IN THE FAMILY COURT
(Sitting at Barnet)

Nuetral citation: [2023]
EWFC 301 (B)
No. ZW23C50157

Civil and Family Courts Centre
St Marys Court
Regents Park Road
Finchley Central
London, N3 1BQ

Tuesday, 12 December 2023

Before:

HER HONOUR JUDGE KARP

(In Private)

B E T W E E N :

LONDON BOROUGH OF HARINGEY — Applicant

- and -

(1) A
(2) B
(3) C and D (Via their Children's Guardian) — Respondents

MS F MUNRO (instructed by The Borough Legal Department) appeared on behalf of the Applicant.

MS R WILSON (instructed by Goodman Ray) appeared on behalf of the First Respondent.

MS J HURWORTH (instructed by Creighton Solicitors) appeared on behalf of the Second Respondent.

DR B JACKSON (instructed by National Legal Service) appeared on behalf of the Children's Guardian.

J U D G M E N T

JUDGE KARP:

1 This is the judgment following the hearing of a fact-finding determination within proceedings brought by the London Borough of Haringey for care orders in respect of two children, C , born in 2021, and D, born in Autumn 2022. The children's mother, A, is the first respondent, the children's father, B, the second respondent, and the children are the third and fourth respondents through their Guardian, Keisha Brome. All parties have been represented by counsel – the local authority by Ms Munro, the mother by Ms Wilson, the father by Ms Hurworth, and the children by Dr Jackson.

Documents

2 I have considered the voluminous documentation contained within the six volumes of the trial bundle. In addition, I have heard oral evidence over three days from Dr Johnson, consultant paediatric radiologist; Dr Rahman, consultant paediatrician; the mother; the father; and the parents' friends, E and F. I have considered the helpful oral submissions of counsel.

3 The findings sought by the local authority in their schedule dated 30 November 2023 are:

(1) That on 21 February 2023, D was seen at the North Middlesex Hospital with unexplained bruising on his body.

(2) D was found to have sustained the following injuries:

(a) .3cm x .3cm blue discolouration pigmentation bruise.

(b) .2cm x .2cm hyper pigmented mark bruise on the body map one. On body map two –

(c) .3cm x .3cm blue discolouration pigmentation bruise.

(d) .2cm x .2cm hyper pigmented mark/bruise and

(e) 1cm x .5cm hyper pigmented mark or bruise. Body map three –

(f) 1cm x .5cm blue pigmented bruise

(g) 5cm by 2cm yellow discolouration bruise.

(h) 1cm x 1cm blue discolouration bruise.

(i) 2cm x 1cm yellow discolouration bruise and on body map four –

(j) pinpoint blue discolouration bruise.

(3) That the above bruises were inflicted.

(4) D will have felt momentary pain when he sustained the bruises and shown this.

(5) D does not have an identified blood clotting disorder.

(6) D has suffered a fracture of the posterior right eighth rib.

(7) The fracture was inflicted.

(8) D will have been in severe pain and shown signs of distress at the time of the fracture.

(9) The rib fracture occurred three to ten weeks before 1 March 2023, between 21 December 2022 and 8 February 2023.

(10) D was in the sole care of his parents at the time of sustaining the rib fracture.

Causation:

(11) The rib fracture D suffered was caused by A or B.

(12) If A caused the rib fracture, B failed to protect D from significant physical emotional harm.

(13) If B caused the rib fracture, A failed to protect D from significant physical and emotional harm.

(14) That the parents have not provided a plausible or consistent explanation for the rib fracture within the timescale that the fracture was sustained.

(15) The parents unreasonably delayed in seeking medical assistance and treatment for D's rib fracture.

4 The parents accept the injuries as described but have remained consistent in denying that either of them intentionally caused harm to D at any time. The parents consider it likely that the father caused the bruising to D accidentally when asked to hold him firmly during the pre-operative procedure to repair his cleft lip and palate on 24 February 2023 when D was hungry, distressed and wriggling. The parents both say that the anaesthetist asked him on two or three occasions to hold D more firmly.

