IN THE FAMILY COURT
(Sitting at Bedford)

No. WD18C00668

2nd Floor
Cresta House
Alma Street
Luton
LU1 2PU

Monday, 30 September 2019

Before:

HIS HONOUR JUDGE PERUSKO

(In Private)

B E T W E E N :

A LOCAL AUTHORITY — Applicant

- and -

A MOTHER
AND OTHERS

Respondents

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MR R. POWELL (instructed by the local authority) appeared on behalf of the Applicant.

MR A. BAGCHI QC and MS E. HUDSON (instructed by Attwaters Jameson Hill) appeared on behalf of the First Respondent.

MS R. CABEZA and MS N. CARPENTER (instructed by Barnes & Partners) appeared on behalf of the Second Respondent.

MR D. SHERIDAN (instructed by Duncan Lewis Solicitors) appeared on behalf of the Third Respondent (through the Guardian).

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A P P R O V E D J U D G M E N T

JUDGE PERUSKO:

Introduction

1 These proceedings concern a 17-month old girl, A, who was born on 18 April 2018. Her mother is the first respondent. She is X years old. Her father, the second respondent, is X year old.

2 This hearing is to determine how A suffered a number of injuries in the first nine weeks of her life, discovered following her admission to hospital on 21 June 2018. The injuries were these:

(a) a bruise on her left cheek, 1 cm in diameter;

(b) a petechial rash on her lower lip;

(c) a torn frenulum under her upper lip;

(d) a bruise on the outside of her left knee, around half a centimetre in diameter;

(e) fractures to four of her ribs, the anterolateral aspects of the fifth, sixth, seventh and eighth ribs on the left side.

3 The local authority asks the court to make findings that all the injuries were inflicted, that is to say not organic or accidental in origin, by one or other or both of the parents. The local authority maintain that the evidence supports a finding that both parents should be in the pool of perpetrators. It would follow that if such findings, or any of them, were made, the threshold criteria set out in s.31 of the Children Act would be met; namely that A had suffered significant harm attributable to the care given to her by her parents, not being what it would be reasonable for a parent to give.

4 The parents separately say that the father's admission, made for the first time in the witness box during a hearing in December 2018, should be accepted as the truth and that he was responsible for the facial injuries suffered by A (those lettered (a), (b) and (c) above). Neither offer any explanation as to how the fractured ribs occurred. They each maintain that the local authority has not discharged its burden of proof in establishing that the rib injuries were not caused accidentally. They both maintain that the injuries were accidental. Both parents say that if I do determine that the injuries were inflicted, neither of them was responsible.

5 This is the second hearing to establish the facts in this case. A hearing took place in December 2018 when the judge heard evidence from the parents and the two experts in the case who had then been instructed: Dr Russell Croft, a consultant paediatrician, and Dr Karl Johnson, a consultant paediatric radiologist. The findings in that judgment were set aside by the Court of Appeal at a hearing on 3 April 2019, judgment being handed down on 9 May 2019. Last week I dealt with the re-hearing over 4 days.

The Background

6 A is the first child of both parents. They have been in a relationship for six years. She was a planned baby. At the time she was born, her parents were living at the house of A's maternal grandmother and her partner. It is a small, two bedroom bungalow. Mother had worked up until late into her pregnancy. Following a difficult attempt at a natural delivery, A was born on 18 April 2018 by emergency caesarean section at 39 weeks' gestation. There were no concerns about the baby and she and Mum were discharged home from hospital on 25 April. Father took four weeks' paternity leave during which time the parents cared for the baby together, initially at the hospital and then at home.

7 A health visitor visited on 1 May, a week or so after the discharge from hospital, when A was seen. The health visitor recorded that A was thriving and progressing well, aside from some mild concerns about jaundice. A was a challenging baby to care for in those early weeks. Mother was struggling with her attempts at breastfeeding, which frustrated her. Her struggles with breastfeeding ended after the first four or five days when mother moved on to bottle feeds. A would stay awake at night, not settling, for several hours and, as I have said, mother was in a lot of pain (sometimes chronic pain) and exhausted, recovering from her operation. It hurt her, for example, to lift A. Both parents, not uncommonly, were deprived of sleep.

8 Both parents ignored the advice given by the health visitor, initially on 1 May and repeated subsequently, against co-sleeping and the serious risks associated with co-sleeping, hence A slept in the parents' bed, on the mother's side, not in the middle. A developed colic. She frequently cried at night and would not settle. She was particularly unsettled during the early hours of the morning. This was the most difficult time for the parents.

9 The mother sought and followed appropriate advice from the health visitor regarding the difficult sleeping pattern, and indeed other issues, for example in relation to colic. On 4 May

A was taken to the GP for a sticky eye and a few days later back to the health visitor. Mother was concerned about nappy rash which had developed.

10 Father returned to work on 12 May. He works night shifts, only some five or ten minutes walk from the family home. Initially on his return to work he worked 10.00 p.m. until 7.00 a.m. for a couple of days, then either 7.00 p.m. to 4.00 a.m. or 6.00 p.m. to 3.00 a.m. They were nine-hour shifts. The timings were changed so that he could get home earlier as the mother was struggling to cope with A's crying and her not settling.

11 The first night Father worked was 12 May. Text messages passing between the parents show the extent to which the mother was struggling. For example, at 3.20 a.m. mother sent a text to the father saying this, "*Like, bitch, I'm trying to help you*." Four minutes later the father replied, "*Oh Jesus, is she having a bitch fit again*?" Mother's response at 3.53, "*I'm gonna lose my shit in a minute*." Then, at 04.42, mother again text the father, "*I was gonna hit her*." Father's response only a minute later, "*You can't hit her, babe*." An immediate response from the mother, "*I told you I can't cope*." Then another text sent immediately thereafter, "*I need to see someone."* Father responded at 04.50, "*You can cope, baby, you just need sleep*." Mother's immediate response to that, "*When you want to hurt your child, something is wrong*." At 04.53 the father responded, "*Of course it's normal, babe*. I've had the same thought to sometimes, you just think oh, if I hit her, maybe she will shut up." Father sent another text immediately thereafter, "*But we don't. That's just normal thinking. Every parent thinks it.*" Then he wrote another text, "*And I'm sure 90 per cent of parents have lashed out because their child is being a demon.*"

12 A couple of nights later, there were further exchanges in similar vein. At 01.21 the mother sent a text to the father saying, "*Help me*", and immediately thereafter another one, "*She hasn't stopped.*" Father responded two minutes later, "*What on earth is the matter with the bloody child?"* An hour later, at 02.28, mother sent a text, "*Did you tell him, the stupid baby doesn't sleep?"* Then two minutes later she sent another text, "*Not just at night when she turns into a fucking demon.*"

13 Eight nights later, 22 May, at 28 minutes past midnight, father to mother, "*Boos, hit her to sleep.*" Father to mother again at 01.37, "*Quick, get a cheeky slap in*." Then, "*She won't see it coming*." Then, "*We can show her that we can be demons too.*" Two minutes later, at 01.39, father to mother, "*Joking, Boos, don't actually do it.*" Then at 01.44, father to mother, "*Oh no, Bubbaboos, like you was ever going to*." Mother responded at 01.55, saying, "*Hurry*

home before I do slap her", and then at 02.00, "*I'm about to lose my shit*." Father responds a minute later, "*Babe, come on, don't joke like that*." Mother's response, "*She's crying for no fucking reason now"*, and then follows it up with another text, "*Well, hurry up, before I fucking cry*." Father to mother, 02.07, "*Okay, Boos, well, resist the temptation*." Then mother to father, "*CBA*", (which means can't be arsed) "*with this shit*." There are other references to A being called a bitch by both her mother and her father in subsequent texts.

