Case No: BH19C00597

IN THE FAMILY COURT SITTING AT BOURNEMOUTH

Courts of Justice
Deansleigh Road
Bournemouth
BH7 7DS
Date: 6.12.19

Before:

HIS HONOUR JUDGE DANCEY

- -

Between:

Dorset Council	**Applicant**
- and -	
M	**1st Respondent**
-and-	
F1	**2nd Respondent**
-and-	
F2	**3rd Respondent**
-and-	
MGM and MGF	**4th Respondents**
-and-	
A, B and C children (by their children's guardian Sarah Louise Clarke)	**5th Respondents**

Katrina Hambleton (instructed by **Dorset Council Legal Services**) for the **Applicant**

Anthony Hand (instructed by **Battens**) for the **1st Respondent**

Andy Pitt, solicitor for the **2nd Respondent**

Steven Howard (instructed by **Preston Redman**) for the **3rd Respondent**

David Beatson, solicitor for the **4th Respondents**

Adam Langrish (instructed by **Eric Robinson**) for the **5th Respondents**

Hearing dates: 12-14 November 2019

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JUDGMENT

His Honour Judge Dancey:

Introduction

1) On 6 July 2019 a 12 day-old baby boy, C, was taken by his parents to hospital with a lump to the top left side of his head. Scans showed C had a linear fracture to his left parietal skull. Happily C has made a full recovery.

2) The local authority seeks to prove that this injury was caused by one or both of his parents, either deliberately or through carelessness or recklessness such as to meet the threshold criteria in section 31(2) of the Children Act 1989.

3) Alternatively, if this was an accident, the local authority says the parents (or one of them) knows what happened to C and has failed to give an explanation.

4) In some cases questions like this are relatively easily answered. There may be a combination of a violent partner, substance misuse, domestic violence, generally neglectful care and mental health or personality disorder pointing to a clear answer.

5) As the experienced allocated social worker, Kim Campbell, agreed however, save for the injury itself, there is not a scintilla of surrounding evidence supporting the local authority's case that this was an inflicted injury. C's parents are in a loving and committed relationship. His mother (M) has successfully brought up C's half-siblings, A and B, girls aged 12 and 11, without any local authority involvement or concerns. There is no evidence of domestic abuse within the parents' relationship, nor is there any substance misuse. Home conditions are good.

Summary of decision

6) I am going to set out here in simple terms what I have decided.

7) It is unclear what has happened to cause C's injury. The doctors say it could equally easily have been an accident as anything else. It is for the local authority to show it was not an accident and that the parents have done something wrong causing the injury.

8) The parents are in a loving and committed relationship. There is no domestic abuse. They don't use drugs or alcohol. Problems which C's father had in childhood seem to be largely behind him. The parenting assessment shows they are good and careful parents. There is nothing to suggest the parents would deliberately harm C or be careless in how they looked after him.

9) I have decided that the local authority have not shown that the injury to C was the parents' fault.

10) I also accept that they don't know what happened to C. So they could not give an explanation.

11) And so the local authority are not entitled to a care or supervision order and C can be returned home.

The parties and representation

12) The children subject of these proceedings are A, B and C, although I am only asked to make findings about what happened to C.

13) The father of A and B is F1. He and M separated in May 2017. M describes that relationship as abusive but I am not asked to make findings whether it was or not. F1 has parental responsibility for A and B.

14) The father of C is F2. He is 23 years old, while M is 41, some 18 years older. They started living together in January 2019. F2 has parental responsibility for C.

15) Following the events of 6 July 2019, A and B were moved to the care of the maternal grandparents (MGPs). C was discharged from hospital into the care of the MGPs (where he remains) on 18 July 2019. Following a short transition, A and B returned to their mother's care on 27 September 2019 where they have been looked after without incident.

16) The local authority is represented by Katrina Hambleton, the mother by Anthony Hand, F1 by Andy Pitt, F2 by Steven Howard and the children by Adam Langrish, instructed by the children's guardian, Sarah-Louise Clarke. The MGPs have also been joined as party to the proceedings and are represented by David Beatson.

The hearing

17) The fact-finding hearing took place between 12 and 14 November 2019. At the end of submissions on the third day I reserved judgment. This is that judgment.

18) I heard evidence from Dr Mankad, Consultant Paediatric Neuroradiologist (by live-link), Dr Cartlidge, Consultant Paediatrician, social workers Annabelle Mitchell and Kim Campbell, and M and F2. I take into account not only their oral evidence but also all the written evidence in the court bundle including a very positive parenting assessment by Elisabeth Clegg which nobody sought to challenge.

19) Following concerns about F2's cognitive ability, an assessment was undertaken by Dr North, psychiatrist. He placed F2 in the low average range for IQ (full-score 86) but not in the learning disability range. He also noted a history of anxiety. Dr North made a number of recommendations about presentation of material and use of language. He recommended the use of an intermediary. An assessment by Communicourt resulted in a series of recommendations including the use of an intermediary in court, use of clear concrete everyday language, approval of written questions, practising from the witness box in advance of giving evidence, regular breaks and other measures to help alleviate anxiety, including cards for communicating with the court. All these measures were planned as ground rules in advance and implemented during the hearing. In addition, F2 was able to hold C's favourite soft toy while giving evidence which he found a comfort.

20) Without wishing to single anybody out I would commend the careful preparation and delivery in particular of Mrs Hambleton's questions to F2. They followed faithfully the recommendations that had been made and enabled him, even under challenge through adverse cross-examination, to understand and answer questions to the best of his ability.

What the local authority seeks to prove

21) At the start of the hearing I raised the question who the local authority placed in the pool of perpetrators. Their answer was the parents. They did not seek to

include A or B, although M and F say that on a couple of occasions B, in particular, had picked up C against instructions. Ms Hambleton made the point that in their written evidence the parents themselves excluded the girls as possible perpetrators.