5 The parents were unaware of the rib fracture until told by the hospital on their account. The only incident the parents can think of which might have caused the rib fracture was on 11 February 2023 when they left the children for a few hours with their friends, F and E, who were staying with them over the weekend. The friends reported that C had climbed onto the bed and was found by F in the beside-me cot, on top of D.

Background and history

6 The parents met in 2017. They have been in a relationship since September 2019, lived together since November 2019. They were married in 2021.

7 Both of the parents agreed that the father was very hands-on in sharing all aspects of care with the mother. At the twenty-week scan in June 2022, they were told that the baby had a cleft lip and palate. They both agreed that a termination was not an option for them. D was born by caesarean section at the North Middlesex Hospital at thirty-six weeks gestation. He remained in the neonatal intensive care unit for 9 days to stabilise and enable his feeding routine to be established. He required a special adapted squeezy bottle to be fed with a specialised teat, as well as the careful syringing of his palate after each feed to prevent infection. The parents spent most of the time in hospital with him whilst C stayed with her maternal grandparents nearby.

8 I am grateful to Ms Wilson for preparing a detailed chronology. On 17 October D was seen by the health visitor. On 20 October D was seen by his GP for reflux. On 26 October D was taken to the A&E department at North Middlesex Hospital, reported to be unwell and diagnosed as a brief resolved unexplained event in an infant. On 10 November D was again taken to the Accident and Emergency at the North Middlesex Hospital and noted to have "blisters roof of mouth, dehydrated, possible blister in mouth from rubbing of bottle, not clinically dehydrated, safe to go home."

9 On 18 November D was again seen in the paediatric clinic and, on the same day, was reviewed by the GOSH multidisciplinary review team. On 21 November D had his six-week examination by telephone. On 28 November he was seen by the health visitor. On 30 November he was seen by a practice nurse at the GP surgery, to have his vaccinations. On 12 December he was seen by his GP, and noted to have a URTI, chesty cough and difficulty feeding. On 18 December he was taken to A&E at the North Middlesex Hospital with vomiting, a chesty cough and was monitored and discharged. On 19 December he was again taken to A&E with vomiting and admitted for observation and a likely viral illness.

10 21 December is the beginning of the date range, according to Dr Johnson, the radiologist, for the rib fracture. On 22 December D was taken to A&E at the North Middlesex Hospital, by ambulance, with gastro oesophageal reflux, noted to be monitored overnight for further episodes of vomiting and reflux, to be followed up by the GP. On 29 December he was seen at the GP surgery for vaccinations and noted that, "His mum feels his reflux is better with Omeprazole." On 30 December he was seen by the health visitor and it was noted:

> "Parents report infant has lost weight. Recovering from viral illness. Parents have been in and out of hospital for review. No concern identified. Coughs and colds caught from older sister. No health visitor concerns were identified."

11 The parents were noted to be attentive to his needs for comfort and feeding in the clinic, and the mother reported that she is much better and well now and that the father was well and receiving social support from the family.

12 On 5 January 2023 D was seen at the GP surgery by the practice nurse, and on 11 January, the surgery texted the parents to report that D's stool sample showed that he had rotavirus.

On 13 January D was seen at the GP surgery by his GP and was noted to be alert and active and smiling and the comment was, "Rotavirus, slow recovery, no dehydration."

13 On 17 January the father called the GP surgery, concerned about D's ongoing green stools. The GP noted that the rotavirus infection causes the gut to remain inflamed for a while, which could explain the green poo and also him being unsettled. On 26 January D was seen by the practice nurse for vaccinations. On 31 January he had an ultrasound of his scrotum. On 1 February he was seen at the GP surgery for a cough and a blocked nose. On 8 February Dr Johnson's probable range for the rib fracture ends, although he accepts that it is possible that it occurred on 11 February.