14 By the end of May A's sleeping was better and she was usually sleeping from ten-thirty at night to 6.00 a.m. On 1 June the GP undertook a six-week check on the baby. There was a full examination. No concerns were recorded. Three days later, on 4 June, the mother saw the health visitor. Mother told the health visitor that A was crying a lot and would not settle. Again, it was noted that mother was not following advice regarding co-sleeping. Advice was given about the risks of sudden infant death syndrome. The risks associated with shaking the baby as well were discussed and discussion about what mother should do if she felt overwhelmed with the task of caring for the baby. The health visitor felt that the mother had mild depression.

15 On 12 June, the mother rang the health visitor. She was concerned that there was blood in A's stools. Advice was given and followed to take the baby to the GP. In fact, the GP was seen twice on 15 June, once for inoculations and once for the stool issue. Mother again took A to the GP on 18 June and again on 20 June, concerning her concerns regarding blood in the stools. Nappy rash extending into the anus was diagnosed initially, with steroid cream being prescribed. Mum was not that happy and sought a second opinion on 20 June. A was examined on that occasion and noted to be well, save for two tiny anal fissures.

16 On 21 June mother contacted the health visitor. She said that A had blood in her mouth. The father had been feeding A and blood was coming from the top lip. A was taken by the parents to Princess Alexandra Hospital on the advice of the health visitor. On examination she was found to have a bruise on her left cheek, a rash on her lower lip, a torn upper frenulum, a bruise on the outside of her left knee and, following a skeletal survey, healing fractures on the anterolateral aspects of her left fifth to eight ribs.

17 A police protection order was obtained. Her parents were arrested on suspicion of inflicting GBH, and both were interviewed. The local authority issued an application for a care order on 26 June and an interim care order was made on 27 June. A was discharged from hospital that day, initially to foster carers but, following a positive viability assessment of the paternal

uncle and his partner, placed with them. A remains placed there, having regular contact with the parents.

The Law

18 In determining the issues at this fact finding hearing, I apply the following principles. First, the burden of proof lies with the Local Authority. It is the Local Authority that brings the proceedings and identifies the findings they invite the court to make. Therefore, the burden of proving the allegations rest with them.

19 Secondly, the standard of proof is the balance of probabilities, ***Re B* [2008] UKHL 35**. If the Local Authority proves on the balance of probabilities that A has sustained non-accidental injuries inflicted by one of their parents, this court will treat that fact as established and all future decisions concerning her future will be based on that finding. Equally, if the Local Authority fails to prove that A was injured by her parents, the court will disregard that application completely. As Lord Hoffman observed in *Re B*:

> "*If a legal rule requires facts to be proved, a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are nought and one*."

20 Third, findings of fact in these cases must be based on evidence. As Lord Justice Munby, as he then was, observed in *Re A (A child) (Fact Finding Hearing: Speculation)* [2011] EWCA Civ. 12: "*It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation*".

21 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 context of all the other evidence. As Dame Elizabeth Butler-Sloss, President observed in ***Re U, Re B 9 (Serious Injuries: Standard of Proof)* [2004] EWCA Civ. 567**, the court "*invariably surveys a wide canvas*". In *Re T* [2004] EWCA Civ. 558, [2004] 2 FLR 838 at paragraph 33 she added:

> "*Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to the other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion of whether the case put forward by the Local Authority has been made out to the appropriate standard of proof*."

22 Fifthly, the evidence in this case, as is invariably the case in proceedings involving allegations of non-accidental injury includes expert evidence from specialists. 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. In ***A County Council v KD & L* [2005] EWHC 144 Fam**. at paragraphs 39 to 44, Mr Justice Charles observed:

> "*It is important to remember that (1) 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. The judge must always remember that he or she is the person who makes the final decision."

Later in the same judgment, Mr Justice Charles added at paragraph 49:

"*In a case where the medical evidence is to the effect that the likely cause is non-accidental and thus human agency, a court can reach a finding on the totality of the evidence either (a) that on the balance of probability an injury has a natural cause, or is not a non-accidental injury, or (b) that a local authority has not established the existence of the threshold to the civil standard of proof ... The other side of the coin is that in a case where the medical evidence is that there is nothing diagnostic of a non-accidental injury or human agency and the clinical observations of the child, although consistent with non-accidental injury or human agency, are the type asserted is more usually associated with accidental injury or infection, a court can reach a finding on the totality of the evidence that, on the balance of probability there has been a non-accidental injury or human agency as asserted and the threshold is established*."

23 As Mr Justice Ryder observed in *A County Council v A Mother and others* [2005] EWHC Fam. 31:

"*A factual decision must be based on all available materials, ie. be judged in context and not just upon medical or scientific materials, no matter how cogent they may in isolation seem to be*".

24 Sixth, in assessing the expert evidence the court must be careful to ensure that each expert keeps within the bounds of his or her own expertise and defers where appropriate to the expertise of others: see the observations of Mrs Justice Eleanor King in ***Re S* [2009] EWHC 2115 Fam**.

25 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. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them: see *Re W and another (Non-accidental Injury)* [2003] FCR 346.

26 Eighth, it is not uncommon 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 various reasons, such as shame, misplaced loyalty, panic, fear, distress and the fact that the witness has lied about some matters does not mean that he or she has lied about everything: see *R v Lucas* [1981] QB 720.

27 Ninth, as observed by Dame Elizabeth Butler-Sloss President in *Re U, Re B, supra*

"*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 may 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 two of her 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 quashed her convictions. There was no evidence other than the repeated incidents of breathing having ceased and there was serious disagreement between the 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, Lord Justice Judge, 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*."

