Instead, I was provided with documentation from different

parties setting out hospital admission chronologies, expert witness summaries and professional interactions. I can not set out those documents within this judgment; one of those documents is itself 34 pages long.

164. Instead, I indicate that I have read each one of those documents, alongside the written submissions they accompany, and have filtered those references into my overall analysis. In particular, the summary of the expert evidence, agreed by a number of parties but provided through F's representatives, has been an excellent *aide memoir*.

165. In order to assist the reading of this judgment, I am going to set out each general area of finding sought and what I have been told by the expert medical evidence in respect of that area. An experts meeting took place prior to the commencement of this hearing and a schedule of agreement/disagreement was produced as a result. That schedule has been updated and amended on behalf of the children, and I am satisfied that the contents of that schedule provides me with a structure on which to analyse the medical evidence.

166. However, before I do so, I consider it appropriate to set out what I have been told about timings of the various injuries. There has been no challenge by any party as to the timings which have been agreed as between the experts. However, I make clear that as I look at the following timings, I keep in mind that the timings are not concrete. Unless they are attached to a fixed moment in time, for example because a scan was taken on a particular day which would have shown an injury but did not, then I work on the basis that I must factor in reasonable overlaps.

167. The following table has been prepared for use within the hearing. Subject to what I have said about concrete timings and paragraph 168 below, I am satisfied that it represents an accurate reflection of the timings involved

Soft tissue scalp swelling

23 June----------7 July
Rib fractures
5 June----------11 June (r&l) 27 June ----------8 July (r 8th only)
Left fibula
10 June----------24 June
Right fibula
27 June ----------8 July
Vertebrae compressions
26 May----------11 June
Bruising / marks (in so far as possible)
26 June----------6 July
Subdural collections
7 July----------27 July

168. The only issue raised in respect of those timings is in respect of the vertebral fractures. The Court appointed expert, Dr Johnson, told me in his reporting that:

"*There are fractures of the T8, T10 and T12 vertebral bodies which, in my opinion, probably occurred some time after 26/05/23 but I cannot be any more specific with regard to the dating of these injuries.*"

169. When he looks to the various X-rays undertaken, he tells me that in the X-rays undertaken on 12th May 2023 and 26th May 2023:

"There may be a slight reduction in the vertebral body height at T8, although the appearances are equivocal"

170. Whereas when he looks at the X-rays of 11th June and 14th June 2023:

"There is loss of vertebral body height at the T8, T10 and T12 levels. In particular, there is sclerosis (increased whiteness) of the T10 vertebral body. Overall …in keeping with the presence of vertebral wedge fractures."

171. That difference may have some significance given the clinical medical evidence. In his report dated 14.11.2023 Dr K provides a summary of the professionals meeting, already referred to earlier in this judgment. Within that summary is reference to a view being expressed by consultant radiologists from the treating hospital. Having reviewed the X-rays, those radiologists had reported with hindsight:

"…that the fracture of the spine at T8 can be seen on the X-ray on 12th May 2023. A repeat X-ray was done on 26th May 2023 and was reported as normal at the time, however with hindsight, our Radiologists feel that there is an abnormality at T8 and T12."

172. That difference in view was something raised specifically with Dr Johnson when he gave oral evidence. Dr Johnson told me that he remained of the view that it was equivocal as to whether here was any vertebral fracture earlier than 26th May 2023. He went on to explain that it was the positioning of the X-ray which caused difficulty in interpreting whether there was evidence of an earlier fracture. He told me that if you were specifically looking for a vertebral fracture, you would not simply take a chest X-ray. Instead, you would take X-ray images from the front, back and side:

"*We are talking about different levels of confidence, you have to take into account that you are not doing the preferred view….chest x-ray…not the ideal view, it is not the best test to look for vertebral fractures. Sometimes, because you centre on the chest, it is like looking through a lens, there are factors that might make you focus on the wrong things in an x-ray. I accept that the bones look slightly unusual but not that they are definitely fractures*"

173. There is nothing within any of the other evidence, medical or lay, which assists me specifically in respect of that timing. In those circumstances, as I consider the

written and oral evidence, I am satisfied on balance that I am unable to proceed on the basis that the vertebral fractures were observable on those images dated 12th and 26th May 2023. To that end, I proceed on the basis of the evidence given by Dr Johnson that they were caused at some point after 26th May 2023.

174. During the course of the proceedings, I have allowed the instruction of a plethora of medical experts. I took the view at an earlier stage in these proceedings, with the assistance of the reporting from the treating clinicians, that N's medical picture was complex and that there may be elements of his existing conditions, symptoms and medications, that have relevance in respect of the determinations that the Court must make. It is rare that I would allow the scope of independent expert evidence that I have in this case. However, I remain of the view, as I did then, that all of the instructions were necessary.

175. The following experts have been instructed and have reported as independent experts:

a) Dr Johnson (consultant paediatric radiologist)
b) Dr Gupta (Haemato-Oncology consultant)
c) Dr Williams (Neuroradiologist)
d) Dr Allgrove (paediatric endocrinologist)
e) Mr Jalloh (consultant paediatric neurosurgeon)
f) Dr McKiernan (consultant paediatrician specialising in paediatric liver disease)
g) Dr Morrell (Consultant paediatrician)

176. I have also been assisted by expert evidence from Dr L (consultant in Paediatric Bone Disease: treating clinician). Dr L is a well know specialist in his field and was approached as to whether he would accept instruction as a Part 25 expert. He declined, and I have warned myself about the differences expressed in *Re F (Fact Finding Appeal)* [2019] EWCA Civ 1244 in respect of the differences between the treating clinician and the Court appointed expert. However, although I have

expressed caution in my approach, Dr L does have particular expertise in the area of bone disease and was part of the multi-disciplinary professionals meeting on 9th October 2023.

Bony injuries

177. There was a considerable amount of agreement as between the experts in respect of basic principles around the bony injuries. Both Dr Johnson and Dr Allgrove told me that fractures are not caused spontaneously. There has to be an application of external force. However, the impact of any application of external force will depend upon the strength of the particular bones. As Dr Johnson told me in his oral evidence:

"If the bone strength was only slightly reduced, fractures would be unlikely to occur just from handling. It is a question of how you measure bone strength, it is not a scale of one to ten. The force needed will depend on his bone strength"

178. Both Dr Johnson and Dr Allgrove agreed with the following propositions:

a) That N had a number of pre-disposing factors for reduced bone density, the key ones being a degree of prematurity and liver dysfunction with compromised nutritional status. Those risk factors specific to N were highlighted as being:

   i. Background inflammation (CMV infection and intermittent sepsis). In respect of the CMV I have been told CMV infection can be active or quiescent, lying dormant in the cells of the body but then reactivating for example if the immune system is compromised. I was also told by Dr Morrell that on admission on 6th July 2023, it is likely N's CMV infection was active given his positive PCR test and other blood markers.
   ii. Prematurity
   iii. Very low birth weight
   iv. Impaired nutrition (due to the prematurity and liver disease)

v. Poor neonatal progress

vi. Liver disease including cholestasis

vii. Possible period of conjugated hyperbilirubinemia[4]

b) That there can be considerable loss of bone density that remains invisible on X-ray. In Dr Johnson's evidence he put that loss at 30%, whilst Dr Allgrove told me he considered it to be up to 40%. Dr Johnson, Dr Allgrove and Dr L all agreed that radiological evidence is not determinative when considering the possibility that a child might have reduced bone strength.

c) That the "normal ranges" for bone biochemistry in blood tests are rough and ready and dependent on the population sampled and so are of limited value. That was not a view wholly shared by Dr Gupta who told me that he considered "normal ranges" to be reasonable guides that can be relied upon, although accepted that it depended on population base.

d) That in any event bone biochemistry can be "normal" even in children who have conditions disposing them to bone fragility. Both Dr Morrell also told me that an individual with normal bio-chemistry can still have fragile bones.

e) That there is no scientifically-measured direct relationship between reduced bone density and reduced bone strength

f) That it is possible, indeed likely, that N's bone strength was reduced so that his bones fractured more easily/with lesser application of force/pressure than another child without his characteristics. Dr Allgrove told me from the witness box:

"*I think that on the balance of probabilities [N] had increased bone fragility*"

[4] Dr McKiernan also agreed with the list

Dr McKiernan considered that there was likely to be some degree of abnormal bone development. However, as a specialist in paediatric liver disease, Dr McKiernan considered it unlikely N's bone density was so severely reduced by virtue of his liver disease, as to result in low impact non-traumatic fractures.

g) The degree to which N's bone strength was reduced is imponderable.

h) That nothing in the site or nature of the fractures themselves gives an indication whether they were caused accidentally or were inflicted

i) That if the court finds that N's bone strength was significantly reduced and he had relatively fragile bones, then the fractures could all have occurred from handling within reasonable limits. If the court finds his bone strength reduced, but only just slightly reduced, then the fractures still require significant excess force to cause them.

j) That it is for the Court to determine whether N's fractures occurred in the context of "normal" handling or whether in the context of abnormal/inappropriate/rough handling

k) That the fact N suffered no further (known) fractures after his removal to foster care does not assist the experts to identify the cause of the fractures.