14 On 11 February was the incident when C was found in D's cot with her knees on his body by their friends who were babysitting. On 16 February D was taken to Great Ormond Street Hospital. On 23 February he was admitted for surgery to his cleft lip and palate. He was discharged following the surgery on 24 February. On 27 February he was taken to A&E at North Middlesex Hospital, as the parents were concerned that he was dehydrated. The records note that he had surgery on 23 February, was discharged on 24 February, but Mum informed that the hospital should have weighed him before the operation, so they weighed him after, as the hospital were not satisfied with the number of wet nappies and they were concerned about dehydration. No bruising was noted. The baby was observed and discharged home. It was on 28 February, on the father's account, that he noticed the bruise on D's thigh. The parents were not concerned by it and assumed that it was caused by the father holding him tightly in the preoperative procedure.

15 On 28 February D was brought to A&E because of the parents' concerns about bleeding from his palate following surgery. A body map was then prepared to which I have referred, medical photographs taken which form part of the bundle on 1 March, and a full skeletal survey undertaken. The medical records of 1 March record the conversation with the senior paediatric registrar, who had examined D. He remembers examining the baby in a nappy on 27 February. No obvious bruising was noted by him during the examination, but he could not definitively rule out bruising on the backs of legs as he had not examined them in detail.

16 On 2 March there was a strategy meeting. The parents were noted to have been appropriate on all the occasions they had been seen and had responded appropriately to the baby's needs. They were upset by the process but also cooperative. All the medical professionals reported that the parents were entirely appropriate, that the child presented well and does not, on the surface, appear to be a child who is being abused.

17 On 3 March there was an email from consultant radiologist, "Re probable rib fracture. Likely to be at least eight weeks old. Obviously only a guide." Completion of a skeletal survey took place on 3 March because the original film was not entirely clear. No further injuries were noted. On 8 March the consultant treating paediatrician, wrote in his report:

> "Due to there being an unexplained bruise on both posterior thighs, the decision was made to admit D and proceed with further investigations for a potential non-accidental injury."

18 His parents were appropriate and cooperative throughout. At the strategy meeting on the same date, the nurse practitioner was noted to say, "It's going to be one of those really difficult ones, where the injuries are unexplained."

19 After being discharged home, the parents' evidence has been consistent that they were managing well and were well supported by the maternal grandparents, although tired from the demands of two such young children, as any parent would be. Neither parent has any history of mental ill health, substance misuse, domestic abuse or involvement with police or statutory services. Over the next months D was seen on very many occasions by the professionals, as I have set out in some detail. This is not a child whose injuries were in any sense being hidden from scrutiny.

Expert evidence

20 I directed a full parenting assessment which was prepared by Ms Montero and dated 18 July 2023. She notes:

> "A prominent strength evident throughout the parenting capacity assessment was B and A's capacity to express how they are very emotionally attuned to their children's needs. They consistently spoke positively about their love for their children, were able to demonstrate empathy and understanding of their children's emotional states during child and parent observations, as well as providing suitable and age-appropriate responses of how they adequately respond to their children's needs."

And:

> "But despite not agreeing to the concerns raised by the local authority, they have demonstrated by their compliance to procedures that have been put in place. For instance, they have been noted to have had a positive engagement with the local authority safety plan and written agreement, hence why the section 20 agreement was assessed to be a proportionate measure to safeguard the children. Both parents have shown that whilst the allegations were made against them are deeply upsetting to them, they are willing to comply in order for the inquiries to demonstrate their position that they have not placed any of their children at risk of significant harm, nor will they do so in the future, as well as providing some evidence of their commitment to resolving the issue. This demonstrates that consistently the parents have offered a unified explanation to family and friends. If various contradicting narratives were conveyed during the support network interviews, this would certainly raise questions about the parents' capacity to maintain transparency and credibility."

Later she notes:

> "I do recognise that it is positive that the parents present as very united, particularly during the local authority's care proceedings process. This could potentially place an incredible strain on any relationship. Furthermore, it is notable that all the family and friends corroborated their accounts and how in sync they are as a couple and family. For example, there were unanimous reports of how they have

never been seen arguing or observed to be stressed with each other or the children."