28 With regard to this latter point, it is important to take into account to an extent that is appropriate in any given case the possibility of the unknown cause. That was articulated by Lord Justice Moses in *R v Henderson and Butler and others* [2010] EWCA Crim. 126 at paragraph 1:

> "*Where a prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative cause, it is tempting to conclude that the prosecution has proved its case. Such a temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude beyond reasonable doubt an unknown cause. As Cannings teaches, even where, on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown*."

29 Tenth, and importantly in the context of this case, when seeking to identify the perpetrators of non-accidental injuries, the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator: see *North Yorkshire County Council v SA* [2003] 2 FLR 849.

30 The Court of Appeal only this year in B (Children) [2019] EWCA Civ 575 considered this issue. As Peter Jackson LJ said

> '*Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool': see Re S-B at [43]. Approaching matters in that way risks, as Baroness Hale said, reversing the burden of proof.*
>
> *49. To guard against that risk, I would suggest that a change of language may be helpful. The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: **Re D (Children) [2009] EWCA Civ 472** at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'.*

31 Further it is always desirable where possible for the perpetrator of a non-accidental injury to be identified, both for the public interest and in the interests of the child, although, where it is

impossible for a judge to find on a balance of probabilities, for example, that parent A rather than parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to do so: see *Re D Children* [2009] 2 FLR 668, *Re SB Children* [2010] 1 FLR 1161.

32 Finally, as this is a rehearing of a case where the original findings have been set aside *Re H* (A Child) (Appeal) [2016] 2 FLR 1173 [2015] EWCA Civ 1284, reminds me that it is essential that I approach the case with a completely open mind, scrutinizing the evidence afresh and not reading into, or taking any steer, from the decision made by the court of appeal

The Evidence

33 Two experts were instructed to give opinions leading up to and at the hearing in December 2018, Dr Croft and Dr Johnson. Both produced written reports and attended an experts meeting on 19 November 2018. Both gave oral evidence at the December hearing.

34 Following the Court of Appeal judgment, further questions were put to the experts and another meeting took place on 7 June of this year. Permission was given by His Honour Judge Waller CBE on 28 August this year, after an application made by the guardian, to instruct Dr Olsen, a consultant paediatric radiologist. He too has reported in writing and attended a meeting with Dr Croft on 18 September. All three experts have given oral evidence, Dr Johnson and Dr Croft by video link (Dr Croft from Serbia, which suffered from significant problems of delay on the link) and Dr Olsen in person.

35 Dr Croft's report of 12 November 2018 was prepared following a review of all the medical notes and the evidence which had, by then, been filed, including the parents' witness statements and police interviews. In it he gave the following opinion in respect of the rib fractures:

> "…*are most likely to be due to abusive squeezing or gripping of the chest. She would have cried at the time that the fractures were inflicted, but another adult who had not been actually present and witnessed this abusive event may not later have realised that it had occurred. She may have been irritable, she may have had difficulty feeding, she may have been breathing slightly rapid, but these symptoms may have been overlooked as they are non-specific. It may be of note that she was crying a lot on 04.06.2018.*
>
> *In the absence of bone disease, documented severe trauma such as a car crash, or birth trauma, non-accidental trauma is the most likely cause of rib fractures in an infant…Normal handling of a baby could not cause rib fractures. A vehicle*

decelerating would not cause this. Even throwing a baby into the air and catching her would not cause rib fractures."

A tear of a frenulum of the mouth in a baby of this age can only be due to inflicted injury in the absence of a highly plausible explanation. Normal bottle feeding does not cause this."

36 He goes on:

"*All the injuries on the face and around the mouth are likely to have been due to the abusive acts. That is to say that she was probably gripped round the face and either hit in the face or had the bottle thrust into her mouth. No other plausible explanation has been given. Normal handling of babies does not cause facial bruising or mouth trauma.*

The right knee bruise was probably a grip mark. The mother's suggestion was speculative anyway and not of witness cause."

The mother had suggested in her witness statement that there might have been a bang to the knee on a play table.

"*In my opinion, at the time, this would have been painful (he is referring back to the knee bruise) and she would have cried. I do not believe that a carer who was in the near proximity would have been completely unaware that something had occurred. I do not know how long she would have taken to calm down, however. She was tearful when her mother saw her but I consider that she would have cried at the time of the injury."*

37 He deferred to the radiologist in terms of timing of the rib injuries but in so far as the torn frenulum was concerned, he said it could have been inflicted on 21 June or possibly the day before. The torn frenulum was still bleeding and was thus fresh. In summary he said this:

"*A had an ensemble of injuries typically seen in abused babies. Facial eye and mouth bruising, torn upper frenulum of mouth and four rib fractures*."

38 In his report of 9 November 2018, Dr Johnson estimated that the rib fractures were in the region of two to five weeks old when the x-rays were taken, although, as he explained, it was difficult to age fractures and, to an extent, this was a subjective estimation. That dating would put the window of when the rib injuries were sustained as between 21 May and 11 June 2018. Dr Johnson said this of the rib fractures:

> *"These rib fractures are typically the result of a severe excessive squeezing/ compression of the chest. The amount of force required to cause these rib fractures is unknown, but in my opinion, it is significant and greater than that used in the normal care and handling of a child. Rib fractures do not occur from normal domestic handling, over exuberant play or rough, inexperienced parenting. For example, in life saving cardiac massage where the chest is forcibly compressed by one third of its diameter, rib fractures very rarely occur.*
>
> *In my opinion, given the location and appearance of the rib fractures, I think it is most likely that all the fractures occurred from a single episode of chest compression. In my opinion, at the time that these fractures occurred, A would not have the strength or level of development to self-inflict these injuries. I would have expected that A would have been in pain and shown signs of distress. This initial distress would have lasted some moments. Following this initial distress, the signs and symptoms relating to these rib fractures could have been variable and I would defer to the paediatrician in all aspects of clinical presentation both at the time the fractures occurred and subsequently. I have not been provided with any suitable explanation of significant trauma to A's chest to account for these fractures. In the absence of any suitable history, rib fractures of this nature in a child of A's age raises concerns about possible inflicted, non-accidental injuries. It is the absence of any suitable history rather than the radiological appearance of the fractures that raises these concerns. The same fracture pattern could have occurred from an accidental or an inflicted injury.*"

39 There is no organic or metabolic disorder or disease that would predispose A to fracturing.

40 One of the questions Dr Johnson and Dr Croft were asked to consider at the experts meeting on 19 November 2018 was whether severe compression to A's chest would have left marks or bruising. Dr Croft said in a lot of cases rib injuries with infants do not present with bruising because the fractures are quite old and are healing so any bruise would have disappeared. It is also possible to squeeze the chest without causing bruising.