179. Dr Johnson reports that:

a) the fibula fractures are each as a result of a blow, impact or bending snapping action applied to the leg, however the radiological appearances are non-specific for mechanism.
b) The rib fractures would have been caused by an application of force or pressure. Dr Allgrove makes it clear that rib fracture require force and are never spontaneous.

c) The vertebral fractures involved severe overbending/flexing of the spine or severe loading compression of the spine

180. During the oral evidence, a number of additional risk factors to those set out at paragraph 178(a) above, were explored with Dr Allgrove. Dr Allgrove told me that other "factor[s] in the jigsaw" which might have an influence on bone strength were:

a) N's prescription for Omeprazole
b) N's Vitamin K levels
c) N's immobility during his stays at hospital.

181. In his evidence to me, Dr Allgrove emphasised that each factor alone could not explain reduced bone density/strength. Rather, it was the combination of factors which would contribute to a greater or lesser degree to N having a degree of bony fragility and that the contribution of each factor may change over time.

182. Although there was agreement, set out at para 178(b) above in respect of weak bones not necessarily being visible on X-ray, I was told by Dr Allgrove that, in any event, he considered that some of N's bones on X-ray appeared to be "*thinner*" than he would have expected. He explained that if they are thinner, that can occur as a result of either an issue with mineralisation as they grow, or demineralisation. However, Dr Johnson disagreed with Dr Allgrove and told me that he considered that the bones looked "normal on X-ray. Dr Allgrove was specifically asked about his view in light of Dr Johnson's opinion. He told me:

"*Dr Johnson is an expert radiologist and has seen far more x-rays than I have. Looking at bone density on x-rays is somewhat a subjective matter, it is not possible to be precise unless there is pretty obvious case. In cases where it is intermediate ….it would be difficult to tell precisely whether there is demineralisation or not. Dr Johnson has seen far more x-rays, I view them as a clinician not as a radiologist and I*

just thought they looked a bit thinner than normal but in the end I think we have to take the opinion of Dr Johnson because he is the radiologist"

183. I was told that there was no way that the medical picture could tell me the degree to which N's bones were likely to have reduced in strength However, Dr Allgrove and Dr Morrell agreed with the suggestion that the Court could look at clinical presentations and descriptions of handling, such as the admission on 12th May 2023, when considering the degree of bone fragility.

184. Dr L, Dr Allgrove and Dr Johnson all agreed that a mechanism of accidentally sitting on N's leg, as described by M, might cause a fracture. Especially if there was an element of bone fragility.

185. Specifically in respect of the vertebral fractures, I was told that these types of injury require significant force. Dr Allgrove told me:

"Vertebral fractures can occur in normal bones with excessive force such as road accidents. In the example of inflicted injury they can occur but with severe force being applied, the force would not need to be as great with weakened bones. ....
....."vertebral fractures are not common in inflicted injury but they do occur. Most of the patients I see with vertebral fractures have secondary osteoporosis; we do occasionally see children with vertebral fractures in inflicted injury....
I think it is possible that he has got reduced bone density and so vertebral fractures may be related to that....he still needs to have some incident to cause them but in the context of reduced bone density it would have required some sort of force to produce them....
[bending N forward on a surface to wind him] could be a mechanism for vertebral fractures in the context of reduced bone density but not with normal bones."

186. Dr Allgrove did not move from his opinion in his reporting that:

"Vertebral fractures, whilst recorded in deliberate injury cases, are rare and would usually require considerable downward force or hyperflexion of the spine. The presence of vertebral fractures is more consistent with reduced bone density".

187. However, during cross examination he went on to accept that if normal winding had caused the vertebral fractures, then it would indicate that N had severely impaired bone density. It is not clear to me what was meant by "severely" impaired.

188. Dr Johnson told me that vertebral fractures arise in inflicted injury and in accidental injury:

"They arise rarely in children with weakened bones; but it is rare that children have weakened bones. There are probably more films available of children with inflicted injury than there are of children with weakened bones"

189. Dr Johnson did not feel able extrapolate as to whether the vertebral fractures are more likely to be inflicted or not. To do so would, he told me, would not be scientific.

190. Following on from the identification of the various bony injuries, the local treating team asked Dr L to consult on the case. He told me that the local clinical team asked him for help in identifying whether here was any underlying bone disease. As part of that assistance, Dr L met with the parents on 26th September 2023. During that meeting Dr L recalls that one of the parents, he thinks the father, described to him a way that he would wind N. That description involved sitting N on a hard surface, in a flexed posture holding N bent forward.

191. Dr L told me that the description was striking to him because it could be a mechanism which might account for the vertebra fractures. In his oral evidence, Dr L told me:

"It was a reasonably comprehensive account. I remember it most clearly. That description was in no way related to a conversation about fractures. It struck me that I was being told about a potential flexion of spine. I am very confident that I don't think the parent telling me grasped that they were describing a mechanism whereby the fractures could have occurred".

Blood tests and bruising

192. Dr Gupta's evidence in respect of the blood testing can be summarised as follows:

a) That N did not have any inherent coagulopathy save for in his first two days of life

b) After that, his coagulopathy was related to his inability to absorb Vitamin K through an oral route. As soon as he received Vitamin K parenterally/not orally, his coagulopathy resolved.

c) Dr Gupta's analysis of blood results shows that N's results had normalised during June 2023.

d) There is no evidence that N was coagulopathic on 5th, 6th, 7th or 10th July 2023.

e) Platelet dysfunction could explain easier bruising. Platelet dysfunction can exist in the face of a normal platelet count, but it is too difficult to test for platelet dysfunction. Dr McKiernan added to this area of evidence by accepting that some research papers indicate that platelet dysfunction can occur in liver disease. However: "*in clinical practice,….bleeding in liver disease occurs with low platelet count…..in clinical practice we don't see bleeding problems unless there are low platelet counts or coagulation problems*".

193. In summary, Dr Morrell told me

a) the photographic evidence of bruising to N's hand on 12th July 2023 after blood testing led him to think it probable N had some vascular fragility not related to coagulopathy; and that although force would still have been required to produce bruising, it was probably less than in a child with normal vascular integrity:

"*I was struck when going through the medical records by the bruising caused when N had blood tests, around his wrist and on his hand. The pictures showed quite significant bruising, more than I would have expected, to me that indicated that there may be some degree of vascular fragility, whether that is vasculitis, I don't know*"

b) Although it had been originally opined that there was a theoretical possibility that CMV may cause vasculitis through inflammation of the blood vessels, that opinion shifted once relevant medical research papers had been considered. Although the cases seemed uncommon, Dr Morrell accepted that it is possible that N may have suffered vasculitis because of his CMV infection

c) The likely mechanism for most of the bruises present on 6th July 2023 was N being gripped tightly with the fingers and the thumb, based upon the configuration of the linear-type bruising.

d) In respect of the specific bruising:

i. Bruising to bottom: most likely mechanism is gripping or alternatively impact to it or from being put down heavily.
ii. Petechiae bruising to armpits: could arise from picking a child up under the armpits with too much pressure
iii. Right knee: the sort of mark caused by gripping with two fingers
iv. Other marks/bruising: pinching or gripping type mechanism

194. Dr Morrell was of the view that despite any vascular fragility, the level of force used to cause those injuries would be significantly more than that normally used. He

agreed with the use of the words "excessive force". He was challenged on that opinion in cross examination. I have recorded this exchange:

Q: So it wouldn't necessarily need to be rough handling that caused the marks, it might just have been picking up the child and holding them firmly, rather than being rough, overly rough?
A: No, I don't think so, that wasn't observed with N, he was admitted to hospital with the bruising, if that were the case you would expect more bruising to occur when staff were picking him up, changing him etc. The only bruising noted in hospital were those caused when taking blood samples…"

"*My opinion is that you would need more pressure than picking them up firmly. That is an opinion, I think it is quite difficult to measure the pressure needed but in my view it would be more than simply picking the child up*"

195. In terms of the variability of any vascular fragility, Dr Morrell told me:

"If there is a disturbance in vascular integrity it can vary over time as to its extent. Variability won't take place over days, it won't vary from day to day"

196. In cross examination on behalf of F, Dr Morrell was taken to other instances of bruising recorded within the papers beyond that seen on 12th July 2024. I have recorded those instances already within the background that I have set out. For the main, they include petechiae bruising seen during admission and post removal to foster care. In general terms, Dr Morrell told me that it is not uncommon for a baby to have a few petechial bruises over their body. They can be associated with passing virus or, when around the head area, from coughing.