She writes:

"B is very much imbedded into the family structure and has played a vital role in the maternal grandparents lives. This is best evidenced by the fact that the family members report that if it were not for B building a close relationship with maternal grandfather, the family may have missed the signs and symptoms that he was experiencing cancer. It was reportedly B's concern that encouraged maternal grandfather to seek medical attention. This eventually led to B permanently leaving his work to become a full-time carer for his father-in-law, as well as to be more physically present to support his wife during the pre and postnatal periods as she was experiencing a difficult pregnancy. B's ability to effectively care for A's health needs has also been observed by the family GP nurse, who commented, 'B, I think, does an amazing job'."

She concludes:

"Based on the series of interviews, home observation and professional feedback I have received, there is sufficient evidence that both B and A demonstrate the capacity to provide a very good level of parenting. It is clear that they have an abundance of love for each other and their children and have shown to be proactive and responsive to many areas of their children's various needs to an appropriate standard."

21 She recommended a psychological assessment of the father. I have considered the psychological assessment of Dr Desai dated 2 August 2023. She concludes:

"I'm not of the opinion that B is currently experiencing a psychological condition or disorder. Regarding the specific concerns raised by the parenting assessor, my assessment would not suggest that B is currently suffering from PTSD. His historic symptoms suggest he very likely would have met the criteria for the diagnosis earlier in his life. For many people, PTSD can resolve without professional intervention, particularly if the person experiences a period of safety and stability.

"Cognitive testing demonstrated that B's intellectual functioning is above the range where there may be concerns about his ability to care for his children and meet their needs. There has also been no suggestion that B may have a neuro-developmental difference, such as autism or ADHD. My assessment did not reveal that B had any difficulties forming warm, secure, stable relationships. As part of this my assessment did not indicate any difficulties with anger management. For example I observed no angry outburst towards professionals in B's GP records, nor does B have anything concerning on his police record, nor did B appear overly defensive during our

clinical interview. Any frustration and resentment which B had expressed regarding current investigations appear to be fairly common expected expressions, given the unusual and stressful situation he is in. He did give the impression of being someone who was reluctant to become emotionally vulnerable with too many people. However, this appeared to be within the bounds of expected personality differences and preferences. I am not of the opinion that this is a cause for concern."

She concludes:

> "There was nothing in B's psychological profile that led me to have concerns regarding his ability to keep either of his children safe from harm, both in the past and in the future."

22 Dr Johnson, paediatric radiologist, reported to the court on 15 August 2023:

> "D has suffered a fracture of the posterior right eighth rib which, in my opinion, is in the region of three to ten weeks of age on 1 March 2023. The radiological dating of any fracture is difficult, imprecise and a subjective estimation. The rib fracture is the result of significant force applied to the bone. The amount of force required to cause this fracture is unknown, but in my opinion it is significant, excessive, and greater than that used in the normal care and handling of a child. This fracture would not have occurred from normal domestic handling, over-exuberant play, or rough, inexperienced parenting.
>
> "At the time that the fracture occurred, D was less than seven months of age and he would not have had the strength or level of development to self-inflict this injury. At the time the fracture occurred, I would expect that D would have been in pain and shown signs of distress which would have lasted for some moments. Following this initial distress, the signs and symptoms relating to this fracture could have been variable, but I would defer to the paediatricians in all aspects of clinical presentation, both at the time the fracture occurred and subsequently.
>
> "To cause any fracture requires both a suitable mechanism and a significant level of force. Rib fractures are typically the result of a severe excessive squeezing compressive force applied to the chest. The amount of force required to cause these fractures is unknown, but in my opinion, it is significant. For example, in life-saving cardiac massage where the chest is forcibly compressed by one-third of its diameter, rib fractures rarely occur. Alternatively, an isolated rib fracture could occur from a direct blow or impact at the fracture site. From the radiological appearances, I am unable to determine if the posterior right eighth rib fracture is the result of squeezing, a squeezing compressive force or a direct blow impact."