41 Another question raised at that meeting was the likelihood of rib fractures like these occurring as a result of the mother rolling on to A while she was sleeping. In relation to that question, Dr Johnson said this:

> "*To cause a fracture you need a suitable mechanism and a significant level of force. An adult rolling on to a child would create the mechanism, although it depends on how much force. Gently rolling on a mattress is unlikely to cause enough force on the rest to cause fractures, although could not exclude, depends on what happened in the rolling episode and how much force was exerted on the child's chest. Forcibly pressing down on a child could cause the rib fracture."*

42 At the same meeting, in relation the facial and knee injuries, Dr Croft said that it was just about possible for the torn frenulum to have occurred twenty-four hours earlier than the presentation at the hospital but it was more likely to have been on 21 June. He said that:

> "*A was likely to have bled at the time of the injury, at the start of the injury, quite a violent event. Someone probably hit her in the face. People often speculate but I am not very convinced that this is due to force feed. It must mean that the bottle by force goes under the upper mouth frenulum, under the upper lip. You have to pull up the lip to cause the injury or else it is a blow to the upper lip. Often perpetrator in my experience says that their hand slipped. The child is more likely to have been hit to the face. In this case we have bruising as well. It could have all happened at almost the same time or it could have gone on over several hours. She would have bled at the time of the injury, although might not have bled again if not disturbed."*

43 When asked about the facial injuries as a whole and asked to consider whether they were separate or maybe as the result of one incident, he said this:

> "*They could have occurred almost at the same time, although more likely to have been different physical acts. There is a bruise on the knee and to the cheek. I cannot imagine it could have been just one blow to the face. It must have been more than one act. It could have been gripping around the leg whilst hitting the face. It could have been over a very short period of time. I think from looking at the photographs, there is also a bruise to the left eye, left upper lid rather than lower eyelid. There was likely to have been more than one physical act of violence."*

44 He was asked about the dating of the bruising. He said:

> *"I cannot state exactly. The bruising is not likely to be one month old rather than one day or some days beforehand. It is unlikely to be three weeks old. Circumstantial evidence is more reliable than medical opinion on the bruising issue."*

45 On 13 December the mother filed her third statement. In it she said this:

> *"I am now aware that Dr Johnson does consider that the rib injuries could result from an adult rolling onto a baby in the bed. Although I am not aware of any such incident occurring, A did sleep next to me in the bed for a period of time. I am aware that this was against the advice of the health visitor. However, this was the only way that A would settle. I cannot exclude the possibility that I rolled onto her and then back without being aware that it happened and was not woken by her crying due to deep sleep, due to my general exhaustion."*

46 Her earlier statements had made clear that although she co-slept with A, against medical advice, she had never rolled over onto A. In her first statement, dated 17 July 2018, she said this:

> *"When I knew she (A) was in a deep sleep, I would then slowly and gently put her to the side of me."*

She had earlier described how A would often fall asleep on her.

> *"And after about an hour, I would remove my arm from supporting her neck and either lay with her cuddled into me or I would move away, leaving enough room between us. I was careful that she never rolled off me and I never rolled over when she was lying on me or next to me."*

47 In her second statement, 30 November, the mother offered no further comment about co-sleeping or rolling over onto A and neither had she offered any such suggestion when interviewed by the police.

48 In oral evidence at the hearing in December 2018, Dr Johnson confirmed his view expressed at the experts meeting, namely that he could not exclude rolling over onto A as a mechanism

to cause the rib fractures but that it would require a level of force involving significant compression of the chest. There was a consistent body of opinion, he said, which says to cause fractures you need to compress the chest. He said this:

> *"To cause rib fractures, the ribs are, along with the other structures of the chest, the ribs form a structure, a tight band that you can compress. To cause a rib fracture, you have got to compress that band to the point that the compressive forces overcome the elastic strength of the ribs, at which point they will snap or will crack. That has to be done in a moment, i.e. there will be a significant compression of the chest such that the compression overcomes the strength of the bones and then they break. In my opinion it would be a moment, therefore. It would not be part of a rolling action. It would be at some point the chest has been compressed. Therefore I cannot say how that would happen or exactly what point but I do not believe the actions of rolling on and off would be the cause of it. It would be the exact significant compression of the chest that caused it."*

49 Dr Croft in his oral evidence at the December hearing said, in answer to a question concerning the possibility of overlaying being the cause of the rib fractures, this:

> *"Well, I don't think it's probable, your Honour. Whether it's possible or not, I've been thinking about, listening carefully to Dr Johnson. (He had sat through Dr Johnson's evidence.) I don't think it's completely impossible and I think I would agree with him, or I would agree with what I think he means, which is that in theory it's possible but I do not know, and I was actually in the comfort break, your Honour, doing a little googling, and I do not know of any reported cases. To my knowledge and experience, the risk of what used to be called overlaying in the olden days was of suffocating the baby, and unintentionally, non-abusively, mothers or parents, especially if they had taken drink, I think, because then they didn't move very much, that was the sort of classic risk of overlaying, as we used to call it, but not of rib fractures.*
>
> *I don't know of any reported cases so I don't think, although in theory it might be possible, epidemiologically, as far as I know, it has not been reported. If there has been an isolated report or reports I'm not aware of, I would stand corrected but I did do a literature check but that's not exhaustive. I will have another look. For example,*

your Honour, if you look at the literature on the causes of rib fractures in infants, which I have read papers on, that's not one of the causes mentioned."

50 He continued that he thought the possibility of rolling on and rolling off the baby as a cause of the rib fractures was very low. He agreed with Dr Johnson's evidence in relation to that. In relation to the other injuries, Dr Croft accepted, in respect of the mark to A's left upper eyelid, that it was possible that it was natural discolouration and not a bruise. So far as the other injuries were concerned, Dr Croft made clear that he thought that the mouth injuries could have been done at the same time. He also said that looking at this case holistically, in her lifetime A has sustained a number of injuries which cannot be explained accidentally.

51 In an addendum report of 20 May this year, Dr Croft, having considered a number of the medical papers, gave his opinion that there was no evidence that overlaying caused rib fractures in infants. Those fractures were found in association with other, highly suspicious injuries. He himself had no experience of death due to overlaying in which at post-mortem rib fractures were found.

52 Dr Johnson, in a report dated 22 May 2019, considered the same medical papers and said this:

"It is my understanding that there is no direct and confirmatory evidence that co-sleeping causes rib fractures, to which I mean it has not been proven or disproven from a scientific standpoint that co-sleeping causes rib fractures. Conversely, it has not been proved or disproven, again from a scientific standpoint, that co-sleeping does not cause rib fractures. It is my opinion that to cause a rib fracture requires both a suitable mechanism and a significant level of force. Rib fractures are the result of significant compression/squeezing of the chest. The amount of force required to cause the fracture is unknown but, in my opinion, it is significant. If an adult lay on top of a child, as could potentially occur in co-sleeping, this would cause some compression of the chest. In my opinion, rib fractures would be more likely to occur if there is a downward force and pressure applied to the child, as opposed to just simple, light touching."

