Neutral Citation Number: [2020] EWFC 71

Case Number: KH19C00092

In the Family Court sitting at Hull

In the Matter of the Children Act 1989
And in the matter of : Child P (d.o.b. 07/09/2015)
and Child S (d.o.b. 06/03/2018)

Between:

East Riding of Yorkshire Council

Applicant

And

Mrs C

1st Respondent

And

Mr C

2nd Respondent

And

Child P and Child S

(By their Children's Guardian)

3rd & 4th Respondents

And

Childminder 1

Childminder 2

Childminder 3

Intervenors

Judgment in a Fact-Finding Hearing

(heard between the 18th May 2020 and the 29th July 2020)

1 This case has now been running for over 15 months since the 8th April 2019 when the Intervenors, understandably, took safe-guarding measures in respect of Child S, then 13 months old. The hearing itself has lasted over two months, with breaks. I have heard and read a great deal of evidence and also written and oral submissions on behalf of the parties and intervenors. The whole process has, for a variety of reasons, taken far longer than is desirable. In the circumstances, I do not wish to keep the parties in suspense a moment longer than is necessary.

2 Having given full and careful consideration to the evidence and the arguments on both sides, I am not satisfied on a balance of probabilities that the local authority have proved their case in respect of the various findings sought. Even if I had been satisfied on a balance of probabilities that the medical evidence, in isolation, pointed towards non-accidental injuries (and I will return to that in more detail in due course), it would, at best, have been marginal, and the "wider canvas", namely the extensive, and almost wholly positive evidence about these parents and their relationship with their children, would have pushed me back across the line to a point where I could not be satisfied to the necessary standard.

3 Putting it in a slightly different way, the positive evidence about this family is so strong that it would have taken very clear medical evidence to persuade me that these parents (or at least one of them, with a degree of collusion from the other) had serially abused their child. That is the way the local authority's case is now put. I find that the medical evidence is nowhere near clear enough for that, for reasons which I will elaborate on later.

4 I can probably do no better than to refer to the written closing submissions on behalf of the parents, and say that I accept those submissions. The final paragraph of those submissions is particularly telling , with its three quotes. The first was from Childminder 3, third intervenor, the child-minder who saw and reported the bruising on Child S which led ultimately to these proceedings. I accept that she is a thoroughly decent and honest woman, and independent of the parents. When asked, if the clock had stopped at 11.45 on the 8th April 2019 (before she saw the bruises), how would she have described the C family, she said "a really good family, a lovely family."

5 Child P, then aged 3 years and 8 months, when being taken by the Social Worker, Ms X, from her parents on the 31st May 2019 to stay with her grandmother pending proceedings, asked: "Why can't I stay with them?" (I57). Subsequently, during an ABE on the 26th March 2020, when asked what made her happy, Child P said "When mummy and daddy are here" (K522). Child P, perhaps more than anybody else other than the parents, knew what happened behind closed doors in the C household. She was said by the child-minders to be protective towards her little brother. I find it improbable that she would have been so positive about her parents if one or both of them had been serially abusing her little brother.

6 Child P's view of her family appears to be echoed in the parenting assessment of Ms X, in particular paragraphs 61 (at G44), 63 and 64 (at G45).

7 During the mother's evidence, (on Zoom), the mother took the court on a guided tour of the family home. It was clearly a very child-orientated home, even though the children have not been living there for the last 15 months. I wish I saw more images like that during the course of my Care work. Unsurprisingly, children from such homes are rarely the subject of Care proceedings.

8 The Parties and their representation

The applicant local authority in this case, the East Riding of Yorkshire Council, is represented by Miss Taryn Lee QC and Miss Charlotte Keighley. The Principal Social Worker is Ms X.

The First Respondent, Mrs C, the mother of the two subject children, is represented by Mr Paul Storey QC and Miss Sara Lewis, instructed by Wollens Solicitors.

The Second Respondent, Mr C, the father of the subject children, is represented by Mr Nicholas Stonor QC and Miss Phillipa Hildyard, instructed by JWP Solicitors.

The children, Child P and Child S are represented through their Guardian, Miss Liz Crosby, by Miss Naomi Madderson and Miss Kylie Peach, instructed by Pepperells Solicitors.