He gives his opinion:

> "The action of kneeling on and compressing a child's chest could create a suitable mechanism to result in a rib fracture. To cause the rib fracture, there would need to be significant compression of the chest. Child development and strength is outside my area of expertise, and I would therefore defer to the paediatricians with regard to the likelihood of C being able to cause the rib fracture from this scenario. In my opinion, a kneeling event on or around 10 or 11 February 2023 could account for the appearances of the rib fracture on 1 March. In my opinion, restraint of D for any medical procedure or investigation would not generate sufficient force to cause a rib fracture."

23 In his oral evidence Dr Johnson confirmed his written views. He explained that the force required to cause the fracture was unknown, but significant pressure, and that somebody observing it would realise that a child had suffered harm. I considered the report of Dr Keenan, a consultant paediatric haematologist. In a comprehensive report dated 16 November, he confirmed that the blood clotting investigations to date had not identified an underlying blood clotting disorder, and he recommended further testing. Those additional tests were carried out, and he concludes that, "The testing of blood clotting is now complete. No blood clotting disorder has been identified."

24 Dr Rahman, consultant paediatrician, prepared a comprehensive paediatric overview and opinion in his report dated 23 June 2023. His opinion was:

> "It is extremely unlikely that D placed himself at risk of injuries. His injuries are therefore inflicted. His bruises did not require any specific medical attention or treatment. Estimating the timing of injuries is not an exact science and is open to significant errors, therefore, I am unable to provide a likely timeframe for the injuries.
>
> "Child protection evidence, systematic review on bruising, March 2020, Royal College of Paediatric and Child Health states, 'Standardised bruises generated in adults had age estimation performed on clinical photographs by forensic examiners. Only 48% of bruises were estimated accurately to within 24 hours of the true age, thus age estimation from photographs is unreliable.'
>
> "It is difficult to quantify the force, however, it is very unlikely that normal handling of the child may have generated adequate forces that may have led to the bruising. The bruises are all small, except the one numbered 10, 5cm x 2cm yellow discolouration. This is quite a large bruise. This is unlikely to be due to the gripping episode, as such a large bruise is unlikely to result from this action and this area. This bruise remains unexplained and may have resulted due to other mechanisms, such as squeezing the tissues with force. All the small bruises may have resulted while holding the child by gripping him tightly and may be in keeping with the history provided by his parents.
>
> "The father has stated, 'We never noticed any bruising on his leg or anything at all like that until 28 February 2023, at about 1pm when I was giving him a full change of clothing and when I lifted his legs up to wipe his rear end, I noticed the bruising on his right thigh.' This

> history requires clarification, as the gripping episode happened during the anaesthetic on 23 February. The sequence of events that leads to a bruise are as follows. The injured area turns red within a few minutes. This is followed by blood beginning to track out of blood vessels in the next few minutes, and this starts to stain the tissues leading to the bruise. Therefore, the time factor is against the history provided."

25 As far as the rib fracture was concerned, he was awaiting the radiological report. In his addendum dated 20 November, he specifically comments on the rib fracture. The father has stated the following in his statement:

> "The only possible explanation I can think of with the possible rib fracture is an incident where C accidentally knelt on D. At the time C and D were in the care of A's and my mutual friends. I believe they looked after C and D on 12 February 2023. We were told by our mutual friends when we returned that C had knelt on D."

26 Two mechanisms have been proposed: C kneeling on D's chest appears to be a possible explanation, given her weight, however, the way the incident has been reported makes it unlikely that D suffered the rib fracture at that time. As no mention about the child's distress has been made at this stage, it is unlikely that this incident led to the rib fracture. C falling headlong is unlikely to cause a single rib fracture, as the force is unlikely to be concentrated on just a small area. D would have been in severe pain, taking a lot of consoling to stop him from crying when he sustained the rib fracture. No external signs are usually visible. A carer who was present when the incident happened is very likely to have been alerted by his cry of distress, however, they may not have realised that the child had sustained fractures. As no external signs will be seen on his body to alert a carer if they were not present at the time of the incident, they may have dismissed his discomfort on handling due to non-specific reasons.