197. When challenged about the fact that N had presented with petechiae bruising prior to admission on 7th July 2023, during that admission and post admission whilst in foster care, Dr Morrell told me:

"*My position is that, there is some disturbance of vascular integrity which would make N more susceptible to bruising*"

198. What Dr Morrell could not say, is exactly how that impacts upon N as it is not possible to measure the degree of vascular integrity or, therefore, the force required to impact that integrity.

199. Whilst Dr Morrell accepted that there had been other instances of bruising seen in hospital, mostly petechiae bruising, he maintained that a difference had to be drawn between handling in hospital, such as holding of wrists for blood to be drawn, application of masks to assist breathing and holding of head still, to what would be expected in a normal domestic setting. He told me that that "normal handling" is subjective to the circumstances:

"The relevance is the amount of force required, if you take blood from a child you do need to squeeze the relevant limb with some degree of force, difficult to define but I would suggest sufficient to make the blood vessels stand out to be seen but not to cause the baby any pain. This is reasonable in hospital but you wouldn't use that sort of force just handling the baby in the normal fashion"

200. Despite robust cross examination on behalf of both M and F, Dr Morrell maintained his position that the specific bruising seen to N on admission on 7th July 2023 was as a result of rough or inappropriate handling, despite N suffering from a degree of vascular fragility.

Soft tissue scalp swelling

201. All of the relevant medical experts agreed that the scalp swelling required some type of impact to have occurred. Dr Morrell suggested that it might also have been caused by a squeezing mechanism.

202. Dr Williams opined:

The soft tissue swelling might be a child knocking its head against the side of a cot but it is more typical of more forceful injury than an everyday event. We see children all the time, children have fairly minor trauma pretty regularly, a child having an injury from a football for example would not cause an injury like that, it is different when a child falls down the stairs or a heavy impact is imposed. Soft tissue swellings are often missed, they are beneath the skin and may not be recognisable in a clinical setting, there is a difference in the evidence that can be seen in radiology."

203. However, Dr Williams told me that the degree of force cannot be determined from the degree of swelling. In essence, from a radiological perspective, he could only say that there was swelling and that some sort of force must have caused the swelling.

204. For his part, Mr Jalloh told me that a propensity for easier bruising could be relevant to the question of scalp swelling.

205. Having accepted in his oral evidence that there was now a possibility that N may have been suffering from CMV related vasculitis, he applied that opinion to the issue of the soft tissue swelling. However, Dr Morrell told me that he found it:

"*difficult to understand why with vascular fragility there wasn't any bruising; I do have some concerns about scalp swelling…..if the scalp swelling was secondary to vascular fragility I would expect to see some bruising. I am concerned that the scalp swelling was caused by an impact injury*".

206. However, he went on to tell me that if there is a tendency for easy bruising, then it may well link to the swelling seen on N. He noted that none of the clinicians had seen any bruising or reddening on presentation; it was only discovered through the CT scan. He told me:

"It is possible the event that caused it may not be one where the carer would think it would result in a swelling or injury. Given the swelling was not picked up clinically, then a parent would not pick up on it"

Subdural effusions

207. As recorded within the schedule of agreement/disagreement, arising from the experts meeting on 1st August 2024, there had been some broad areas of agreement and disagreement prior to the commencement of the hearing. I set them out before looking at whether and how those views changed during the oral evidence.

208. Mr Jalloh and Dr Williams:

(i) The two possible explanations for collections seen in N's brain are:
   (a) Traumatic (accidental or inflicted) or
   (b) Non-traumatic, possibly related to CMV; or (per Mr Jalloh) an unknown inflammatory cause that might include vasculitis.

(ii) The evidence on earlier ultrasound and MRI of intraventricular bleeding, probably related to prematurity, is not related to the bilateral subdural collections seen on MRI on 27 July 2023

(iii) To examine the possibility of a non-traumatic cause such as infection, there is a need to marry up the clinical data to see if there is evidence of ongoing, active intra-cranial infection since that is the way such cases generally present.

(iv) Usually children presenting with infection-related effusions are in hospital and are septic. In his oral evidence Dr Jalloh clarified that he did not agree with that entire general proposition. He told me: "*I agree that the vast majority of infants with meningitis associated with a subdural effusion it is diagnosed usually when they are an inpatient on intravenous antibiotics but not always septic, by that I mean compromised blood pressure and heart rate from the infection*".

(v) There is no evidence on N's scans of frank bleeding in the subdural collections

(vi) There is no history provided of accidental cause or resuscitative shaking

209. Dr Williams:

(i) N's effusions did not evolve in the context of loss of brain volume as a result of infection.

(ii) The effusions developed between 7th and 27th July but nothing else changed for N in terms of brain volume or visible brain damage.

(iii) The two case reports produced by Mr Jalloh did not clarify whether subdural collections were due to CMV itself, or coagulopathy, and did not provide a clear link.

(iv) Subdural collections in the context of vasculitis are considered rare, although they can occur

(v) We should bear in mind it is not known whether there is a real or theoretical connection between CMV and vasculitis

(vi) The collections *could* be the consequence of vasculitis, but that would (a) be a rare complication of vasculitis; and (b) rare in association with CMV.

210. Mr Jalloh:

(i) CMV is (he understood) one of the commonest congenital infections;

(ii) However, he could find only two case reports relating to CMV and subdural effusions.

(iii) It is not well understood how subdural effusions form in infection, but it is probably inflammatory-related.

211. During the oral evidence, it became clear that there were two clear differences in the views expressed by Dr Williams and Mr Jalloh.

212. Having considered, and produced, a small number of medical research papers in respect of a suggested association between CMV and subdural effusions, Mr Jalloh maintained his view that the subdural effusions could have either been caused by a traumatic event, or by an inflammatory process related to the CMV infection. He accepted that the medical research papers were scarce in respect of any CMV related association. He told me:

"*the evidence is that it is possible that CMV infection, inflammation might cause a subdural effusion…* but i*f it is possible it is likely to be a rare association, on the basis that Dr Williams hasn't seen it and I have only found 2 infants in the case report….In my opinion there is a possible association but if it does exist it clearly doesn't happen a lot….*

213. Mr Jalloh accepted that the "*lack of lots and lots of reports reduces the likelihood of the association*".

214. However, Mr Jalloh told me that the whole picture, in terms of what N was presenting with, had to be considered. Looking at the picture as a whole, he could not prefer one cause over the other. The following extract of his oral evidence best sets out his position:

"The subdural effusion in N's case is relatively small, it is not associated with frank coverage[5]*, it is not associated with any likely traumatic injury to the brain or brain substance itself. I have discussed how subdural effusions complicate infections due to the inflammatory process. The likelihood of that occurring with CMV is not something I can not help the court with other than direct them to the two papers where others have made the association. In my opinion it is conceivable that the effusion is relative to the inflammatory process related to the CMV infection. It is also possible that it is a traumatic subdural effusion. I am not able to distinguish between the two differential factors on a basis of the subdural effusion alone".*

[5] Fresh blood

215. As can be seen from the quote above, Dr Jalloh was only able to provide an opinion on the basis of the existence of the relatively small subdural effusions alone. The absence of any other symptomology, commonly associated with traumatic events, was explored with both Mr Jalloh and Dr Morrell. Both accepted that the absence of the following factors normally associated with traumatic injury ought to form part of the Court's overall analysis:

a) No evidence of encephalopathy
b) No hypoxic Ischaemic injury
c) No damage to the tissue of the brain
d) No spinal bleeding
e) No retinal haemorrhages
f) No metaphyseal fractures
g) No rib fractures within the same time frame as the subdural effusions.
h) No bruising.

216. Looking at the subdural effusions in that context, Dr Jalloh told me:

"Given the absence of other traumatic features in the brain, I find it difficult to stratify, to prefer one possibility over the other".

217. Dr Williams took a different view. He told me that CMV is the most common congenital infection in babies, but it is not generally associated with subdural effusions. Dr Williams said he considered that subdural effusions were a rare complication of CMV but that there did not appear to be any clear association between subdural effusions and CMV infection:

"…there is no known association between congenital CMV and subdural effusions. Mr Jalloh has said that if there is an association it is very rare. CMV is very usual, subdural effusions are not considered a usual finding in congenital CMV…..there is no clear association".

"*The evidence [of a couple of case reports produced by Mr Jalloh] is not sufficient to say that there is an association… The cases he cites are specific and there are other factors… Cases need to be judged very critically particularly when we have a large body of evidence that doesn't support an association….we don't know what the cause was in these very rare instances, each had haematological abnormalities that may have contributed. The weight of evidence shows that these children don't have subdural effusions*"

218. When challenged on behalf of MGA, Dr Williams responded:

"*It is difficult to rule out theoretical CMV (as a possible cause for the subdural collections), the question is how likely is it that any vasculitis might cause subdural effusions. I would contend that it is an unusual explanation for a theoretical possibility. The hypothesis is a potential explanation but although I can't exclude it. I would suggest that it is an unlikely explanation*".