22) Having heard the medical evidence, however, the parents are left in the position where they say they simply do not know what happened to C. They do not want to think that either of the girls would cause harm to C, even accidentally, but they cannot exclude the possibility.

23) As I canvassed in submissions, this gives rise to questions of procedural fairness for the girls who have been asked the question whether they picked up C (they both said not) but have not had put to them directly the possibility that one of them may have caused the injury or had the opportunity to give any fuller explanation.

24) The schedule of facts sought put forward by the local authority can be summarised in this way:

a) C has been subjected to physical abuse in the care of the parents because:

i) between 26.6.19 and 6.7.19 he suffered a linear fracture of the left parietal bone with overlying haematoma (described in the schedule as cephalhaematoma but excluded as such by Dr Cartlidge in evidence);

ii) the fracture did not occur at birth;

iii) C does not have an underlying medical condition predisposing him to easy fracture;

iv) the fracture was likely to have been caused by a single direct impact with an unyielding object;

v) C is likely to have cried out in pain at the moment of impact and been distressed for at least 10 minutes;

vi) anybody present would have realised C had sustained a painful injury;

vii) the injury was inflicted by one or both of the parents or was caused by an undisclosed but significant incident in the presence of both or one of them which they, or one of them, have unreasonably failed to report.;

b) if a finding of physical abuse is made against one parent the other failed to protect C; and

c) they have both failed to be open and honest with social care and medical professionals as to how the injury was sustained.

The parties' positions

25) I can summarise the medical evidence in a nutshell as follows:

a) the injury is consistent with an impact equivalent to a fall head first onto a hard surface from 60cm;

b) it is not possible to say whether the injury was caused by a fall or some other mechanism;

c) the density (or brightness or attenuation) of the haematoma (blood collecting and forming the swelling) dates the injury to up to 7 to 10 days;

d) the swelling is likely to have come out in 24 perhaps 48 hours but possibly less;

e) birth injury is excluded as a likely cause because of the dating and because the delivery was by uncomplicated C section which did not involve the use of instruments;

f) the injury remains unexplained.

26) The local authority maintains its case that the injury was inflicted by one or other of the parents and the other parent knows what happened and has failed to protect.

27) The parents are consistent, as they have been throughout, that they do not know what happened to C. They say he was not accidentally dropped by either of them. They do not know whether one of the girls might had dropped him or otherwise caused the injury. They do not like to think so but remain open to the possibility. They say the local authority has failed to prove its case on threshold.

28) Mr Beatson for the MGPs made limited submissions but made clear the MGPs do not believe the parents caused the injury.

29) The guardian maintains an essentially neutral position while questioning whether the girls should feature at all as possible perpetrators. The guardian is concerned, if the injury was accidental, at the parents' reaction to it and failure to give an explanation.

Legal principles

What needs to be proved?

30) The purpose of a fact-finding hearing is twofold:

a) to establish what happened so that a decision can be made whether the local authority has proved threshold;

b) if threshold has been met, to inform assessment of risk for the purpose of the welfare decision.

31) The court only needs to make findings to the extent that they further these purposes.

32) In *Re A (No. 2) (Children: Findings of Fact)* [2019] EWCA Civ 1947[1] Peter Jackson LJ said that the questions for every fact-finder, in no set order, are *What, When, Where, Who, How and Why*? Some answers, he said, will be obvious, while other questions may be extremely hard or even unanswerable. Sometimes a question may not need answering at all. The answers to the

[1] A decision dated 14 November 2019 and only seen by me immediately after the close of submissions. I have referred the case to the advocates giving an opportunity for further submissions on it, while indicating I did not see that submissions were needed. In the event I have not received further submissions on the basis of this decision.

questions will be provisional until they have been checked against each other to provide a coherent outcome.

33) This case also reminds us that the court is not bound by the local authority's schedule of findings sought and may reach an alternative solution of its own: *Re S (A Child)* [2015] UKSC 20. If, however, the court is to go 'off piste', there must be both good reason and solid evidential basis for doing so and procedural fairness must be maintained: *Re G and B (Fact-Finding Hearing)* [2009] EWCA Civ 10.

34) Section 31(2) provides (so far as is relevant in this case)

> A court may only make a care or supervision order if it satisfied –
>
> (a) that the child concerned is suffering, or is likely to suffer, significant harm; and
>
> (b) that the harm is attributable to –
>
> (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; …

35) So there are three essential elements to threshold – significant harm, attributability to a carer and an objective standard of care.

36) It is important in the context of the present case to note that the harm must be attributable to a carer, not to somebody outside the family or, as everyone accepts, to a minor sibling within the family. It may of course be found that the carers themselves have failed to protect by negligently or recklessly leaving the child in the care of somebody else, but that would simply be to attribute the lack of care to the carer, not that somebody else.

37) The question whether harm is attributable to unreasonable care was considered by Ryder LJ in *Re S (A Child)* [2014] EWCA Civ 24 where he identified the use of the term 'non-accidental' as a catch-all for everything that is not accidental and drew the true distinction necessary for section 31(2) as between

> "an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction".

38) As Ryder LJ pointed out, it may be useful to distinguish deliberate infliction from negligence, but that is not strictly necessary for threshold which only requires findings meeting the three elements. The distinction would of course be highly relevant to the second purpose of a fact-finding hearing – informing assessment for the welfare decision.

39) During the course of submissions there was some discussion around accident, negligence and recklessness in the context of this case. So, for example, if C was dropped because he arched his back or wriggled and his carer lost control of him, or the carer tripped over that may well be pure accident. If the child were dropped because the carer was intoxicated then, depending on the level of intoxication, that could be negligence or recklessness. Dr Cartlidge gave an example during his evidence of a case where a baby had been left by his carers

on a bar stool and fell off. That would seem to be a clear case of an objectively foreseeable risk being taken which would likely amount to recklessness.