27 In his oral evidence Dr Rahman accepted that there was a small possibility that a two-year-old child kneeling on a baby could cause the rib fractures. In response to cross-examination from the parents, he accepted babies' pain responses were variable, but said, "I cannot accept that even a sleeping child would not be affected by a rib fracture." He described it as very unlikely. His view was that the variation in pain responses was in how long and how loud babies cry for, not whether they cried at all. On the bruises he maintained his position that dating bruises is difficult and caution is required. He would expect bruising to appear in a matter of hours, due to blood leaking out of the damaged blood vessels. It was his view that a bruise occurring on 23 February must show up before 28 February and that you would have been able to see it on 24, 25, 26 and 27 February.

28 I considered the written statements of the parents. They are detailed and largely consistent with the accounts that they have given to all professionals in the time that the bruising was discovered. In their oral evidence I found them to be plausible, open and honest. They clearly love each other and both of their children, and they have a close and loving relationship with the maternal grandparents. Both parents were clear in their evidence that they had not noticed any bruising on D until 28 February. The father saw it first and showed it to the mother. Neither was particularly concerned and assumed that it was due to the father holding the baby tightly in the preoperative procedures, or from the surgery itself. Both parents confirmed that they were worried about his mouth, the stitches and the

bleeding, and whether he had become dehydrated. They did not bathe him between 23 and 28 February. Their bedroom had the curtains closed and fairly dim lighting.

29 On the description of what they were told by their friends E and F, the babysitters on 11 February, there are some discrepancies between the father's written account and the later account given by F and E, but I do not find these discrepancies are significant and find that they may be accounted for by the fallibility of memory and the events having been talked about by the parents since then. The father was clear that C had climbed onto an upturned curry pot to get onto their bed. F did not remember that.

30 I found both parents to be sensitive, impressive witnesses, who did not seek to evade or exaggerate. I particularly noted the distress of the father when talking about how he must have unintentionally caused pain and bruising while holding D tightly for the pre-anaesthetic procedure. It was only during the trial itself that the mother said that she had WhatsApp messages from 11 February whilst the parents were out. A message timed at 22.34 asks, "How is D doing?" from her friend E. She replies saying, "Absolutely fine. He's been knock out asleep, apart from when C tried to climb in the cot with him."

31 At a very late stage, at short notice and some ten months after the event, F gave two brief statements and oral evidence by video link to the court. He wrote in his statement:

> "When we came back to A and B's home, E suggested to B and A that they should go out for a drink while E and I looked after the children. We knew how busy the children kept them. B and A agreed to this and left around 9.00 p.m. to 9.30 p.m. Before leaving A gave a bottle to D and showed E how to feed him."

He then goes on to say:

> "I started making tea whilst E was entertaining C. C then wandered around in each room, running around and playing with her toys. There was a baby monitor in the kitchen for D, which E was watching. I then started cooking dinner. Whilst I was cooking, I saw C go into the bedroom. I immediately followed C as I knew D was sleeping. When I walked into the bedroom, I saw C kneeling on top of D's stomach. I could see both C's knees on D's stomach. I believe she had climbed on the bed and then gone towards the cot in which D was sleeping in. I immediately removed C from D. D appeared to be grumpy as he had been woken up, but appeared half asleep with his eyes closed. It looked like he wanted to go back to sleep. D was not upset nor was he crying. D appeared groggy. I picked up C and went to E and told her what had happened. I told E to check on D. E went to check on D and came back about fifteen seconds later and said, 'Everything is fine, as D has gone back to sleep.' D slept until A and B returned. I told A and B what had happened when they returned."

32 In his oral evidence he confirmed that he had not seen C climb into the cot, so did not know how she got there. When he saw her, she was kneeling on D's stomach and lower legs. He described D after he scooped C off him as "grumpy a bit", "semi-confused". He said that there was "no wail, and he went back to sleep."