53 He goes on to say:

"One could not exclude co-sleeping as a possible cause for the rib fractures but I am unable to determine the level of probability. From my experience of providing reports

for the court, the issue of co-sleeping and rib fractures has been raised on more than one occasion." He went on to say in oral evidence that this was in court proceedings, not in clinical practice.

54 There was another experts meeting on 7 June 2019. Yet more medical literature was considered and discussed.

55 As I have mentioned, the court gave permission for Dr Olsen to be instructed, in particular, not just to review the evidence, but also the medical literature, given the extent to which the two instructed experts had been asked to look at various medical papers. Dr Olsen is a consultant paediatric radiologist, practising at Great Ormond Street Hospital. He is also academically active and, since 2014, has been managing editor of **Paediatric Radiology**, a global journal dedicated to paediatric radiology. He too conducted a study of all relevant research and looked at the diagnostic imaging of A. He agreed with Dr Johnson's opinions about the presence of and timings of those injuries, although he said that if there was compelling evidence of a causative event slightly outside the window of two to five weeks, that might take precedence.

56 He offered the following opinion:

"On the balance of probabilities, the rib fractures were not spontaneous or self-sustained, were not caused by normal handling, were not caused by birth trauma, had been caused by one episode of compression of the chest, front to back or back to front, required forces of magnitude sufficient to reduce the chest diameter by about one third, remained unexplained since it is my opinion that causation by overlaying is only a remote, theoretical possibility, and were caused either by an accident that has not been disclosed or by an accident that the parents did not witness or by inflicted injury. However, the relative likelihoods of these alternatives cannot be determined radiologically."

57 He went on to give the following opinions relating to the causation of the injuries based on his experience and the literature. He rejected the possible explanations of throwing the baby into the air and catching her as a remote theoretical possibility and strapping A tightly into a car seat as not being sufficient to generate enough force. Both had been offered as possible explanations by the parents.

58 In terms of overlaying whilst co-sleeping as a possible cause, he said this:

> *"In my opinion, the required mechanism and force would only arise if A was on her back, the maternal body part exerting force was placed on A's chest, pressure was exerted fairly specifically on the chest, otherwise the child would have suffocated if any part of the mother overlay the face, or the pressure would have been dispersed and rendered insufficient. The force must have been such that even when accounting for the cushioning of the mattress/bedding etc, the chest would have been significantly squeezed, by about one third of its diameter. The pressure must have been released within seconds or else A would not have been able to expand her chest to breathe."*

59 He also said:

> *"I do find it challenging to envisage exactly how this may have happened. In my opinion, the weight of the mother's arm or leg would far from suffice in generating the required force. If mother rolled on top of A without noticing in her sleep then it is only by extreme luck that A did not suffocate. Perhaps mother's arm rested against the baby's chest and acted as a standoff when mother rolled onto the baby, and that mother rolled onto the baby in such a way that the airway was kept free. The mother then rolled off fairly soon, so the baby could regain normal chest expansion in order to continue breathing. Alternatively, perhaps mother somehow rolled to exert pressure obliquely from the front of A's left chest. Somehow the baby was not pushed sideways and away from the mother but rather very firmly into the mattress and, again, the pressure was released to allow A's continued breathing. It follows, in my opinion, that while the proposition that overlaying caused the rib fractures cannot be rejected as impossible, the only viable conclusion is that it remains a remote theoretical possibility only."*

60 He did not identify any evidence in the medical literature for overlaying causing rib fractures. He had no clinical experience with any case, and he has dealt with hundreds perhaps thousands of cases, of overlaying causing rib fractures. He said that were overlaying to happen and cause fractures, it would most likely kill the baby. He regarded Dr Johnson's written opinions on this issue, namely that overlaying can cause rib fractures in young infants, as being very similar to his. In an experts meeting on 17 September, which was attended by Dr Croft and Dr Olsen, Dr Olsen maintained this view, namely that he thought that his opinion on the issue was probably the same as Dr Johnson's.

61 Dr Croft expressed the view that Dr Olsen's opinion on the causation issue was very well argued and clear and he agreed with it. He also agreed that if mother had rolled onto A in her sleep, she would have most likely suffocated and not suffered rib fractures.

62 All three experts gave evidence at the hearing last week. Dr Croft was asked about the father's explanations, in his fourth statement, as to how the frenulum, lip and cheek injuries occurred (father's explanation that the cheek injury had happened when he had put the baby onto the cheek (sic) after the bottle had been forced into her mouth):

> *"It is fairly clear there are a number of abusive facial injuries. It is possible that the bruise occurred by hitting the shoulder but not terribly likely that one of the injuries (namely the bruise to the cheek) is not abusive. When you feed a baby, you normally don't do it in such a way that it hits the shoulder. All very strange and contrived. Mechanically it was possible if it was done after the feeding event. It depends how the baby is held. Normal people don't hold babies, nine-week old babies, in that manner. You hold the baby in a way that it doesn't happen. Even if a parent jumps up in surprise, it doesn't strike me as a natural way that people would hold their baby."*

63 He was asked about the lower lip bruising and whether it was consistent with the bottle having been shoved into the baby's mouth. He said this:

> "*I'm not completely convinced that it would damage the lower lip. It's possible but I don't feel constrained to accept it. A lower bruise to the lip, a bruise to the cheek and the frenulum injury, complicated facial injury, possibly the child being hit in the face or gripped. I think there are other acts, not associated with bottle feeding. I don't think shoving in the bottle necessarily bruises the lower lip. It's not obvious. It would be nice to see the bottle in question."*

64 Dr Croft had not seen, either physically or by photographs, of the feeding bottle. He was shown in evidence and then sent photos overnight and said, in writing, that the teat, probably being softer, would probably not tear the frenulum but the cap could possibly bruise the lower lip. That implied that the whole episode of oral injury may not be explicable by acts involving the bottle. He made clear though the limitations of that opinion, particularly as he had not handled the bottle. Dr Croft had not been shown the bottle previously and during evidence was only shown photographs. He did not have physical possession of it. The bottle was produced overnight and was available for the court. The bottle had an insert and Father's

counsel suggested the insert was not flexible. Certainly I could flex it. I do not think it matters hugely and I do not put any weight on what Dr Croft says in relation to the teat / insert as he had not examined it.