219. Instead, Dr Williams was clear to me that his opinion was that the subdural effusions were caused by trauma:

"*The most likely reason for the subdural collections is a traumatic injury, a shaking type event…..what evidence would I have to say this is due to CMV….the answer is none, what we are left with is multifocal subdural effusions between 7th and 27th July and the most likely reason in my view is trauma*".

220. Dr Morrell had the benefit of coming at the end of the other medical expert evidence and considering all that had been said before, as well as being able to consider the various pieces of medical literature that had been produced during the hearing. When asked what the Court was to make of the two different expert views, one that there is no clinical evidence and the other that there appears to be isolated examples, Dr Morrell said:

"It is very difficult. I suppose what the Court can take from the experience of Dr Williams and Dr Jalloh, is that the risk of the [subdural effusions] being caused by a CMV association, is quite low. The evidence base is quite small. Looking at the research papers it is possible that they [subdural effusions] may be caused by something secondary to CMV infection, or it may be due to inflicted injury. The level of evidence is not great to decide one way or the other"

221. Referring back to his earlier oral evidence in respect of vascular fragility generally, Dr Morrell told me:

"From what I can understand, it is plausible that N did have some degree of vascular vulnerability. There is no proving that, but it is likely that there was some disturbance of the vascular structure. The problem is that there is no way of telling how that affects N. I think it is reasonable to suggest that there is some disturbance and that then increases his vulnerability to bleeding in various places, including brain".

222. To conclude in respect of Dr Morrell's evidence, it is worth repeating what he said within his substantive report in respect of the injuries as a whole:

"Finally, it is possible that N does have some vulnerabilities, partly as a result of the CMV infection (including a vascular fragility and the liver disease) and partly due to other factors such as prematurity and poor nutrition, and this has caused a degree of fragility of bony and vascular integrity which has made him vulnerable to certain injuries at a lower force than what would be expected in a child of his age…".

Parties positions

223. At the end of the evidence I have had the opportunity of receiving detailed written submission prepared by each party. Having received those written submissions, I have also allowed additional supplemental oral submission to be made. Although some additional submissions were made orally, I am grateful to the

succinct way that the parties used that opportunity, rather than rehearsing what was clearly set out within their written documents.

224. What follows is not a regurgitation of those written documents and supplemental submissions. To simply repeat the contents of the written documents would be to cause an already lengthy judgment to considerably balloon in size. Rather, I intend to distil the principal arguments set out by each party.

Local Authority

225. Having only slightly amended the findings it seeks, the local authority invites me to the view that, having heard all of the medical and lay evidence, I can be satisfied that the findings are made out to the requisite standard. In general terms, the local authority submits that I can be satisfied that the injuries to N have been inflicted, at the very least as a result of rough handling.

226. The local authority accepts that the medical picture for N is complex. Prior to the commencement of the hearing, a schedule had been drawn up following the experts meeting, where areas of agreement and disagreement had been set out. Following the evidence that schedule was updated by counsel on behalf of the children. I understand that document to be agreed as an accurate reflection of where the various pieces of expert evidence finally settled, albeit each party highlights particular aspects of it to me. I attach it as Annex A to this judgment.

227. It is the local authority's overall position that the medical evidence did not shift to any great extent as between the two schedules. In their submissions, the Local Authority suggests that the medical evidence can be broadly summarised as such:

a) CMV infection can in rare examples be associated with Vasculitis, which is a form of vascular fragility.

b) Even in the event of vascular fragility, a degree of force was required to cause the bruising seen on 6 July 2023
c) Any vascular fragility is relevant to the soft tissue swelling and potentially the subdural effusions
d) In the context of vascular fragility, impact or gripping would still be required to cause the swelling
e) It is likely that N has a form of bony fragility
f) The medical evidence cannot assist with the extent of the fragility, and that remains a matter for the Court taking into account all of the wider evidence.

228. In respect of para 227(f), whilst accepting that there are factors in N's presentation which may predispose him to fragility, the local authority reminds me that even if a child has weakened bones, that does not preclude the possibility that they have suffered inflicted injury.

229. That is a submission which is repeated not only in respect of bony fragility, but also vascular fragility. And, say the local authority, even if I am not satisfied that an individual has intentionally inflicted an injury of N, that does not exclude rough handling as a cause of some, or all, of the injuries.

230. The local authority say that I must take care to consider what each medical expert says, but that I must not be blinkered by the medical evidence alone. Rather, I must consider the wide canvas of evidence, of which the medical evidence is but one part.

231. To that end, the local authority submits that I can consider the evidence of the stressors that were operating within the family home at the time, as part of my overall analysis. The local authority points to the following:

a) N's birth and the immediate aftermath had been particularly traumatic.
b) The care of N, with the ongoing medical issues he had, would have placed stress on any care giver

c) There is a background of volatility, mental health concerns, cognitive difficulties and immaturity on behalf of M.
d) There is evidence of unusual text messages being sent by M and web searches being made on M's phone, which suggest both volatility and an intention to mislead professionals.
e) There is evidence of controlling behaviour being exhibited by F in his relationship with M and annoyance when he had woken to tend to N, but the mother had not.

232. The local authority says that when I look at the evidence of M and F, there are aspects of that evidence which should cause the Court concern. They say that there are inconsistencies as between the accounts of M and F, and internally. They invite me to the view that F has attempted to minimise not only the stress of caring for N, but also his involvement and knowledge during relevant period of time.

233. I have set out in the background to this case the stressors which I have identified and I will consider them further in my analysis.

234. The subdural effusions were caused at a time when MGA was caring for N. The Local Authority accept that the evidence, in particular during her supervision of the parents whilst in hospital, suggests that MGA seemed to take those responsibilities seriously. If I accept MGA's evidence that at no point did she leave N unsupervised with the parents, then the Local Authority say that if the Court determines the subdural effusions to be inflicted, then they must have been inflicted by MGA. The Local Authority readily accepts that it would be unusual for a child to be abused by two different sets of carer, but that does not prevent me from making such a finding if that is where the evidence leads me. I am reminded that if I find that one or both of the parents inflicted the other injuries, that does not mean that they inflicted the subdural effusions.

<u>The mother</u>

235. Those on behalf of M draw my attention to the particular features of M's personality, her vulnerabilities and openness during her evidence.

236. It is accepted that there were particular stressors within the home following N's birth, both emotionally and financially. I am specifically referred to the evidence given by the mother that the traumatic nature of N's birth and the various interventions that then followed, were described my M as still causing her flashbacks and nightmares.

237. However, despite concerns being raised within the evidence in respect of the relationship between M and F, I am invited to exercise caution as I consider those dynamics, and home stressors more generally, as supportive of a suggestion that the mother inflicted injuries on N. Instead, it is submitted that M has been open and honest in her evidence, which has been free-flowing and credible, despite the cognitive difficulties she has and the support she has required to properly participate.

238. I am invited to the view that whilst I have heard evidence from professionals and family members of frequent mishandling of N, for example by not properly supporting his head, the overall picture of M is of a loving, caring and gentle mother. A mother who, far from being rough or inappropriate in her handling of N, was rather described by the MGM as lacking confidence in handling, of being frightened to do so, and seeking reassurance on a regular basis.

239. It is submitted on behalf of M that I must start any analysis by looking at what risk factors existed for N, leading up to and including the point of his injuries. It is submitted that not to do so would be to clearly fail to understand the complex context of his own medical difficulties. I am invited to the view that the outcome of the medical evidence points to a number of risk factors which must be considered as "part of the jigsaw" of the wider picture. It is submitted that those risk factors specific to N and relevant to the medical picture when the injuries were discovered are as follows:

a. Prematurity
b. Restricted intrauterine growth
c. Very low birth weight
d. Impaired/poor nutrition (leading to periods of TPN[6] and/or NGT[7] feeding)
e. TPN feeding
f. Poor neonatal progress
g. Conjugated hyperbilirubinemia
h. Congenital CMV infection
i. Neutropenia
j. Intercurrent illnesses such as sepsis, bronchiolitis, para-influenzae, bleeding
k. Background inflammation
l. Respiratory problems
m. Liver disease including cholestasis which did not resolve until early July
n. Lack of absorption of Vitamin K requiring treatment
o. Likely problems with absorption of Vitamin D and A and other nutrients due to liver dysfunction.
p. Lack of mobility
q. Omeprazole use

240. It is not submitted that those risk factors taken alone would have resulted in the injuries seen to N. But rather, that it is the cumulative effect of those risk factors which must be considered. For example, I am reminded that the medical expert evidence seems to agree that as a result of those risk factors N is likely to have reduced bone density, impacting upon the fragility or strength of his bones. The question, not able to be answered by all of the medical evidence, is the extent of N's bone fragility. Indeed, as already outlined, the degree of that reduced bone strength is described in the medical evidence as being "imponderable".