33 After I had heard all the evidence and submissions, I was asked to admit into evidence the WhatsApp messages between the mother and her friend, E. She also attended a Teams hearing and gave oral evidence to me. In a WhatsApp message dated 18 July 2023, she wrote, "I said, as you'll likely be aware, there was a time when I looked after them and C went to hug him and accidentally knelt on him, leant on him and he yelled a bit, but he was fine." In her written statement and oral evidence, she clarified that it was her partner, F, who had seen this first.

34 In her oral evidence, she confirmed that D yelled a bit. She heard it directly from the kitchen and through the baby monitor at the same time. It only lasted two to three seconds, and he managed to settle himself back to sleep.

The law – Burden and standard of proof

35 The standard of proof is the balance of probabilities, as set out in *Re B (Care Proceedings: Standard of proof)* [2008] 2 FLR 141:

> "Neither the seriousness of the allegations nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies."

36 The burden of proof lies with the local authority. The binary system which operates in the Family Court is made plain by Lord Hoffmann in [2] of *Re B* above:

> "If a legal rule requires a fact to be proved (a "fact in issue"), a judge or a jury 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 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened."

37 If the local authority establishes on the balance of probabilities a fact has been proved, the court will treat that fact as established, and all future decisions will be based on that finding. If the court is to determine issues of fact, its finding of fact must be based on evidence. Evidence may include inferences properly drawn, but not suspicion or speculation – *Re A (A Child) (Fact-finding hearing: Speculation)* [2011] EWCA Civ 12, Munby LJ. Whether a fact has been proved to a requisite standard of proof must be based on all of the available evidence, and in the context of the wider emotional and moral factors – *A County Council v A Mother, A Father and X, Y and Z (by their Guardian* [2005] EWHC 31 (Fam). The Court must not reverse the burden of proof – *Re M (Fact-finding hearing: Burden of proof)* [2012] EWCA Civ 1580, where the Court of Appeal allowed an appeal against a finding of non-accidental injury, which appeared to be based primarily on the absence of a satisfactorily parental explanation for the child's injuries.

38 If an explanation or hypothesis is put forward by or on behalf of the parent which is not accepted by the court, a failure to do so does not establish the local authority's case. The

court is entitled to survey a wide canvas of evidence, as well as the expert medical and scientific evidence and when assessing each part of the evidence and the credibility of each of those giving evidence when coming to a conclusion. *Re U (Serious Injuries: Standard of proof)* [2005] Fam 134. This has been repeated and confirmed by the court on many subsequent occasions, and it is essential that the judge forms a clear assessment of the parents' credibility, responsibility and reliability. The parents must have the fullest opportunity to take part in the fact-finding part of the proceedings, and the judge will rest considerable weight on their evidence and the impression formed of them – *Re W & Another (A Child) (Non-accidental injury)* [2003] 2 FCR 346.

39 I have considered the evidence and the oral submissions in the light of the legal framework in this puzzling case. There are concerning injuries in a non-mobile child. The combination of bruising and rib fractures are timed by the experts as occurring on at least two separate occasions. As far as the rib fracture is concerned, Dr Johnson and Dr Rahman accept that it is possible for it to have been caused by the C incident, but Dr Rahman's view is that it would have caused significant pain for a short period of time, which does not fully accord with the babysitters' or parents' evidence.

40 Of the ten bruises, Dr Rahman accepts that nine out of ten of the bruises could have been caused by the father gripping a wriggling, distressed baby to enable him to be anaesthetised. He did not accept that the larger bruise would have been caused that way. Furthermore, the hospital entry for 23 February says, "No bruising noted". The parents changed the baby's nappy, washed him, stripped him down to his nappy several times a day between 23 and 28 February, albeit in a darkened room. If the bruising was there, surely they would have seen it. The hospital again did not note any bruising on the admission on 27 February at 4.00 a.m. The local authority submit that there were two occasions when looking after this vulnerable, needy baby became too much for the parents and that one of them lost their self-control when sleep-deprived and injured the baby and that the other parent has colluded. They do not posit a specific mechanism for them injuring the baby, but they had care of the child; no one else did during the relevant times.