65 So far as the knee bruise was concerned, it was put to him that this could have occurred by inappropriate roughness or grabbing during a nappy change and he said this:

> *"In my opinion, what we know is babies don't have bruises unless they're ambulant, crawling. They don't get bruises if handled appropriately. As a mechanism, the fact that the parents are not offering an explanation is very telling. If you grip a child inappropriately, it's abusive. You would know. You wouldn't speculate some time later it may have happened. The short answer is no, I don't accept that as a mechanism or explanation. That's why. They would know. I don't have to say how it happened. Probably a grip mark. Theoretical, it's speculative but I don't actually know. It was inflicted but the exact mechanism we will never know, probably a grip mark. An educated guess. You don't see those marks on a nine-week-old baby properly looked after."*

66 As far as the rib injuries are concerned, he would not assume, he said, that rough radiological dating proved that this was a single injury. He was not necessarily agreeing with Dr Johnson's opinion in that regard. He felt that the rib fractures could have occurred on separate occasions but he did defer to the radiologists in that regard, if the court was satisfied with their evidence.

67 Dr Croft was cross-examined at length in relation to the research, and indeed a paper not previously produced at all by the father's team until the morning of the hearing was also considered. That paper was a study of dead rabbits who had inflicted rib injuries after death. He also answered a written question about that paper overnight. That did not take matters particularly further. He stuck resolutely to his opinion, that causing rib injuries by way of overlaying was not impossible but it was very unlikely. He felt that there was no material difference between his opinions regarding the rib injuries and the radiologists.

68 Dr Johnson in oral evidence said he agreed with Dr Olsen's opinions, save in respect of the way Dr Olsen expressed the opinion that overlaying causing rib fractures would be regarded as a remote theoretical possibility only. He said he did not disagree with that proposition but could not himself express an opinion on the likelihood of that explanation as being a cause of the injury. He could not calibrate the likelihood of that being a possibility.

69 He had never seen clinically an explanation offered for rib injuries as being caused by overlaying, except in the context of court proceedings. Neither was he aware of any such report in any of the medical literature. He did emphasise in his evidence that the history given in a particular case was important in establishing the cause of an injury.

70 Dr Olsen was questioned at length about his opinion concerning the causation of the rib fractures and, in particular, the mechanism of overlaying or a bed roll. He said this:

> "*The background here is I was asked specifically to consider whether an adult rolling onto the baby might cause rib fractures, her rib fracture, so how does one answer that question? One has to look for evidence, examples of mechanism with that outcome. I cannot find any examples of the same. I certainly know from my own professional life that there are examples of babies being taken to hospital after overlaying but all the babies I have seen have been dead and I've not seen any fractures, none. Of course one can say how do I know never, at any time, has there been an example of a rib fracture caused by this mechanism. How do you know somebody else hasn't observed it and not published it? These objections can always be made. This is medical practice and science. How science works is one forms a hypothesis based upon relevant reasonable observations and extrapolation from relevant and reasonable observables and one tries the hypothesis on one's peers. In this case the hypothesis is that rolling onto a baby does not cause rib fractures and, in my view, that's a very reasonable proposition. Science then works in this way, that hypothesis can never be proved; it can never happen, but as long as it has not been rejected, the hypothesis stands. I referred to a remote possibility. I cannot determine or predict that there will never be a case but I am not aware of any such evidence and that makes it, to me, a remote possibility."*

71 Later, in cross-examination, he said this when asked about Dr Johnson's opinion that he could not calibrate the likelihood of this being a possibility:

> "*To me it's not a big problem. I understand the problem for the court but to me as a medical practitioner, you work without necessarily having hard evidence for everything I do. I would not do my job very well if I only acted on hard evidence. I rely on the following. It's very reasonable to hypothesise that co-sleeping does not cause rib fractures, or at least does not have a strong association with rib fractures. That remains a hypothesis. It can be justified because how would the rib fracture be*

caused by overlaying a two-month-old baby without killing the baby. Also based on large studies of babies dying after co-sleeping because of overheating or strangulation. One of those papers is in the bundle. There's not been a single, as far as I understand, not a single one had a rib fracture.

We're talking about post-mortem studies, much more accurate as this would directly involve an inspection of the ribs. It's reasonable to propose the hypothesis that co-sleeping does not cause rib fractures. The task for people who disagree is to come up with evidence to the contrary and, as far as I'm aware, no paper rejects such a hypothesis. Although one cannot say that there will never be a case where that causal mechanism could cause the fracture, in my opinion it remains a remote theoretical possibility."

72 He was also asked questions about the mechanism of force, in other words the way the force was applied to the chest, front and back. He was asked by mother's counsel to not really think about the classic double-handed squeeze, to think about an alternative mechanism with the baby lying on the back and the parent's movement involving some sort of levering effect by way of the elbow going into the side of the ribcage, a momentary but significant force as the parent tried to shift position, more of a bony, pointed impact on the side, that sort of possibility. He said this:

"*I'm not entirely sure which word to use, direct pressure, but to me that would not suffice, would not be an explanation. I don't see how an elbow would cause linear fractures of four ribs adjacent to each other without a degree of compression front to back. As I said earlier in my evidence, I can't be 100 per cent sure but to me that's a very, very unlikely mechanism."*

73 In cross-examination by father's counsel, Dr Olsen speculated, as he had in his report, about the possible causes of the fractures as possible explanations for the injuries. He considered those in a balanced way and maintained his position. He said this:

"It's very difficult for me to envisage how the mechanism was caused to fracture those four ribs, major trauma without killing the child. I'm adding to that, to my knowledge there's absolutely no description in the world of medical literature of overlaying causing rib fractures. This might be the first case. It's for the court to decide how

remote or proximal the explanation is but, from my professional position, it seems fairly remote."

74 The parents also gave evidence and I have of course read their written evidence and the transcripts of their oral evidence in December 2018. Mother has always denied that she inflicted any sort of injury to A. In terms of the rib injuries, she was, understandably, questioned closely about her explanations given to the police and the court, particularly in the context of the concerning text messages. Further, she had never mentioned in any of the evidence filed before the experts meeting about the possibility of rolling on and off during sleep being a possible explanation for the injuries. It had only been suggested by her after the experts were asked about that being a possible explanation.

75 At the hearing in December 2018 she could not explain why she had not mentioned overlaying as a possible cause of injuries to the police. She accepted that in the relevant time period she had been sleep deprived, she was stressed, but she continued to maintain that she was not responsible for the injuries.

76 At the hearing before me, she was questioned closely about the content of the text messages and her feelings of stress and frustration when the father returned to work. She admitted she had violent thoughts towards the baby but said that the texts were her way of letting out her frustration. She described vividly how difficult life was for her at that time. She denied adamantly that she had lost control and squeezed A or hurt her in any way. The rolling over theory was explored. She accepted not having suggested overlaying until it had been raised by the experts. She also said that she felt it was unlikely that the father had squeezed A with her not noticing. She thought she would have heard him if he had done that in temper and that he had squeezed the baby hard. In the relevant window within which the rib injuries were sustained, A had only been left with the father for a couple of minutes or so if she went to the toilet or went into the kitchen to make some food. She continued to genuinely believe, she said, that the rib injuries had happened while she was asleep.