241. I am asked to consider that N was a very "visible" child during the relevant time frame. This is a child who was being seen by health professionals on a regular basis,

[6] Total parenteral nutrition: feeding that provides nutrition directly into bloodstream through a vein
[7] Naso Gastric Tube: feeding that provides nutrition by tube through the nose to the stomach

and significantly because the parents were bringing N to see health professionals because of their own concerns. It is submitted that there is no evidence to suggest that N was being hidden away, rather the opposite is true. That also has a bearing in respect of whether any of those regularly seen professionals raised any concern themselves prior to 7th July 2023. It is submitted that they did not. There is no evidence to suggest that N was seen with bruising or pain responses which might have been indicative of abuse or of the underlying bony injuries the medical evidence tells me that he had during that time frame. Indeed, I am reminded on behalf of the mother that some of the timeframes associated with the point of injury, include times when N was an inpatient.

242. Having taken the Court through the various relevant parts of the medical evidence, already highlighted as part of my analysis of the medical evidence where I consider relevant, it is submitted that when I consider the totality of the evidence, lay and expert, even if there had of been an event which caused any of the injuries, that event/s could have been caused by "normal handling". To that end, it is submitted that the Local Authority have not discharged their burden of proof in respect of the injuries having been inflicted[8].

<u>The father</u>

243. Like the mother, it is submitted on behalf of the father that it is critical that the Court considers N's medical history and presentations, in the context of the injuries. I am specifically reminded that nearly all experts accepted, when the proposition was put to them on behalf of counsel for the father that:

"Every case is unique when you get to this level of complexity"

244. I am drawn to consider that the medical evidence as a whole indicates a consensus that N had reduced bone and vascular integrity. It is submitted that I can accept that principle on the basis of the expert evidence I have before me. If that is right, the real question for me is the extent of both the bone and vascular fragility. It

[8] Either "intentionally" or through "rough" or "clumsy" handling.

is a question that all of the experts are unable to answer. It is submitted that whilst it is right that the medics put the question back to the Court as the determinator of fact, great caution must be taken by the Court in attempting to answer a medical question, which the medical experts are themselves unable to answer.

245. The father repeats many of the submissions made by the mother in respect of the analysis of the medical evidence how the inherent medical issues and risk factors that N is already vulnerable to, interacts with the potential for causation of the injuries seen. There is a danger, submits counsel, that because these types of injuries are commonly seen in infliction cases, that a focus on that commonality obscures my consideration of these injuries having been caused in an uncommon, or rare, set of circumstances.

246. I must take great care, it is submitted, not to reverse the burden of proof. It is not for the parents to prove that any bone or vascular fragility was so significant that normal handling might cause injury. Rather it is for the local authority to prove that the injuries were inflicted, or through rough handling. In a case where the medical evidence is unable to provide an answer as to the degree of bone or vascular fragility, it is submitted the burden is on the local authority to prove that any handling was therefore inflicted or rough in nature.

247. I am specifically invited to approach the evidence of Dr Morrell in respect of the bruising, with some caution. I am asked to consider that Dr Morell was on one hand indicating that he was unable to identify the degree of likely vascular fragility and the force therefore required to cause bruising as seen on N. However, he was then able to say that the bruising that N presented with on 6th July 2023 was as a result of rough or inappropriate handling. I was warned against the possibility of confirmation bias within Dr Morrell's evidence, especially once other instances of bruising had been identified.

248. Like the mother, it is submitted that N could not be described as "hidden" and that when I consider the wider evidence, I can in fact determine the opposite. N is a

child, it is said, who was being regularly presented at hospital because of concerns being raised by the parents. That evidence suggests that far from being abusive to N, these were parents who were loving, caring and who wanted him to be seen by professionals to advance his well-being.

249. I am cautioned against placing too much reliance on any evidence as to the age gap between the parents, the suggestions of controlling behaviour on behalf of the father, or the stress factors involved of caring for a small very unwell child. Whilst they are stress factors, it does not follow that these parents are more likely to inflict any of the injuries on N.

250. Having set out in detail within their written submissions the medical evidence to which I have already referred, and the uncertainty arising from it, it is submitted that when I stand back and look at the injuries in light of both the medical expert and lay evidence:

> *"…the local authority has fallen significantly short of proving its case against the parents. Its case lacks the foundational support of the expert evidence, is inconsistent with the direct evidence of those present and caring for N and draws heavily upon speculation, assumption, worries and concerns rather than fact and evidence".*

<u>The MGA</u>

251. The finding sought against the MGA relate solely to the subdural effusions. Like the parents, the fact of the subdural effusions is accepted. It is causation which has been the focus.

252. On behalf of the intervenor I am invited to undertake a global analysis of the evidence and consider:

a) That MGA was clear and consistent in her evidence

b) That the Court can accept that the MGA took her role as supervisor of N and the parents contact seriously; that she understood how important that supervision was.

c) That I can be satisfied that there was no time when MGA allowed M or F to have even a short period of unsupervised contact.

d) That there is nothing in the wider canvass of evidence to suggest that MGA was susceptible to lose control or respond inappropriately to N.

e) That, beyond the fact of what have been described as small subdural effusions, there are no other indicators of trauma or of a shaking type event.

f) That Dr Jalloh who had produced papers in respect of CMV related vasculitis, was unable to prefer a shaking episode over a CMV related cause:

> *"In my opinion it is conceivable that the effusion is relative to the inflammatory process related to the CMV infection. It is also possible that it is a traumatic subdural effusion. I am not able to distinguish between the two differential factors on a basis of the subdural effusion alone… Given the absence of other traumatic features in the brain, I find it difficult to stratify, to prefer one possibility over the other".*

g) That out of the 4 medical experts who considered themselves able to comment on the issue[9], it was only Dr Williams who was willing to say that it was more likely than not that the subdural effusions were as a result of a shaking incident.

h) That I must take care in the weight I attach to Dr William's opinion because:

   i. Dr Williams, as a paediatric radiologist has a particular skill set in reading and analysing scans

   ii. That it seems that Dr William's opinion seems to be based upon CMV related vasculitis being a theoretical possibility

   iii. That the research papers produced by Dr Jalloh and subsequently by the parties, suggests that, although rare, it is more than a theoretical possibility

[9] Dr Gupta, Dr Williams, Mr Jalloh and Dr Morrell

253. When I consider all of the evidence as a whole, I am invited to the view that the subdural collections, without frank blood, without any indicator of shaking, in a catalogue of CMV related symptoms, is more likely to have been due to the underlying CMV and resulting vascular fragility/vasculitis. As I consider that submission I remind myself again that it is not for the intervenor to prove that the subdural effusions were CMV related, but rather it is for the Local Authority to prove that they resulted from infliction or rough handling.

254. To that end, it is submitted that the local authority has not discharged its burden in proving the allegation as against MGA.

Children's Guardian

255. I have been greatly assisted by the robust way that those representing the Children's Guardian have approached this case. Too often in fact finding hearings, the Court is often not assisted by a position of neutrality adopted on a child's behalf. That has not happened in this case. Quite properly, those representing the Guardian have sought to understand the basis for the opinions derived from the medical expert evidence and have robustly challenged any inconsistencies within the evidence as a whole. I see that as an entirely proper way of ensuring that the Court has all of the best and relevant evidence before it when considering findings that directly relate to significant harm that N may have been caused.

256. I am reminded that there is no dispute in respect of the existence of the various injuries referred to within the local Authority's schedule of findings. The real issue in this case is as to whether a combination of factors relevant to N:

a) Have caused, or materially contributed to any one of N's injuries; and if so
b) To what degree.

257. The difficulty in determining those issues is, as set out within their written submissions:

> *"The real complexity in this case stems from the attempt to answer each of these questions on the basis of expert evidence grounded in clinical experience and current research".*

258. But I am reminded that the expert medical evidence is only one part of the picture and that I must look to all of the evidence in this case to assist me in my determinations. To that end the Guardian raises the following points:

a) There were stress factors within the home: difficulties in the parental and wider family relationships, overcrowded living arrangements, financial difficulties, M's poor mental health and her feelings of being overwhelmed in the care of a vulnerable a baby with complex medical needs.
b) N had complex needs which of itself, would have been stressful and very difficult for the parents.
c) There were inconsistencies in the evidence of M and F, both internally, but also in respect of their own separate accounts.
d) There is clear conflict as between the evidence of FW and both parents as to her visit on 6th July 2023
e) There is conflict as between what Dr L reports the parents telling him about winding and what F and M then said from the witness box[10]
f) There was a delay in seeking medical attention for N on the morning of 6th July 2024.
g) Dr Morrell has opined that even if there were vascular fragility, to cause the bruising/marks seen on N on 6th July 2023 would have required force above normal handling
h) Whilst the medical experts agreed that, on balance, N had increased bone fragility:

[10] In connection with the described mechanism of winding potentially creating the types of forces that might cause vertebral fracture.

i. Some level of force was still required as bones do not fracture spontaneously
ii. All experts agreed that they were unable to quantify the extent of N's bone fragility
iii. It was a matter for the Court to determine whether the fractures could have been caused by normal handling, as opposed to rough or inappropriate handling.
iv. The Court can rely on previous clinical presentations and descriptions of traumatic handling, such as the incident on 11th May 2023, which did not cause fractures
v. The incident on 11th May 2023 can provide a "benchmark" as to what level of bone fragility N might have had at the time.

i) There are different views from the relevant experts in respect of the likelihood of the subdural effusions having been caused by a shaking type incident. It is suggested that the incident on 19th July 2023 may be a red herring, and that the court is left with no clear understanding as to when the subdural effusions arose following the scan on 7th July 2023.