41 I accept that C and D are the much-loved and wanted children of both parents. There is a plethora of evidence of the closeness of the parents' relationship with each other. There is convincing evidence from several sources of their individual, strong, attuned physical and emotional parenting abilities. The maternal grandparents have a close relationship and frequent contact with them and the children. The parents sought medical advice for D for their health concerns on very many occasions after the period when he was allegedly injured by them. There is no evidence of any attempt to conceal or hide D from professional scrutiny, quite the opposite. If even one parent had injured D and the other was not aware of it, allowing this amount of professional contact from health visitor, practice nurse, GP, specialised cleft palate nurse, and the hospital would be surprising.

42 Both parents have been largely consistent in their accounts, explanation and bafflement shown when the fracture was identified. They have only ever come up with one possible scenario, that C unintentionally caused it in a partially witnessed incident by an independent observer babysitter, confirmed to have happened on that day by a WhatsApp message on the night, well before any fracture was discovered. Neither parent has had any involvement with police, social services, alcohol or drug misuse, mental health services and there is no evidence of post-natal depression in the mother.

43 The children have lived with the grandparents and the parents together in their home under section 20 for some ten months, without any further concerns being noted by anyone. They have cooperated fully and willingly with all the assessments and investigations. Their friends and family all report them to be calm and coping, with no evidence of any arguments or anger management issues. There have been no historic concerns over their care of either child, other than in respect of these injuries. The parenting assessment shows that the children were well cared for and well presented, that the parents have been receptive to advice, adhered to suggestions and were proactive in seeking help and scheduling appointments.

44 The specialist nurse for D's cleft palate and the health visitor both reported positively on the parents' management of D's health needs, and the psychological report on the father similarly finds no concerns impacting on his ability to parent. It is within this context, when I saw the father demonstrate in the witness box how he was holding the wriggling baby and told to grip tighter on two or three occasions, I found it easy to accept that a child might have been bruised in the way D was during that episode. It would be unusual, but I do not find it impossible to believe, that the extent of the coloration of the bruising and, therefore, the appearance to the parents did not become obvious to the parents caring for the child post-serious surgery, particularly on a child with darker skin, until some five days later.

45 I find as a fact that C was found with her knees on baby, D, inside the beside-cot, on 11 February by F, and that he did not see how she got on top of the baby. I accept that the baby did cry out before F came into the room. E's evidence, corroborated by the late disclosed WhatsApp message, refers to that cry. The lack of a cry and distress in the baby, which gave concern to the paediatrician, is not sufficient enough for me to discount the parents' explanation for the fracture. Both experts accept the mechanism and timing are possible. I find that these explanations, incomplete as they are, are a more likely explanation than that one of these otherwise impeccable parents, with no evidence of depression, drugs, alcohol or other concerns, no evidence that they were not coping, deliberately injured their much wanted baby on two separate occasions, and that the other parent either has colluded, putting their children at risk, or was not aware of it. It just does not sit with their willingness to have D seen by so many professionals throughout the relevant period and risk being discovered.

46 In particular, if an assault had occurred between him being seen at the hospital on 27 February and being brought to the hospital on 28 February, it is unlikely that these intelligent parents would have brought him there voluntarily, when the bruising was obviously going to be seen and questioned. For all these reasons, on the balance of probabilities, I do not find the local authority to have proved that the parents caused the injuries. The threshold for state intervention is not met. This is a single-issue case, and the proceedings are dismissed.

47 The local authority and the hospital were entirely correct and thorough in their safeguarding procedures. This is a testament to the social work teams' work and to the parents that, despite the high stakes involved, they have worked so cooperatively together over so many months, and I particularly want the maternal grandparents as well to be acknowledged for the huge role they have played.

CERTIFICATE

Opus 2 International Limited hereby certifies that the above is an accurate and complete record of the Judgment or part thereof.

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This transcript has been approved by the Judge.