Other principles

40) The legal principles to be applied in the fact-finding exercise are well established. See, for example *Devon County Council v IB and EB* [2014] EWHC 369 (Fam).

41) The burden of proving the facts on which it relies is on the local authority.

42) The standard of proof is the balance of probabilities. If a fact is proved it happened, if it is not proved it didn't happen and must be disregarded – the so-called binary consequence. The court can take into account inherent improbabilities in deciding whether the standard of proof has been met: *Re B* [2008] UKHL 35.

43) Findings of fact must be based on evidence, not on speculation: see *Re A (A Child) (Fact-finding hearing: Speculation)* [2011] EWCA Civ 12. While the court may draw proper inferences from the evidence it must be careful not to reverse the burden of proof.

44) This requires the local authority to adduce proper evidence to establish what it seeks to prove using best evidence available where it is challenged. The local authority must also link the facts relied upon with its case on threshold to demonstrate why the facts justify the conclusion that the child has suffered, or is at risk of suffering, significant harm. So bald statements in threshold criteria such as that as 2(b) of the schedule "[the parents] have failed to be open and honest with social care and medical professionals as to how the injury to [C] was sustained" must go onto explain how this feeds through to the conclusion that C has suffered, or is at risk of suffering, significant harm: *Re A (A Child)* [2015] EWFC 11 (Munby P)

45) The court must take into account all the evidence, considering each piece of evidence in the context of the other evidence – surveying a wide landscape – and must avoid compartmentalising: see *Re U, Re B (Serious Injury: Standard of Proof)* [2004] EWCA Civ 567.

46) In submissions, Mr Hand cautioned against relying on propensity to cause injury, referring to *Re CB and JB (Care Proceedings: Guidelines)* [1998] 2 FLR 211. At p217A Wall J framed the wider question: whether it was normally sensible to admit psychiatric or psychological assessment of the parties before a split hearing and whether evidence of propensity or character should be admitted at that stage, or at all. However, in answering that question at p219B, Wall J confined himself to saying that it would normally be inappropriate for expert psychiatric or psychological evidence to be adduced as to the propensity of a parent to injure a child or as to the likelihood of a parent having done so, especially when the court is dealing with an issue at a split hearing on which the threshold criteria depend.

47) The point made in *CB* was that expert evidence is not needed on the question of propensity, not that that propensity (positive or negative) is irrelevant or inadmissible. It is a matter for the judge within the assessment of credibility and reliability. If relevant, propensity forms part of the wider landscape of the evidence that the court must assess.

48) Expert opinion evidence must be considered in the context of all the other evidence, remembering that the expert advises but the court, with the advantage of the entire landscape of the evidence, decides.

49) Experts must be kept within the bounds of their own expertise and, where appropriate, should defer to others.

50) The court has to allow for the possibility of medical uncertainty and unknown cause.

51) The evidence of parents and other carers is of the utmost importance and the court must make a clear assessment of their credibility and reliability.

52) It is common for witnesses to lie in the course of investigation and hearing. They may do so for a variety of reasons – shame, misplaced loyalty, fear and distress being examples. It does not follow that because they have lied about one matter they have lied about everything: *R v Lucas* [1981] QB 720.

53) There is a different but related question of witness fallibility, which is a matter of reliability rather than credibility. The court should bear in mind that recall of events by a witness is a process of fallible reconstruction which may be affected by external influences and supervening events, moulded by the process of litigation and the drafting of lawyers, with past beliefs being reconstructed to make them more consistent with present beliefs and motivated by a desire to give a good impression: *Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor* [2013] EWHC (Comm), Leggatt J.

54) In *Lancashire County Council v C, M & F (Children - Fact-finding)* [2014] EWFC 3 Jackson J (as he then was) said:

> "…. in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record-keeping or recollection of the person hearing and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith. "

55) Wherever possible the court should try to identify the perpetrator of 'non-accidental' injuries (applying the balance of probabilities standard) but should not strain to do so: *Re D (Children)* [2009] EWCA Civ 472. The question to ask is whether the evidence establishes that a particular person perpetrated the injuries: *Re B (A Child)* [2018] EWCA Civ 2127.

56) If a perpetrator cannot be identified, the next task is to identify who is in the pool of perpetrators. The test whether somebody goes into the pool is whether there is a real possibility that he or she was the perpetrator: *North Yorkshire County Council v SA* [2003] EWCA Civ 839. The question to ask then is why

somebody should go into the pool, not why they should be excluded from it, for that would risk reversing the burden of proof: *Re B (Uncertain Perpetrators)* [2019] EWCA Civ 575.

57) Finally, in *Re L-W (Children)* [2019] EWCA Civ 159 the Court of Appeal cautioned against automatically 'bolting-on' failure to protect findings in injury cases. There has to be a causative link.

The evidence

The parents' backgrounds

58) M described to Ms Clegg a settled and happy childhood with good relationships with her parents and sister. She has held a variety of jobs, most recently as a carer in a care home, although she is currently on maternity leave. She described her 15 year relationship with F1 as emotionally abusive, although this is denied by him. She met F2 at work in July 2018 and he gradually moved into the family home with her, A and B between January and March 2019.

59) F2 describes a less settled childhood. His parents divorced when he was 8 and there was a period of years when he moved between them. He got on with a younger sister but felt (and continues to feel) she was a favoured child. He witnessed domestic violence between his parents. His mother's new partner was physically and emotionally abusive towards him, so he went to live with his father. His father then met a new partner who was unpleasant towards F2 and didn't want him living with them. There was what F2 reported as excessive physical chastisement by his father towards him and his sister.