The First Intervenor, Childminder 1, is represented by Miss Jacqui Thomas QC and Mr James Goodwin, instructed by Morgan LaRoche.

The Second Intervenor, Childminder 2, is represented by Miss Janet Mitchell, instructed by JMW Solicitors.

The Third Intervenor, Childminder 3, is represented by Mr Cyrus Larizadeh QC, Miss Sally Collins and Miss Chloe Ogley (co-juniors), instructed by Stephenson's Solicitors.

9. The Background

I am not going to set out the full history of the case, but merely an outline, in so far as it is relevant. I will, of course, deal with specific issues and events in more detail later.

Although the focus of this case has been events concerning Child S (now 2 years and 4 months old), it is very relevant that Child S is the second child of his parents, the First and Second Respondents. Their first child, Child P was born on the 7th September 2015, and is now approaching 5 years old. There have never been any problems or concerns relating to Child P. She has not, so far as I am aware, had any particular medical issues. She has never come to the attention of Social Services, except in the context of these proceedings, which started when she was already over 2 ½ years old and started only because of events concerning her younger brother, Child S. Child P was, and remains, a happy little girl who loves her parents and wants to be with them (see the quotes above).

Child S was born on the 6th March 2018, and is now approaching 2 ½ years old. So far as the outside world was aware, he, like his older sister, was a happy, contented child (the evidence of the child-minders) from a happy family (the quote from Childminder 3, above). For the first 13 months of his life, he never came to the attention of Social Services or the police. He did have some medical issues, but it is now clear that, despite the originally incomplete medical chronologies from the two consultant paediatricians, Dr Robinson and Dr Fonfe, he was highly visible to medical services. Of course, the local authority make much of an alleged failure by the parents to seek medical attention for the "problem" that Child S appeared to have, at least for a time, with being placed on an adult's hip (I will return to that), but the fact remains that he was seen on many occasions by medical professionals, who raised no concerns. In particular, between September and November 2018 (when aged around 6 months), Child S was taken to see various doctors in relation to problems with his arms.

From the 12th November 2018, Child S, now aged 8 months, became even more visible, as he started to attend regularly at "The Childminders" child-minders, with his sister Child P, on a regular basis three times per week. The intervenors in the case are Childminder 1 and Childminder 2, who own the child-minding "setting", and Childminder 3, who works with them. I am perfectly satisfied that they are conscientious and well-informed. Childminder 1 told me about her responsibilities and knowledge connected with child-minding, and told me, with understandable pride, about her "outstanding" Ofsted reports. It was, of course, Childminder 3 and then Childminder 1 who "raised the alarm" when bruises were seen on Child S on the 8th April 2019. Prior to that, although they had seen some (relatively minor) bruising which they did not feel it necessary to report, they had seen nothing to cause them any concern in relation to Child S (or indeed Child P). It was apparently quite the reverse. I come back to that quote from Childminder 3.

Everything changed on the 8th April 2019, when Childminder 3 saw fairly extensive bruising on Child S. The alarm was raised. The police were called. Child S was taken to hospital and examined. Large numbers of fractures were found.

The local authority now say that there is evidence of serial abuse of Child S dating back to when Child S was 4 weeks old (the bruising on the jaw-line, shown on photos produced by the parents themselves).

One of the most striking features of this case is the lack of any of the usual signs which the courts so frequently see in cases of physical abuse of children: in no particular order, parents who have drink or drug problems, evidence of neglect, parents who have anger-management problems or who have a known history of violence, often including domestic violence, repeated failures to keep medical appointments. This is not intended to be an exhaustive list. None of that applies in this case.

It is right to say that the local authority point to what are suggested to be unusual dynamics between the parents, which they suggest may have caused stresses and frustration leading to physical abuse. The mother accepts she is very forthright. That is demonstrated by some of the texts I have seen. In my view that pales into insignificance compared with the picture we often see in physical abuse cases.

While it is a valid line of enquiry, I find it does not take me very far. I suspect that there are a great many parents who have raised children perfectly safely who have worse skeletons in their closets. Fortunately for them, most of them will not have had their lives dissected in the way that Mr and Mrs C have in this case.