77 In terms of the facial injuries, the mother described how shocked and very upset she was when she heard for the first time the father's admissions in the witness box last year that he had caused the mouth injuries. She was angry with him. She denied causing those injuries herself and denied that the father may have made up his explanations to protect her. She said that after the first few weeks, A had been good at taking the bottle from her. She explained how on 21 June father had come into the lounge holding A on his shoulder. He said, "*I don't know*

what's wrong. She's bleeding." He had a worried voice and was crying a little bit. She said there was not much blood despite describing in a text to a friend whilst A was at hospital that day, that the blood was "*pissing out of her mouth*." She said she had been exaggerating. She did not know why she had exaggerated.

78 She was asked at some length, including by me, about the content of the text messages. She explained that she was exhausted and frustrated. The language, she said, was disgusting and she could see why people would think that she had done something to A but told me, "*I love her too much to be able to do something to her*."

79 The father's account of the mouth injury, first given in oral evidence in December 2018, was this:

> *"I was asleep. I woke up. When I woke up, I was tired. I'd not had much sleep from Wednesday night because my body was adjusting back into day mode. A's bottle was already prepared on the bedside. I was wearing boxers, sitting up in bed. A was awake. She was due a feed at 10 a.m. or 10.30. The bottle had been prepared by [the mother]. I picked A up off the table and cradled her in my left arm. My hand was on her bottom to tap her, to relax her. I'm right-handed. Then I got the bottle and took the lid off and placed the bottle in her mouth and she took it. She did not take the milk straightaway. [the mother] saw me put the teat in A's mouth. A was not really feeding. The teat was in her mouth but she was not comfortable with it. She tried to move her head around a bit. She more than likely didn't want it. [the mother] left the room.*
>
> *I took the bottle out of A's mouth because she would not feed. I tried a second time. She would not feed the second time and was shaking her head, moving back and forth. I felt really down. This had been going on for two weeks, where I could not feed her properly. From time to time in hospital, I tried to help and fed her well in hospital. I could not understand what I was doing wrong now. It made me feel like a shit father and I felt quite down. I had two attempts at putting the teat in her mouth. Then I took the teat out after the second attempt and I got frustrated with myself and I shoved the bottle at an upward angle in her mouth and it caught her lip and pulled her lip up. The teat did not go up to the roof of the mouth. It went between the gum and the lip and the teat bent because I pushed it in too hard. When it happened, I took it out and put it in a fourth time, not as hard, and she started to drink. She was sobbing and teary eyed but did not scream. She was sucking normally and gulping and I noticed a*

blood spot on her bib or Babygro and I noticed the milk was dark around the lip area, around the bottle.

I took the teat out because I was really worried. I saw blood on the teat. I put the bottle down and I jumped up because I was worried and that's when her face hit my collar bone. I rushed in to [the mother] because I felt I hurt my daughter but I never intended to hurt her. I said to [the mother], 'She's bleeding from the mouth.' I handed her to [the mother]. She told me to calm down and [the mother] took her off me and dialled the health visitor. I could see blood was dripping out now and again, not loads of blood. She told me to get tissues to clean it up, while phoning the health visitor. It was gradually bleeding, not gushing. The milk made it watery and came out faster. It stopped after five or ten minutes with the tissues on it. I've never told [the mother] this. I've had to deal with it for six months. It's been so hard. I think I tore the frenulum. It was not a thrust but I pushed it in. I never meant to hurt her intentionally. I saw the teat bend and the upper lip move upwards. I did not know I had torn her frenulum until I saw the blood."

80 In his oral evidence in the hearing before me he demonstrated with a baby doll the mechanism of trying to feed A. It was in similar terms to that which he expressed in the last hearing. He expressed emotion whilst he demonstrated this. He said:

"The second time I put the teat in, I pushed up. She didn't take it. The third time, I thrusted it up at a different angle and rammed the bottle in at an angle. The teat went into the lip, right up. I shoved it in. That's when she started sucking and blood came out with milk."

81 It was put to him that Dr Croft said that it was unlikely that she would take the teat the fourth time. If she had been injured, she would be in pain. He said this:

"She didn't scream. She was sobbing. That's why milk was coming out. It was a mixture of blood and milk. My first thought was what had I done. I wasn't thinking. I jumped up. I threw her to my shoulder, the opposite shoulder, and she smacked my shoulder."

Then he pointed to where she had smacked on his shoulder.

"I was scared. It wasn't normal handling. I wasn't truthful to [the mother]. I couldn't tell her. I made some story up about her bleeding from the mouth."

82 It was put to him that he was hiding the full extent of what had happened. He said this:

"I took her straight to [the mother]. She was worried. She said she'd ring the health visitor. I knew what I'd done was wrong and she should go to hospital. I didn't stop [the mother] calling. I care about her. There was something that was going on in myself. I couldn't feed her. It was confusing me."

83 He was asked why he lied repeatedly. He said:

"I was scared. When the x-rays came back and I knew that I hadn't done that, the ribs, so I thought I'd get away with the other injuries. It would go away. I didn't know it was going to escalate. I got frustrated with myself. I was worried she'd be taken away if I told the truth. I admitted what had happened because I couldn't lie anymore. It had come to judgment day. I didn't know who to talk to. I knew people would judge me. After I'd given my evidence, I still felt bad but a little better."

84 The father was questioned about the inconsistencies within his accounts, to the hospital, the police, in statements. It was put to him that his account given to the hospital when he said that he had noticed blood on the Babygro initially was not consistent with his now explanation. To the police he had said nothing about repeatedly trying to feed A. It was put to him that he was covering up and that he was not telling the whole truth. He denied suggestions that he was covering up for the mother and denied that the first account that he gave, in other words spotting blood on the Babygro, was true. Neither had the father to the police said he had hit A's head on his shoulder. He could not explain why. He denied being out of control when he forced the teat into A's mouth but accepted it was a violent act and abusive and that he was cowardly for not owning up earlier. He said, *"I gave in to the red mist."*

85 In terms of the rib injuries, he said he had no reason not to admit to the rib injuries if he had done it. He did not think that the mother had caused the injuries. He admitted that the language in the texts was concerning and that the texts he had received from the mother when he went back to work worried him a little but not too much. They would use language like this in ordinary exchanges and in banter.

86 I find it difficult to assess the credibility of the parents in this case, particularly in the context of lies having been told and lies having been admitted to be told. Those lies have had serious consequences. Who has been lying and why have they been lying? Is this a joint cover up by the parents to shield the mother from any blame? That question has troubled me a good deal.