60) When he was 13, children's services from another area became involved with F2 after his father returned home drunk and hit him with a slipper.

61) At a mental health appointment in September 2018 F2 admitted that he had been violent and aggressive towards his mother and younger sister as a young person, including threatening his mother with a knife on one occasion. He felt this was because of abuse he was suffering at the hands of his stepfather at the time.

62) F2 had several changes of school where he was bullied. He went to college to study public services before working at the care home where he was to meet M in due course. Before that however he went at the age of 18 to Australia to meet with his then girlfriend who had moved there only for her to 'dump' him at the airport. He decided to stay on in Australia for a year where he made friends. During this time, he told me in evidence, he felt able to turn his life around.

63) Having returned from Australia F2's sister told him that she had been raped. This had also happened to his mother in 1994. By the end of July 2018 F2 says he had been suffering from depression for two years and he reached a crisis point. He was hearing voices and sleeping poorly. He became intoxicated and took an overdose of paracetamol. F2 was referred for psychological therapy and prescribed anti-anxiety/depression medication. He stopped drinking save for an occasional beer. He does not take drugs (although he tried cannabis when young). He gave up smoking cigarettes in December 2018.

64) F2 continues to engage with the Community Mental Health Team (CMHT) although he missed two appointments for reasons connected with M's pregnancy. He was diagnosed with asthma in June 2019 which helped him understand what he thought were panic attacks inducing shortness of breath.

This had led to a series of medical tests at the beginning of 2019 which he found particularly stressful.

65) In evidence F2 admitted that he did have anger issues when younger. He had hit his sister and the family dog. He has had trust issues in relationships in the past. He explained that although he might still get frustrated, for example by people not telling the truth, he knows how to deal with it – by playing football (which is his passion), going out for a walk or running. He said he had not hit out at anybody or anything since he was a child. Whereas he used to lie, he has not done so since returning from Australia. He occasionally hears voices but that is under control with medication.

66) As a result of the concerns around C's injury, F2 has been suspended from his job as a carer. He now works in a laundry as a production operative. He enjoys working there and told me he probably wouldn't go back to his job in the care home even if offered it.

The parents' relationship

67) The parents each describe a loving, trusting, committed and supportive relationship, free from domestic abuse. A and B were spoken to by social workers following the events of 6 July 2019. They said nobody in the house was cross.

68) The pregnancy was unplanned and this led to F2 moving into the family home sooner than they had anticipated. The MGPs were slow to accept the relationship because of the age gap but have become supportive.

The parenting assessment

69) Ms Clegg's parenting assessment speaks very highly of the care given by M to the girls. M is said to balance well the competing demands of three children in a considered way. Both M and F2 have been observed to be mindful of risks to the children. Sometimes M has given advice to F2 (who had no previous parenting experience of course) but he has accepted advice without argument and acted on it.

70) B found the introduction of F2 into the family unit difficult and initially she refused to accept the relationship. Over time and sensitive handling however, relationships between F2 and the girls have improved. They have a shared interest in football which F2 has been able to develop to good effect. He is described in the parenting assessment as engaging in nurturing and attuned relationship building activities with the girls within the contact sessions that both M and F2 have regularly attended.

71) There is clear evidence from the parenting assessment of mature, sensitive consideration being given by both M and F2 to complex issues concerning the girls. M demonstrated a good understanding of attachment and the needs of the girls (and C) in light of their experience since July 2019.

72) M is described within contact sessions to be a calm and measured parent, providing clear explanations to the girls when required. F2 has also been observed to be calm and has not raised his voice or demonstrated any response indicating anger. F2 has deferred to M in disciplinary matters. Occasionally he has been observed not to challenge rudeness from the girls towards him.

73) Throughout a difficult process both parents have remained co-operative with professionals. While the removal of the children has been a huge shock they have both expressed their understanding why it has happened and their wish to work with children's services and others to secure the return of all three children. Bar only the lack of explanation for the injury it is common ground that these parents have done all they could to work collaboratively and demonstrate their abilities as parents.

74) Altogether the parenting assessment is universally positive concerning the parents.

C's timeline (taken from the parents' evidence and the medical evidence)

75) C was born on 24 June 2019. It was an elective C section. The medical staff described it as straightforward. No instruments were used[2]. C was described as in very good condition. F2 was present and cut the cord. C underwent review, including skeletal survey, all of which was normal with no fracture identified.

76) Dr Cartlidge described C section as the least traumatic birth method, for the baby at least. M described being pushed hard on the stomach four or five times and wondered whether that could have caused the injury. Dr Cartlidge was clear that the baby would be surrounded by fluids which would protect the baby and did not consider that a realistic cause.

77) M and C remained in hospital for two days, being discharged home on 26 July. During that time no bruising or swelling was noted.

78) Home is a fairly modest two-bedroom bungalow with one bedroom occupied by M, F2 and C and the other by the girls. A's bed is close to the wall adjacent to C's crib in the next room.

79) Once home C slept in a crib on F2's side of the bed. This was so he could pass C to M when he needed feeding during the night, given her ongoing recovery from the C section. The open side of the crib faced at 90° to the bed towards its bottom. F2 is a heavy sleeper and this was, as I understand it, a safety measure to ensure he could not roll onto the open side of the crib.

80) On 26 July A and B met C for the first time. F2's mother (PGM) also visited. The only people with care of C were M, F2 and PGM but one of the parents was, according to M, present at all times.

81) On 27 July M and F2 remained at home with C save that F2 took C out in his pram to B's school so B could show people her new baby brother. The midwife arrived while they were out and agreed to call again the next day. M recalls (although F2 does not mention in his evidence) that F2 told her B had pushed the pram with C into the kerb rather than lifting it and said to F2, "I know what I am doing".