Analysis

259. At the start of this judgment, I indicated that I do not apologise for it's length. As I near the end, that remains my position. This is not a case that involves a single injury within a relatively short time frame. Instead, this is a case involving multiple injuries over an extended time-frame in the context of ongoing and relevant underlying health issues.

260. Added to that already complex picture is expert medical evidence which identifies vulnerabilities, be they bony or vascular fragility, without being able to assist as to extent of that respective fragility and therefore the force required to cause the injures seen.

261. In those circumstances this is a good example of the need for the Court to stand back and consider the wider evidential picture, not compartmentalising the medical evidence but interweaving it into the other factual evidence. It is only then that a complete picture can be considered.

Subdural effusions

262. I start with the subdural effusions. The medical evidence is clear that they were caused at some point between 7th July 2023, when N was still on ward, and 27th July 2023 when the MRI scan was undertaken. During that time, there is no evidence of any unusual event beyond the admission on 19th July 2023. That admission took place as a result of a well witnessed event which appears on the medical evidence to be accepted as having been caused by reflux. Whilst Dr Morrell indicated that the description provided of N, with eyes rolling back and change of colour, may be interpreted as encephalopathic, there is absolutely no other evidence to suggest that the episode followed any traumatic event. What has been described by MGA and others, is similar to what has been previously described by the parents resulting in hospital attendance.

263. In their written submissions, those representing the Children's Guardian suggests that the incident appears to be a "red herring". The local authority has not sought to challenge the wider witness evidence in respect of that incident and I consider MGA's account of that distressing event to have been credible and compelling

264. I was struck by the clear emotional toll that the incident had on MGA. Even in recounting the event, I could see her distress in the re-telling.

265. I agree with those representing the Children's Guardian that I am unable, on balance, to associate the causation of that injury with the events of 19th July 2023. In the absence of any other concern being raised within that relevant timeframe, I am left with no clear understanding as to when N suffered the subdural effusions.

266. I look to the wider evidence to consider the circumstances of N's placement with MGA. There is no evidence to suggest that MGA was providing N with anything other than a high level of care. Whilst caring for a baby, and a baby with specific enhanced needs, is likely to be stressful and difficult, there is no evidence to suggest that any such stress or difficulty had an adverse impact on the care that MGA was providing. To the contrary, all I have read about MGA's care of N has been positive.

267. One element explored by the Local Authority has been the possibility that MGA's supervision of the parents might not have been as rigid as hoped. As such, MGA was challenged specifically as to whether there were any times when she might have left one or both of the parents alone with N whilst he was in her care. MGA was adamant that she had not and reiterated to me how clear she had been as to the importance of the supervision. I was struck by how emphatic MGA was in respect of the need for supervision.

268. That line of questioning on behalf of the local authority was not extensive because the reality is that there is no evidence before the Court to suggest anything other than an understanding and dedication from MGA in respect of supervision. I have already referred to wider evidence in the papers from nursing staff who felt that MGA was well aware of the responsibility of supervising contact and had shown "meticulous" compliance to the supervision whilst on ward.

269. From the factual evidence then, I determine on balance:

a) N's presentation on 19th July 2023 was not as a result of a traumatic event
b) MGA acted appropriately in response to N's presentations on 19th July 2023
c) There are no other reported incidents that could have resulted in the subdural effusions
d) There had been no concerns in respect of MGA's care of N

e) There were no concerns that MGA was anything other than meticulous in respect of her supervision of the parents contact.

f) The subdural collections were identified, not because of an incident or concern around presentation, but as a result of a follow up MRI scan. I reflect that the same can be said for all of the bony injuries identified as well.

270. It is to that factual picture that I then filter in the medical evidence.

271. I can understand the concern raised by Dr Williams in respect of the evidence in support of an association between subdural effusions and CMV related vasculitis/inflammation. The reality is that the evidence base for that association is slim. Even on the research papers provided, and keeping in mind the limited assistance case specific research papers can give, if there is an association then it is uncommon or even rare. I understand therefore why Dr William's has formed a view, in light of his own expertise, that the subdural effusions were more likely formed from a traumatic event.

272. However, the Court has the benefit of the whole evidential picture. That picture encompasses not only those factual matters to which I have already referred, but consideration of the context of the subdural effusions themselves. Dr Jalloh and Dr Morrell have agreed, those subdural effusions must be considered in the absence of any other aggravating presentations. There is nothing, beyond the subdural effusions themselves, which points to a traumatic event.

273. I am left then with disagreement between the experts. I am left with Mr Jalloh, generally supported by Dr Morrell being unable to say on balance whether the subdural effusions were caused by CMV related inflammation or trauma, and Dr Williams preferring trauma as a probable cause.

274. As I stand back and look at the entire evidential picture, I have formed the view that the local authority has been unable to prove to the requisite standard that the

subdural effusions were caused by rough or inappropriate handling. They have certainly not shown that they have been caused as result of a shaking episode.

Bony injury

275. I include within this analysis all of the bony injuries, including the long bone fractures, rib fractures and vertebral fractures.

276. I look to the background evidence first.

277. The M has told me that the months following N's birth at home were particularly stressful and that she was anxious and worried, especially following his early life experiences and outlook. Whilst F did not seem as willing to accept how hard that time was, I still gained the impression that he accepted that life was at times difficult. The stressors were not just in respect of the fact that N was a vulnerable newborn with his particular difficulties. The situation was exacerbated by the fact that there were a number of people living in the family home including F's two children, that the parental relationships with wider maternal family members was volatile and that the relationship dynamics as between M and F were, in my determination, unhealthy. The stress for M of having to deal with the majority of N's care needs, assisting in the care of F's children and having to manage F who seemed bent on regularly questioning her faithfulness, must have been extremely high.

278. But set against the stressors of home life is the clear evidence I have in respect of both M and F's general caring and loving interactions with N. Whilst there are regular concerns being expressed by professionals and family members about M's ability to support N's head, that does not appear to stem from recklessness or lack of care, but rather inexperience and a lack of confidence. There is nothing in that behaviour which suggests the use of excessive force or rough handling. Whilst concerns are raised by MGM, and now M, about F's controlling behaviour towards M, that does not equate to concerns about F's handling of N. For example, FW's interactions with

the family resulted in her recording that when she saw N in F's care on 6th July 2023 he was being gentle with him and that, further, F is always gentle when observed changing nappies.

279. As I look through the chronology, I can see no concerns being raised at any point in respect of either parent being too rough or inappropriately handling N. Whilst in many cases that may be because of a lack of an opportunity of observation, N was a child who was seen often by professionals with opportunity for parental interactions to be observed

280. In setting out the extent of the various health and medical appointments N has had since discharge from hospital after birth, it is clear to me that N has been a very visible child. That frequent visibility has not occurred just because of pre-planned appointments. Nor has it occurred because of concerns raised by professionals around the care that N was receiving from his parents. Instead, what is clear from the chronology is that these parents are making N available for professional scrutiny because of their own concerns around his well-being.

281. From the various records and evidence of family members I am able to find on balance:

a) N was regularly and frequently being seen by professionals, mostly health professionals.
b) Those regular interactions with medical professionals took place during the timeframe that N suffered from bony injury.
c) During those interactions N was regularly examined by a number of different medical professionals
d) During those interactions no concern was raised by any medical professional in respect of markings or bruises.
e) Except for the admission on 15th May 2023, during those frequent interactions no medical professional raised any issue in respect of pain response on examination

or issues with limb extension or chest examination.

f) During those interactions, no concerns were being raised in respect of either parents handling or care for N. The concerns raised by nursing staff in respect of N's state of dress and not being fully strapped into the car seat on 15th May 2023 were understandable, but the urgent circumstances which led to the attendance at hospital provide a plausible explanation for the way he attended that day.

g) N was regularly seen by wider family members, including MGM who had him overnight on average of 1 x night a week and with who he stayed, alongside M, from 19th May 2023 to the beginning of June. No family member has raised concern in respect of bruising, marking, pain response or issues on handling.