87 The text message exchanges are truly horrendous. To call their new-born child, "*a bitch*" and talk about harming her is both shocking and abhorrent. The exchanges show frustration and indeed hostility to the child. That said I do think that there is some truth in the parents' explanations that this is the way they interact with each other, unacceptable though that may be to the observer and reader. The texts also show that the mother, in the early period, in the weeks after the father returned to work, was under incredible stress and not coping well with life or on her own, in particular at night. One can see in those circumstances why it could be concluded that it was her who lost control and perhaps may have taken her frustration out on A. She might have squeezed A in an act of frustration.

88 I found the mother quite emotionally flat when she gave her evidence. Of course she cried and expressed some emotion but overall I thought she was flat. In some ways that is understandable. These proceedings have lasted fifteen months already. She has faced two substantive hearings and a trip to the Court of Appeal. She has not cared for A for most of A's life. But in terms of her overall evidence, when cross-examined in some detail, she remained consistent in her explanations about how the facial injuries had been caused.

89 Although the father was emotional when describing how he had injured, he said, A's mouth, I also found him quite defensive. I thought his explanation about why he had not admitted the mouth injuries earlier was telling; he thought that he would get away with it.

Discussion

The rib injuries – the 'overlaying' explanation / hypothesis

90 It is safe to conclude on the balance of probabilities that:

(a) all four injuries happened on the same occasion. I accept Dr Johnson and Dr Olsen's evidence in that respect;

(b) that they happened some time between 21 May and 11 June 2018;

(c) they were caused by the compression of the chest of a significant force, well outside what would be normal handling of a child, requiring the chest to be compressed by about a third;

(d) there is not an organic, medical or accidental explanation.

91 I reject the parents' hypothesis that overlaying in some way caused these injuries. Hence those injuries must have been inflicted. I come to those conclusions for a number of reasons. Never, it seems, in any published literature or in the clinical experience of the three experts in the case, but particularly the two paediatric radiologists who have observed in clinic many thousands of patients over many years, has there been a rib injury explained by overlaying. That of course does not mean it can never happen but it satisfies me, on the balance of probabilities, together with all the other evidence, that the local authority have proved that this is an inflicted injury. There are other injuries to the child which it is accepted are inflicted. That, in my view, inevitably increases the possibility that the unexplained rib injuries are inflicted.

92 Whilst all three experts accept that the hypothesis suggested by the parents could explain the mechanism which might have caused the injury, it is, in my view, extremely unlikely that the force required to fracture the ribs would be generated by overlaying. It is even more unlikely that A would be alive. Those conclusions are, in my view, well founded in the experts' opinions in this case.

93 For the sake of completeness, I would add that I accept and prefer the evidence of Dr Olsen where there is a difference between him and Dr Johnson. I accept that rib fractures caused by overlaying is a remote theoretical possibility. I reject the suggestion that overlaying caused the injuries to A. It follows that the rib injuries are inflicted. That is to say they have not happened by accident.

<u>The facial and knee injuries</u>

94 Is it possible to identify, on the balance of probabilities, who caused the mouth injuries? Do I accept the father's admissions regarding these and the bruise to the face or was he covering up for the mother? It is clear to me, looking at the evidence as a whole, that the father did cause the injuries to the mouth, that is to say the frenulum and the lower lip. I do not believe

that he is covering up for mother. That said, like Dr Croft, I do not believe that the father has given a full and complete account of what actually happened.

95 The father lost his temper with A in frustration because she was not taking milk from him and he had been struggling with that for a couple of weeks. As he said, he gave in to the red mist. I believe that he did just that but I do not accept that, in doing so, he banged A's cheek on his shoulder in the way that he described. I think it is more likely that in the course of forcing the bottle into A's mouth, an action which would have been violent, he would have grabbed her face or something similar and caused the constellation of injuries to the face and the mouth. I do not think that this was a slap to the face but this was an uncontrolled, violent outburst on a tiny, vulnerable baby, which the father then sought to conceal. It was only when he knew that the court would find one or other of them as responsible, did he have the nerve to own up.

The rib injuries – who caused them?

96 Is it possible, looking at all the evidence, to identify, on the balance of probabilities, who caused the rib injuries? There is evidence pointing to the mother, in particular her state of mind, her physical state, the appalling text messages at the start of the window within which these injuries occurred. She was exhausted. She was struggling in many, many ways. She was in constant pain. She had very little help to care for this baby. The father had gone back to working his nightshifts. She was threatening in texts, which are horrendous, to harm the baby and effectively pleading with the father for help. It is easy to see how she might have flipped in a moment. She also had a lot more opportunity than father, being the primary carer of the child.

97 There is also evidence that points towards the father causing the injuries. He played his part of course, albeit to a much lesser extent, in talking in texts about having thoughts about hurting the baby, hitting the baby, and getting in a "*cheeky slap*". It is also significant that he caused the facial injuries some two to five weeks later in an uncontrolled, violent outburst. He has lied already about the facial injuries. That does not necessarily mean he is lying about the ribs, but he did lie and eventually made an admission, albeit, in my view, not a full one. He has before felt that he would get away with accepting responsibility for the mouth injuries. He talked about the issue, he hoped, "*going away*." Perhaps he thought that the experts having accepted the possible mechanism of overlaying, would explain away what had happened. Indeed, that is what did happen at the hearing last year.

98 What cannot be ignored in my view is the inherent improbability of both parents having inflicted two separate sets of injuries on a baby only nine weeks old, neither, apparently, being aware of the injuries that the other had inflicted. What carries in my mind considerable weight in respect of the rib injuries is the finding that I have made against the father concerning the facial injuries.

99 I again remind myself that I must not strain to find a single perpetrator, I must be careful not to do that. Taking all of that evidence into account I conclude, on the balance of probabilities, that the father is responsible for these rib injuries. He lost control, I think, of himself, in frustration perhaps at A not sleeping or feeding and in a moment, although I do not speculate, probably squeezed A. That could have happened in a moment and it could have happened without mother being aware. I find that mother would not have been aware of what had happened.

The knee injury

100 In the context of the constellation of injuries suffered by A, this is perhaps the least concerning. That said, it is Dr Croft's evidence that this was likely to be inflicted, probably a grip mark. I accept that this injury is also inflicted and I reject the parents' possible explanation that the knee may have been hit on a play table. I believe that the most likely explanation is that the injury was inflicted by the father at the same time or during the same process as the facial injuries on 21 June. It is likely that in handling the baby roughly or in an uncontrolled way, he gripped the baby's knee.

Conclusion

101 The findings that I have made exculpate the mother from responsibility for causing any of these injuries or knowing that they were inflicted. That she knew nothing of them means that, despite my reservations concerning the texts, she has not failed to protect A from harm. In terms of the father, what needs to happen now is this. The father needs to reflect on his position. He should give a full account of what has happened. I very much hope that he has a role to play in A's life. She needs him. Obviously there will need to be an assessment of the risk that he presents to A and the extent to which the mother can now protect her.