[2] The Scrub Nurse said in written comments recorded in a letter from Dr Verling, Consultant Paediatrician, dated 26 July 2019 that no implements except forceps were used to deliver C. All other records show no instruments were used and I proceed on the basis that this was an aberration.

82) On 28 July F2's grandparents came to visit mid-afternoon. M says nobody was left unattended with C.

83) On 29 July C was taken to hospital for a heel prick test. While there they saw a lady at the Breast Feeding Clinic and there was a discussion about how to latch C to the breast. During that M says that the lady physically pushed C to M's breast with such force that she was pushed backwards onto the bed. Dr Cartlidge was asked whether this could possibly account for the injury. He did not think so.

84) Otherwise 29 July was spent at home with C and the family.

85) On Saturday 30 June M and F2 took C to Poole with them so they could buy presents for A's birthday. They met up with the MGPs and A. The MGPs' neighbours also met C for the first time. According to M nobody had care of C unattended.

86) During that evening C had what is described as a 'blue' incident – he went blue around the lips. M called the out of hours maternity unit who advised they call an ambulance. They did so. C was left in the care of paramedics while the parents made arrangements to go to hospital. M travelled to hospital with C in the ambulance and F2 followed in his car.

87) C was seen by Dr Fowles at 23:10 that evening. No abnormality was noted and no bruising was documented. C was admitted for observation and the parents remained with him overnight.

88) At 01:00 on Sunday 1 July a nurse noted a bruise on the right side of C's neck, commenting "Dr's aware". Neither Dr Harbour, Paediatric Registrar, nor Dr Parslow, Consultant Paediatrician, recall seeing, or being informed about, a bruise. The parents were not told about it. It is common ground that this evidence of a bruise is insufficient to be of relevance or concern.

89) That morning physical examination by Dr Hope was normal and C was discharged home at midday.

90) I July was A's birthday. After school a friend came round and they cuddled C. He seemed fine. The parents were in and out of the kitchen preparing tea. The friend left at about 18:30 after which the family walked to the MGPs' home for A to open her presents from them. MGM cuddled C. The parents were in and out of the room but did not leave the MGPs' home.

91) On 2 July the girls were at school and the parents took C to a nearby town to buy baby equipment. They visited a number of shops. They were out between 11:00 and 15:00. M says C was fine all day.

92) On 3 July the parents took C to visit F2's grandparents and his uncle. All the adults cuddled C but none were left unattended with him.

93) On 3 July M received a call from A's school asking that she collect her because she had hurt her knee at sports day. The parents took C with them in their car to collect A. C remained in his car seat until they got home.

94) That evening F2 went to band practice. M remained at home with all three children. Although she cannot be sure as to the timing, M believes it was that evening that she came out of the toilet to find B carrying C, as she described it, like a teddy bear under her arm with his head resting on her shoulder and trying

to go out of the kitchen door to put a bottle in the recycling bin outside. M says that she remonstrated with B about what she was doing. She said she had made clear to both girls that they were not to pick up C unless one of the parents was present. C seemed fine and M does not believe that any harm came to him during this incident. She says that B can be strong willed and want to get her own way.

95) On 4 July M's sister and her son came to visit, bringing with them a pram she had bought. They stayed a while as M says she was having a particularly tiring day and was feeling emotional. M left C with her sister and F2 while she showered. At some point MGM visited to bring part of the new pram that had been forgotten.

96) The health visitor visited at 09:45 on 4 July and undertook a hearing test and took length, waist and head circumference measurements (enquiries of the health visitor during the hearing confirming she had measured the head). C was undressed. Physical examination was noted as satisfactory with nothing untoward found.

97) That evening, at about 18:15, M, A and MGM went to A's school for a presentation evening. F2 remained at home with B and C, who was asleep in his Moses basket in the lounge. F2's mother and her partner arrived a few minutes after M left. At around that time F2 says he saw B going to pick up C from his Moses basket. He could not be sure in evidence whether B actually picked C up or was in the process of doing so. This happened, he told me, just as his mother and her partner were arriving. F2 does not mention this incident in his statement and nor does M. Indeed she said in her statement that nothing untoward happened.

98) However, at 18:45 that evening, about 30 minutes after the incident, F2 sent a Facebook message (and he thinks a text message) as follows:

> "Just got [C] off to sleep in his moses basket to then I came out of the lounge to start packing up laptop etc and put monitor in it so could wash up for your daughter [B] to go and pick him up and fucking wake him again not happy leave him alone [B] ugh"

99) It was put to F2 that this message clearly showed he was frustrated and angry, even 30 minutes after the event. He accepted he was annoyed by B ignoring what she had been told but did not accept anger.

100) M returned home at about 20:15 to find C asleep in MGM's arms.

101) On 18 July the social worker visited A at school. She said that at 02:00 on 5 July she woke up because C was crying. She said she heard him screaming. She said she had asked M in the morning what C had wanted in the night and said M had told her he wanted feeding. M could not recall this conversation, although accepts it may have taken place if A recalled it.

102) M described 5 July as a busy day with C. They had to get the girls to school and then attend the Registry Office to register the birth. That was followed by a visit to a local housing association to discuss increasing the size of the home to accommodate the new arrival. They then went shopping to a supermarket. Whilst out and about M describes C as safely strapped either in his car seat or pram.

103) At about 12:45 M, F2, C and visited M's nephew's sports day. M says at no point was C left unattended with anybody.

104) At 16.25 that afternoon M bathed C. A photograph shows him in the bath. There is no evidence of swelling to the left side of his head which is visible (there is little hair covering the head). M says C was fine at this time.

105) M fed C as usual at about 02:00 on 6 July and noticed nothing untoward. I understand it is her practice to stroke C's head while feeding.