282. Given the live issue of bone fragility, and the extent of any such bone fragility, I am invited by both the Local Authority and Children's Guardian to consider closely the circumstances of the admission on 15th May 2023. When I do, I am invited to the view that the 15th May can be used as a "benchmark" as to the extent of any bone fragility.

283. The admission took place because the parents had taken N to hospital following a concern that F may have accidentally hurt N. There are descriptions in the papers as to what F was describing had occurred, and which I have already set out in this judgment. It involved F reacting to a choking event during which he was concerned, as he repeated on a number of occasions, that he may have "squeezed the baby too hard". Despite that concern and description of handling, there were no marks, bruises or rib fractures identified. I am invited to the view that I am able to consider that N's bone strength was sufficient at that stage to withstand injury from what was being described.

284. In addition, the Local Authority also remind me of the incident on 30th April 2023, shortly after discharge, where F gave N backslaps during a choking episode with no mark, bruise or bony injury identified.

285. I have already raised my concern about the F seeming to row back from descriptions of his actions, recorded contemporaneously. However, there is a real danger, in my view, of attaching significant weight to those descriptions of handling and then inferring that any bone strength was unlikely to be significantly diminished. As I understand their evidence, the main concern for both M and F on 15th May 2023 was their belief that N was in pain. That was the primary reason why N was taken to hospital; because of what they thought was a pain response to the handling. To that end I am reminded about what M told me in respect of that incident:

Q: When you saw F pick N up the house, did you think it was too rough?
A: Not at the time. I didn't think that F picked him up too hard, it was only when he started showing pain that I thought he might have

286. I am unable to determine whether the perceived pain response was as a result of the handling or part of the choking incident, which then led to the handling. Certainly, there is no medical reason reported for the perceived pain response. In my view I must be careful then with the weight I can attach to a description provided by father in the context of trying to explain the pain response.

287. The medical evidence tells me, uniformly, that N was likely to have reduced bone strength. I have set out the reasoning for that view earlier in this judgment. I am not assisted by the radiology except to say that I can say on balance that his bones were likely not reduced in density by 30-40%.

288. The medical evidence is unable to assist me as to the extent of the reduction in bone strength, and therefore what level of pressure or force would need to be applied to cause fractures. Instead, the experts leave it to the Court to determine. Whilst I understand why they do so, I make clear that what I am actually determining, is whether the local authority have been able to prove, to the requisite standard, that the fractures were inflicted or caused as a result of rough or inappropriate handling. I must be careful that I am not attempting to answer medical questions that the medics themselves are unable to answer.

289. Questions have been raised of the experts in respect of pain response, which might assist me in determining these issues. But again, unfortunately the expert evidence has been variable. Dr Morrell tells me that he would expect a child to show a pain response to each of the fractures, albeit it could be non-specific and not immediately apparent to a carer as to cause. He told me that it is quite common for rib fractures to go unnoticed by medical staff. In an interesting piece of evidence from Dr Allgrove as to what causes the pain response, he told me that in fractures where the bone has not separated, the pain response is caused by disruption of the periosteum; the membrane that covers all of the bones in the body. He told me that the fibula fractures may not have caused a disruption to the periosteum and that rib fractures can be present in the absence of any identifiable injury and have been known to appear in the absence of symptom.

290. I was impressed by the evidence given by Dr L in respect of the conversation he had with the parents on 26th September 2023. He was clear to me that the description he was provided in respect of winding, he thought by F, was a mechanism that could have caused the vertebral fractures. Again, although the F denied the description noted to have been provided, I am satisfied that Dr L's recollection is credible. I am reminded that in M's evidence, she also denied that she winded N in the way described, or had seen F wind N in the way set out in Dr L's notes. I have gone back and looked specifically at my note of M's evidence on the point. The extent of the evidence is:

"*No, I have never seen him do that. It has always been the same as me*"

291. As I consider that evidence, I remind myself that there were occasions when F was caring for N, on a night time, when M was asleep. I have considered the evidence from Dr L, F and M and set out my impression of that evidence already. Having considered that evidence I am satisfied to the requisite standard that:

a) It was F who was describing winding techniques to Dr L

b) That F described the winding technique as set out by Dr L on 26th September 2023
c) That F has attempted to avoid criticism by denying that the detail of the conversation is accurate.
d) That M genuinely may not have seen F winding N in the way described.
e) That the mechanism described by F to Dr L is consistent with the forces required to cause vertebral fractures

292. However, like the remainder of the bony injuries, the question of bone fragility and the force needed to cause the fractures remains unresolved.

293. Whilst I have had just over 2 weeks to write this judgment, a significant amount of that time has not been in the writing, but rather upon reflection of the factual evidence alongside the medical expert evidence. Having done so, I am satisfied on balance that during the timeframe that all of these bony injuries were caused, N probably had reduced bone strength.

294. However, what I am unable to do is determine the extent of the bone strength in the context of whether the injuries were caused by handling which was beyond "normal". Whilst I have spent a considerable amount of time reflecting upon previous incidents where the Local Authority invite me to the view that I could expect to see injury, including bony injury, I am not satisfied on the evidence, for the reasons set out, that the local authority has shown that the bone strength was in fact resilient enough to withstand "normal handling".

295. Although I have considered the different bony injures separately, I am not satisfied that the local authority has proven to the requisite standard that any of the bony injury was inflicted or as a result of handling in excess of what could be considered "normal" handling

Bruising

296. I look to the background circumstances once again in respect of the parents handling of N. As I have set out already, I cannot identify any incident where either the M or F have acted in a way whilst caring for N, so as to cause any concern that bruising might be suffered. I accept that there were stressors involved in the care of N, which must filter into my overall analysis, but they do not of themselves mean that either M or F have caused N injury. I have also been unable to identify any instances of unusual bruising, on any of the evidence including the parents, outside of hospital admissions when he was involved in medical interactions, or the limited petechiae bruising observed whilst in foster care.

297. Those on behalf of F are right, there are incidents pre-7th July 2023, during N's admission from 7th July 2023 and post discharge, that point to evidence of N easily bruising. Dr Morell accepted that it was likely that N has an issues in respect of his vascular integrity.

298. I have looked carefully at the descriptions of the bruising from 6th July 2023 as opposed to the wider descriptions of what is often referred to as "petechiae" bruising. I have been careful in doing so because of the lack of photographic evidence for the majority of those incidents upon which the experts can comment. However, the descriptions differ. Almost all of the bruising seen outside of the 6th July 2013 observations, is described as "petechiae" bruising In preparing this judgment I have had the benefit of considering photographs of the bruising upon which the Local Authority seek findings. They are the same photographs seen by the medical experts. In his evidence to me Dr Morrell told me that petechiae were small dots of burst blood vessels. When asked what could be seen in the photographs of N's presentations on the 6th July 2023, Dr Morrell told me:

"The marks I would describe on the photographs, was some petechial bruising, and some bruising"

299. The only other comparable bruising seen on N is the bruising to N's wrist when bloods were being taken on 12th July 2023[11], described by Dr Morrell as "quite significant bruising", with the associated unusual petechiae bruising on the palm of the hand.

300. On 5th July 2023 the parents had taken N to A&E because they had generalised concerns about his well-being. Those concerns were low level and seem to be associated with earlier temperature, not being himself and perhaps not feeding as fast as he would ordinarily. He was checked and no concerns were raised by medical staff. There is no reference within the medical notes, and no suggestion from the parents, that there were any unusual markings or bruises on N at that time, or at the point he was put down to bed.

301. It was M who put him down, she tells me without issue. It was F who woke at approximately 2am in order to see to N's needs. It has not been suggested that M woke up at that point.

302. M was clear in her evidence to me that the first time she saw markings to N was when she was getting him changed out of his wet clothes at approximately 6am-7am. No one has suggested that any sort of handling by M that morning, prior to seeing marks for the first time, caused the bruising. M was not consistent in the various reports she gave in respect of which marks she saw first. However, she was clear that the mark on his back was there and that further marks began to develop over the day. I have taken some care where the words being used vary between "rash" and "mark" or "bruise", when I consider the significance I should attach to that inconsistency.

303. On the basis of all I have heard and read, I am satisfied on balance that whatever caused those bruises and marks, whether through normal handling or otherwise, occurred during the night of 5th July 2023, prior to M noticing that first mark.

[11] Accepting that there is reference in the medical records to a "bruise" to the leg on ward, but with very little description provided.

304. Issues of vascular integrity have been one of the central issues explored within the medical evidence. Dr Morrell tells me that he accepts that N had issues with vascular integrity which probably meant that he was experiencing vascular fragility. However, in his substantive reporting and responses to the schedule of agreement/disagreement, he informed the Court that his opinion as that the extent of the vascular fragility was not such so that the bruising would be caused by "normal handling".