106) At 06:30 on 6 July M went to the toilet and on her return picked C up to feed him. Whilst feeding C she felt a lump to the top left side of his head and roused F2. M called her mother who advised applying butter (what she described as an old wives' tale) which M did. C seemed alert and happy and was feeding normally, so the parents decided to monitor the situation.

107) That morning F2 had arranged to register A and B with a local football team at 12:30. This was, he told me, a very important step in the development of his relationship with the girls and he was anxious to see it done. While they were out B asked whether C's head had got bigger. The parents checked him and agreed his presentation had changed and decided to take him to hospital. Initial assessment took place there at 15:00.

The medical evidence

At hospital

108) C was alert and active on examination by Paediatric Registrar, Charlotte Weeks. He was warm and well, had no nappy rash and was dressed in clean clothes and a clean nappy. The parents' behaviour during examination was appropriate.

The injury

109) Ms Weeks reported a soft, boggy 2.5cm x 2.5 cm swelling above C's left ear. There were no overlying skin changes and the swelling did not seem tender on palpation. No other evidence of injury or bruising was noted. Bloods and skeletal survey were normal.

110) A CT scan showed the left parietal fracture with an overlying surface haematoma (described by Ms Weeks in the notes as a cephalhaematoma which she thought would be unusual at 12 days) but no evidence of intercranial haemorrhage.

111) Dr Mankad talked about a linear fracture with two components forming the L shape. He was not confident we were looking at a cephalhaematoma and would not classify it as such. Dr Cartlidge said he had assumed (as had the doctors at the hospital) that it was a cephalhaematoma but deferred to Dr Mankad. Dr Cartlidge explained that it made no difference to the question of timing whether it was a cephalhaematoma, save that it might have implications for how long the swelling lasts. Because a cephalhaematoma sucks blood by osmosis from surrounding tissue the bleeding may stop but the swelling may continue as fluid is drawn in from surrounding tissue. And so the swelling may last longer.

112) As I understand it cephalhaematoma is commonly associated with birth trauma. Indeed, Dr Cartlidge told me that he had started by assuming this was a birth injury but, having considered all the evidence, had come to rule that out as a

possible cause. Birth injury was certainly considered a possibility by the doctors at the hospital and Dr Waters mentioned that to the parents who clearly hung onto it as the most feasible explanation.

Timing

113) A very experienced radiologist, Dr Gawne-Cain had also referred to a cephalhaematoma. She said the high attenuation in haematoma suggested an age of less than 12 days. There was no intercranial abnormality.

114) In his report, not received until the Friday before the hearing, Dr Mankad noted an undisplaced L-shaped fracture of the left parietal bone. He confirmed that, as skull fractures do not calcify, it was not possible to date the injury by looking at the fracture alone. There may be calcification of blood at the margins of a haematoma but there was none here.

115) The extracranial haemorrhage overlying the fracture had hyperdense (bright) components consistent with recent (0-7 days old) injury. A scan on 11 July showed the haematoma reducing in depth. Dr Mankad gave a range of 7 to 10 days based on density of the haematoma but, agreeing with Dr Cartlidge, with the swelling likely to have appeared within 24-48 hours after injury. With a significant impact such as this the blood would collect from ruptured small veins and capillaries once traumatised and there was no rule that a swelling would take 24 hours to come out. It could happen immediately or within a few hours. Dr Mankad did not consider this swelling would have taken 5 days, for example, to develop and could not associate the injury therefore with the 'blue' episode on 30 June. He thought it possible to stretch timing back to the night of 3 July if the swelling was missed during the 02:00 feed on 6 July.

116) Neither Dr Mankad nor Dr Cartlidge agreed with Dr Gawne-Cain's timing of up to 12 days, which of course could have taken the injury back to birth. Mr Hand pressed Dr Mankad on this. I pointed out that we were talking about a 20% margin on his outside range of 10 days (although he thought the density more consistent with 7 than 10 days). There followed a discussion about whether 10½ days would be possible (a margin of 5%). Dr Mankad conceded that. He supposed, talking in those terms, that we could not rule out a margin of 20% as plausible, but doubted whether 12 days was realistic. This remains the position of both experts.

117) I am left, in terms of timing, with an expert consensus that although the density of the haematoma allows for injury occurring at up to 7-10 days before 6 July, it is likely that it happened during the 24 to 48 hours before the swelling was found at 06:30 on 6 July, or possibly for some hours before that if the swelling was missed at the 02:00 feed that morning. Dr Mankad and Dr Cartlidge consider it unlikely that the swelling was present on 4 July when C was examined by the health visitor or when M bathed C at around 16:25 on 5 July given the absence of evidence of swelling in the photograph taken then or M noticing anything untoward.

Mechanism

118) Dr Mankad reported no evidence of shaking or rapid acceleration-deceleration forces (no subdural haemorrhage). He said skull fractures imply direct impact, either of the head against a stationary hard object (for example, during a fall) or a moving object (for example, a ball) against the stationary head.

119) Fracture type does not help differentiate accidental from inflicted injury. Dr Mankad noted however that this was not a simple linear fracture such as might more commonly be seen in accidental injury. There is a secondary fracture (forming the L shape) extending into the coronal suture. Dr Cartlidge explained this as the linear fracture reaching a weak point in the skull and going into it.

120) Both experts confirmed that a fall head first from 60cm onto a hard, flat surface would be likely to cause a fracture of the type seen. Dr Cartlidge accepted that a fall from a lesser height onto an edge of, for example a table, might result in similar kinetic energy. Dr Cartlidge said that whatever caused the injury we had to think in terms of replicating a fall from about 60cm.

121) Dr Cartlidge said that nothing in this case pointed to inflicted injury rather than accidental fall. There was for example no fingerprint bruising that might be associated with inflicted injury. Babies being dropped is not uncommon in his experience.

122) Dr Mankad confirmed that, as the skull sutures are quite open at birth even a low height fall can cause considerable skull and brain injury. He said that the shape of the fracture says nothing about the shape of the impacting object.

C's likely reaction to injury

123) Dr Cartlidge considered that following injury C would have screamed loudly unless rendered unconscious, which he thought unlikely. If C was stunned for a moment he would be likely to scream when he recovered. He might be soothed by a feed as sugars within the milk would act as a mild analgesic. His sleep might be fitful for a day or so. He might be lethargic if he was not feeling well. Because the cognitive functioning of a baby is less than in an adult, reaction may be different and difficult to predict.

Other possible causes

124) A skeletal survey on 8 July 2019 confirmed there were no additional fractures and bone mineralisation was normal. In evidence Dr Mankad accepted that bone density reduced to 70% would show as normal on CT/MRI scans. He was clear though that the available evidence did not suggest de-mineralised bones.

125) C is being explored for possible cystic fibrosis. Dr Mankad and Dr Cartlidge confirmed this would not be causative. Dr Cartlidge explained that although cystic fibrosis may result in osteoporosis or osteopenia (shortage of bone mineral) it could not be relevant at this stage as the necessary proteins come from the placenta not nutrients in the gut.

126) Dr Cartlidge said the only appropriate investigation was for Ricketts. He considered the treating radiologists at Southampton (where the scans were reviewed) were very experienced and it would be very unusual for them to overlook Ricketts. Alkaline phosphatase, always increased in Ricketts, was normal.

127) The parents wondered whether C might have banged his head against a collar-bone or bony knee. Dr Cartlidge ruled this out.

128) They have also wondered whether a ½ kg plastic toy elephant dropped on C's head, perhaps by a sibling, could have resulted in the injury. Dr Mankad said

being hit by a toy like that might cause a fracture. Whether a drop of an object like that on the head could be responsible would depend on the height of the drop. Dr Cartlidge did not consider this a likely cause.

129) Mr Hand does not abandon the possibility of injury at birth. He points to the initial conclusions of Dr Waters, Dr Gawne-Cain and Dr Cartlidge himself, coupled with the timing of up to 12 days given by Dr Gawne-Cain.

130) However, having regard to the relatively straightforward nature of the C section, the fact that no lump was seen at birth, on discharge from hospital, at hospital on 30 June, by the health visitor on 4 July or by M on bathing C on 5 July, Dr Cartlidge confidently rules out birth injury. Dr Mankad deferred to Dr Cartlidge on this question.

The parents' response

131) Save only for the absence of explanation, the local authority accepts that the parents' response has been appropriate throughout. They were arrested and interviewed and essentially maintained the consistent position they have put throughout. They do not know what happened to C and are unable to give an explanation for his injury.

132) If they really do not know what happened, it is understandable (indeed reasonable) that, having been told by doctors that the injury may have been birth related, they should hang on to that as the probable cause. That enabled them to effectively rule out the girls as responsible in their statements. The girls were both spoken to by the social workers. They maintained they had at no time picked up C without one of their parents being present. So far as B is concerned, that conflicts with M's evidence about what she saw on 3 July (if that was the date) and F2's evidence about what he saw on 4 July.

133) Given the lateness of Dr Mankad's evidence there was little opportunity for the parents (or indeed anybody else) to review the medical evidence before the hearing. And so it was not until Dr Mankad and Dr Cartlidge gave their evidence on the first day of the hearing that it could be said the medical issues, particularly as to timing, were clarified, and notwithstanding that Dr Mankad deferred to Dr Cartlidge on the possibility of birth injury.

134) This explains to a large extent the emergence at the hearing for the first time of the possibility that somebody else in the household may have been responsible.

135) Any inconsistencies that there might be in the parents' positions over time are either insignificant or explained in my view. Otherwise their position has throughout been unified and consistent. It may be said that it is easier to maintain a lie by simply saying denying any knowledge than by seeking to maintain a false positive explanation. The former only requires the witness to remember they have said "I don't know", while the latter requires the witness to remember the detail of a positive false story they have told at different times.

136) Nonetheless, I bear in mind in this case that F2 in particular has some relatively minor cognitive difficulties. Even if M were able to maintain a consistent lie, I question whether F2 would be able to do so as unhesitatingly as he has over an extended period and under challenge in evidence.

Assessment of the witnesses

137) The social workers and experts all gave balanced and considered evidence, open in this complexing case to all possibilities. Ms Campbell was prepared to say, contrary to the local authority's case, that her gut reaction was this was an accident.

138) The parents, as might be expected from what I have said about them already, came across as apparently straightforward, consistent, reliable and credible witnesses. If one or both of them knows what happened to C they have done an exceptional job of concealing it. Instead I got the impression of two capable, concerned and committed parents genuinely at a loss to understand what has happened and searching themselves for an explanation.

139) My assessment of the parents' credibility and reliability weighs heavily when I come to consider the totality of the evidence.

Discussion and findings

140) The first question is whether the local authority has proved that C's injury was caused by the negligent (careless), reckless or deliberate act or one or both of the parents.

141) The medical evidence, which I accept, clearly shows that C suffered an impact to his left parietal skull. I accept the evidence ruling out any other explanation. I also accept that the medical evidence supports a finding on balance that the impact happened in the 24-48 hours before 06:30 on 6 July. The absence of swelling during bathing at 16:25 on 5 July is not necessarily determinative whether impact had already happened because the swelling may not by then have developed. I am unable therefore to be more precise in a finding about timing than to say the impact probably happened between the morning of 4 July and 06:30 on 6 July.