305. In robust cross examination on behalf of F, Dr Morrell was taken to other instances of "bruising" seen in hospital, which he had not seemed to consider as part of his substantive reporting. I have referred to those instances already but for convenience set them out here:

a) 14th June 2023: spots on right hand (had bloods taken here a couple of hours prior) which appeared like petechiae.
b) 15th June 2023: few non-blanching spots to arm, felt it was from holding during cannulation attempts on 14th June. However, some non-blanching spots to head, neck and other arm.
c) 8th July 2023: bruise to back of N's left calf (little detail provided in respect of that bruise)
d) 15th July 2023: …multiple petechiae and bruising over the dorsal aspect of his right hand… impression that these marks are consistent with routine hold (and "squeezing") that would occur during routine attempted venepuncture at this age.

306. In addition, Dr Morrell was also taken to observations of petechiae bruising whilst in foster care.

307. In his evidence to me, Dr Morrell maintained that there was a distinction between "normal" handling in a hospital context, for example in the application of force when taking blood, as opposed to "normal handling" in a domestic context.

Whilst he accepted that some of the petechiae bruising might be associated with holding a head still or applying a face mask, he remained clear in his evidence that the bruising he saw in the photographs would have required a higher degree of force than normal handling, even in the context of vascular fragility. Dr Morrell referred back to the extent of the bruising and marking seen on N following his admission on 6th July 2023.

308. In his oral evidence, Dr Morrell directly considered that, apart from handling for the purposes of medical intervention, N's basic care needs were still being met in terms of feeding, dressing and nappy changing whilst in hospital. He noted that there was no evidence that those types of handling, the type of which would have been taking place in the family home prior to admission, has resulted in the extensive bruising seen in the photographs.

309. I reflect that whilst all of the various marks, rashes and bruises are set out within the local authority's schedule of findings, they are only seeking findings in respect of that marking which Dr Morell has identified as significant enough to require that higher level of application of force. For example, although a pinpoint non-blanching rash was observed across N's torso, neither Dr Morrell or the Local Authority seek to establish that it was caused by rough or inappropriate handling.

310. I have considered carefully the submission, made on behalf of F, that I must be wary of confirmation bias. That is particularly relevant in respect of Dr Morrell, it is submitted, because he has expressed a view and then looked for evidence that confirms those views. I have gone back and read not only Dr Morrell's written evidence but also my extensive note of his oral evidence. Whilst I understand the submission on behalf of F, I do not detect any confirmation bias taking place. It seems to me that Dr Morrell's position has always been that when looking at the photographs of the bruising on admission on 6th July 2023, that bruising was caused by rough or inappropriate handling, in the context that there is some level of underlying vascular fragility. I do not detect that Dr Morrell has then undertaken selective observation in respect of the other identified bruising set out above.

311. In my view Dr Morrell was candid and open in his responses to counsel that it is difficult to identify the level of vascular fragility that N was, and perhaps continued, to suffer from. However, what he was very clear about, and about which he remained consistent and firm during his evidence, was that the handling which caused the bruises observed on 6th July 2023 was excessive, even taking into account that N likely had vascular fragility. He formed that view on the basis of the photographs, descriptions of the bruises, in the absence of bruising on ward from basic care tasks and in the knowledge of the other bruising which had been reported within the medical notes.

312. On balance, having carefully considered Dr Morrell's responses during his oral evidence, I am satisfied on balance that I am able to accept Dr Morell's evidence in respect of the bruising seen to N on 6th July 2023. I am satisfied on balance, that something occurred on the night of 5th July/morning 6th July 2023, which caused the bruising identified within the Local Authority's schedule of findings

313. However, looking to the wider picture in the context of the medical evidence, I am not satisfied that the Local Authority have discharged their burden of establishing that they were "inflicted". Rather, I am satisfied that on balance the identified bruising was caused by rough or inappropriate handling, out with the normal handling for a child of N's age and specific circumstances.

314. Having so established, I look to whether I am able to identify who has caused that bruising through that handling.

315. In so far as the accounts between M and F vary in respect of the circumstances of the morning of 6th July 2023, I accept the evidence of M. Whilst there was some inconsistency in respect of the chronology of which marks/bruises had been seen by her, I accept her evidence that as soon as she saw marking to N that morning she raised it with F. Having heard from M in oral evidence, I have formed the view that any discrepancy in her accounting of the chronology of the bruising, is down to the

passage of time rather than an attempt to deceive. I have formed the view that his was a mother who was anxious and continuously worried about N's health. I have no doubt that having observed unusual markings to N, she would have alerted F. I also accept her evidence that from the point that she put N down to bed the night before, through to when she got up to meet his needs at around 6-7am, she was not aware of any issues.

316. I have some concerns in respect of the internet search that was undertaken by M on 28th August 2023. The subject of the search is concerning in the context of the injuries suffered by N. I have considered whether that search assists me in establishing whether the mother is attempting to cover up something she has done, or is seeking to assist the F. I have filtered the fact of that internet search into my overall analysis, however on the limited exploration of that issue in oral evidence, I am not satisfied that I am able to find that it was M who made that search.

317. Conversely, I do not accept the evidence F gave me in respect of the circumstances of that morning. I found his account in respect of what happened at the 2am feed to be strikingly vague, whilst the detail he provided of his interactions with M and his knowledge of the marks and bruises to be inconsistent and nonsensical.

318. I ask myself why, having just the day before attended hospital for low level concerns, the F was so quick to dismiss the concerns being raised by the mother. I ask myself why F has sought to distance himself from knowledge of the bruising and marks, and has provided inconsistent and incoherent accounts in respect of that chronology. I ask myself why the F was unable or unwilling to give any additional detail in respect of the care giving he provided in the early hours of that morning. I have had to consider those questions because F has been unable to provide me with any satisfactory response from the witness box.

319. Given I have found that F has been evasive and avoidant in his evidence, at times attempting to minimise his own behaviour to avoid a negative light, I have reflected

whether the evidence he has given around the morning of 6th July 2023 is simply because he continues to avoid a negative light. Or whether, the lack of credibility in his account has been for some other reason. I have turned my mind to those *Lucas* principles and reminded myself that the fact he may want to avoid a negative light does not mean, in of itself, that he has caused that bruising and marks. The question is *why* he is trying to avoid a negative light in respect of the events of 6th July 2023. As I consider that question in the context of my finding of rough handling, my acceptance of M's account and the likely timing of when that rough and inappropriate handling took place, I am drawn to the conclusion that he has done so because he has still not been entirely honest with the Court.

320. In the context of my finding of rough handling, I have formed the view on balance that the answer to those questions at para 318 above is because F knew that something had happened during his care in the early hours of 6th July 2023, about which he is yet to tell the truth. I consider that to be a shame, and invite F to reflect on that position on the basis that I consider this was a one-off incident which is not in keeping with his general care of N.

321. Although I have my suspicions in respect of whether the cot was involved in that incident, to make any findings on the limited evidence I have, and in the way that the evidence became a focus, would be wrong. I decline to make any finding which is based on suspicion or speculation.

Scalp swelling

322. I understand why it may be suggested that having made the finding in respect of the bruising, I can then find that the scalp swelling was caused within the same incident. However, there is a danger in making the jump that just because bruises were caused by rough or inappropriate handling, so was the scalp swelling. Although Dr Williams opined that scalp swelling is more typical of more forceful injury than an everyday event, I have reflected upon the evidence of Dr Morrell who, having

considered that there may be an interplay between vascular integrity and the swelling and the uncertainty that brings, opined:

"It is possible the event that caused it may not be one where the carer would think it would result in a swelling or injury. Given the swelling was not picked up clinically, then a parent would not pick up on it"

323. I am not willing to draw an inference on the evidence I have before me that the head swelling was probably caused during the same event that caused the bruising. As such, I do not consider that the local authority has proved that finding sought to the requisite standard.

Concluding remarks

324. For the reasons set out above, the only findings I make are:

a) Currently pleaded finding 3
b) Currently pleaded finding 4, amended to read: Marks b, c, f, g, j, l, m, n and o highlighted above have been caused by pinching or gripping N. They are the result of rough or inappropriate handling, out with normal handling for a child of N's age
c) Currently pleaded 5, amended to read: The marks and bruises listed above were caused by the 2nd Respondent during an incident yet to be disclosed.

325. Having made the above finding, I have re-evaluated and cross-checked against the other findings sought in this case and considered whether the fact of that finding influences my determinations on those other matters. I have undertaken the same task when considering the bruising in circumstances where I have refused to make the other findings in light of N's underlying medical issues.

326. Having done so, I am satisfied that I have considered both the factual and medical pictures in the round, and that my final determinations have been based on

my consideration of the entire evidential canvas.

327. This has been a particularly difficult case to determine, and I am grateful for the skilled assistance and sensitive approach undertaken by each of the advocates.

328. That ends my judgment.

HHJ MURRAY

Sitting in the Family Court at Teesside Combined Court Centre

18.10.2024