142) The medical evidence does not point towards either accidental or inflicted injury. All other things being equal, as Dr Cartlidge said in evidence, inflicted injury is less common than accidental injury.

143) There are of course a number of possibilities. One or other of the parents might have lost control and inflicted the injury. One of other might have dropped C or otherwise hit his head unintentionally but negligently or recklessly. Or one of them might have dropped him accidentally without fault. Or one of the girls might have done any of these things.

144) So far as the parents are concerned there really is nothing to point to inflicted injury. True it is that F2 has had emotional and mental health issues relating to his childhood, but he appears to have taken effective steps to bring that under control. The absence of domestic abuse within the parents' relationship and the committed, supportive and loving nature of that relationship would seem to bear that out. So too would the coming round of initially sceptical grandparents to acceptance of the relationship and the development of the relationship between F2 and the girls and their confirmation that nobody got cross in the house.

145) It seems to me inherently improbable that this was an inflicted injury.

146) Nor is there any evidence to point to the injury being caused by carelessness or recklessness rather than pure accident. There is no evidence, for example, of substance misuse or neglect of any of the children, indeed quite the contrary.

147) Assuming for a moment that one or both of the parents know what has happened and has failed to give an explanation – that would not of itself point towards how the injury happened. They might just as likely not be prepared to own up to dropping C accidentally, for example, as they might not be prepared to admit to inflicting an injury on him deliberately. It would be wrong to infer that failure to give an explanation points one way or the other.

148) I accept the evidence of M about what she saw on 3 July and that of F2 as to what he saw on 4 July. On the first occasion B was carrying C and on the second she was in the process of picking him up from his crib. I am unable from the evidence to rule out the possibility that she may have picked up C on other occasions. I do not come to any conclusion that B (or A) was responsible for C's injury but the fact that there are other possibilities means that it is not inevitable (or necessarily even probable) that what happened was at the hands of one of the parents.

149) There was some question from what B said to the social worker whether something might have been worrying her and that she had something to say. Drawing any conclusion from this would be speculation.

150) On the critical question whether the local authority has proved on balance that the injury to C was caused by negligence, recklessness or deliberate act, I conclude that they have not.

151) The next question is whether one or both of the parents do know what happened to C and have failed to give an explanation. And, if so, how is that relevant to threshold?

152) The only piece of evidence that points to a reaction from C comes from A in her interview with the social worker on 18 July. She used the word 'scream'. It is hearsay evidence which, though admissible, has not been tested by questioning. The interview was informal and not conducted under ABE guidelines. What is difficult to know is the significance to attach to A's use of the words 'screaming' and 'crying' and whether they were interchangeable. It is difficult to know from what A said whether she identified any qualitative difference in what she heard in the early hours of 5 July and the other nights when C was crying for his feed. Mrs Hambleton would say it was enough for her to mention it to M the next morning (although M cannot recall the conversation) and so must have held significance for her. Mr Hand, supported by Mr Howard, submits that I should be cautious about reading too much into this singular piece of evidence.

153) For the reasons I have indicated I cannot attach much weight to this evidence. The uncertainties around it make it unsafe for me to conclude on balance that what A heard was C's reaction to an incident in which the injury occurred.

154) I have to weigh the evidence of Dr Cartlidge about C's likely reaction to injury coupled with the confined size of the house and the presence throughout of one or other parent against their evidence that they saw and heard nothing to alert them to anything untoward happening to C. This is altogether more difficult. There is plenty of evidence that C cried a lot. The girls said as much. Would a carer necessarily be able to distinguish the cry of a hungry baby from the scream of a hurt baby? C did not seem to be in distress or pain at the hospital

(the swelling was not tender on palpation). The evidence of the parents is that there was no point at which he was off his feed or unsettled.

155) The question is, once again, have the local authority proved on balance that one or both of the parents knew what happened? The impression I have of these parents weighs heavily in my assessment. I am inclined to believe them. I do not consider the points in favour of the local authority's case on this question outweigh this and I again conclude the local authority has failed to prove knowledge.

156) Even if I am wrong about that, I ask myself the question what the relevance would be to threshold. Unless the local authority were in position to prove delayed presentation for treatment which caused additional suffering, I do not see how it could be relevant. Failure to be open and honest or give explanation is only attributable to the extent that it causes, or risks causing, significant harm. Because we do not know, and I am unable to find, when the injury happened, there is no evidence of delayed presentation. Assuming therefore that C was presented for medical treatment promptly, would failure to give an available explanation of accidental injury in itself have caused significant harm or risked it? The tests undertaken would presumably have been the same. The treatment (if there was any) would not have differed.

157) Put at its highest I suppose it could be argued that failure to give an available explanation

a) resulted in C being removed (along with A and B) from the care of the parents; and

b) gives rise to concern what the parents might do if there were a similar incident.

158) It does not seem to me that, standing on their own, either of these conclusions would enable the local authority to prove threshold. Neither point is in fact relied on by the local authority as I understand their case.

Conclusion

159) The local authority has therefore failed to prove its case under section 31(2). It follows that their application for public law orders must be dismissed.

160) I am sending this judgment in draft on 21 November. Subject only to allowing time for the local authority (or, indeed, the guardian or F1) to consider whether to request permission to appeal, C should now be returned home to his parents.

161) I ask the parties to liaise with listing to fix a date when this judgment can be formally handed down.

Postscript

162) I have this morning handed down this judgment which I sent out in draft on 21 November. Down to this morning nobody had heard from the local authority in response to the draft judgment. Mrs Hambleton told me that the opinion of senior counsel had been obtained as to whether permission to appeal my decision should be sought. A decision had only been made in the early hours of this morning not to seek permission to appeal.

163) Very sensibly the parents have agreed that the return of C to their care should be done in a planned way rather than immediately. That, I am told, will happen on the morning of Monday 9 December.