For the rest, up until the 8th April 2019, the Cs gave every appearance to the outside world of being a perfectly normal, happy family who loved their children and cared for them. The question for me now is whether that was, in large part, an illusion; whether the matters which came to light as a result of the investigation which commenced on the 8th April have now established, at least on a balance of probabilities, that one or both of these parents was a serial abuser, who had caused a large number of fractures and bruises to Child S, then only recently turned a year old. The case for the local authority is that this was not just an isolated incident of loss of control. There must have been a large number of separate applications of force to cause the 16 fractures in a variety of different locations. Indeed, according to Professor Offiah, on whom the local authority rely heavily, the likely explanation of the unusual appearance of the fracture sites on the X-ray images at the time of the second skeletal survey in June 2020 was that most of the fracture sites had been subjected to fracture upon fracture; the growth plates had been damaged, and the metaphyseal fractures had not undergone the rapid (within about 6 weeks) and complete healing process which would normally be expected. That therefore suggests a very large number of fractures indeed, all inflicted on Child S by the time he was just turned 13 months old. In addition, extensive investigations revealed the various historic instances of bruising to Child S which have been referred to throughout the case. The local authority say that the bruises seen at "The Childminders" on the 8th April 2019 were only the last (although the most serious) of a long list of bruises seen on Child S from the age of 4 weeks (the jaw-line bruises in the parents' own photographs). The local authority say there is good evidence that those were non-accidental injuries which can also be laid at the door of one or both of the parents. They therefore submit that the evidence shows a pattern of abuse starting no later than when Child S was 4 weeks old, and extending up until the 8th April 2019, when the extensive bruises on Child S, and subsequently the many fractures, were discovered.

The parents, on the other hand, have always said that Child S bruised easily; so far as fractures were concerned, they say they had no knowledge of any fractures. They now say, in the light of the medical evidence, that Child S must have a propensity to fracture easily, but they were never aware that he had suffered fractures until the fractures were revealed by the first skeletal survey.

The Relevant Law

I have been very helpfully provided with two summaries of the relevant law, one provided by the local authority, and one provided jointly on behalf of the parents.

I am not going to repeat them here. There appears to be nothing controversial in either of them. I shall endeavour to apply the relevant law.

The one piece of law which is central to this case is the burden and standard of proof: it is for the local authority to prove their allegations, upon a balance of probabilities. It follows that it is not for the parents to prove anything.

This is a case in which the medical evidence has featured strongly. Child S is a child who has two *known* genetic anomalies, and the genetics expert, Dr Saggar, has raised the possibility of "the unknown unknown" – an, as yet unidentified, genetic anomaly which may cause or feed into a condition which causes Child S to suffer fractures with lesser force.

It follows that it is not for the parents to prove there is such an anomaly; it is for the local authority to disprove it, on a balance of probabilities.

The Medical Evidence

As Miss Lee pointed out in her closing submissions on behalf of the local authority, at the start of this hearing all the medical evidence appeared to point in the same direction. In the absence of any evidence of an underlying medical condition which explained Child S's injuries, the medical experts agreed that they were likely, on a balance of probabilities, to be non-accidental, and therefore inflicted. If that had remained the case, I might have been driven to the conclusion for which the local authority (and the Guardian) still contend. Even then, I would have had to consider the wider canvas which, given the matters I referred to earlier, would have drawn me away from the conclusion suggested by the local authority, but may still have left me in a position where the case was very finely balanced.

In the mean-time, the picture has changed dramatically in terms of the medical evidence. Thanks to Dr Fonfe, part-way through the hearing, Child S underwent a second skeletal survey. That produced a number of unexpected findings, which were set out in the report of Dr Olsen at E438-443. There was then a Multi-disciplinary team meeting (MDT) in which all the experts save Professor Offiah participated. Although the experts present spoke of wanting to hear from Professor Offiah, in her absence, the overall picture appeared to have changed considerably. Three points struck me in relation to that MDT meeting. Firstly, Dr Olsen was clearly very concerned about what he considered to be very unusual aspects of the images from the new skeletal survey. Secondly, Dr Robinson referred to the fact that, although metaphyseal fractures were relatively common in infants, they were rare in 1-2 year-olds (Child S was 13 months on the 8th April 2019, and twice that age by the second skeletal survey) (E502C). That meant that the absence of evidence of new fractures since Child S had been in alternative care suddenly appeared much less significant: the great majority of his original fractures were metaphyseal fractures, so he would have been unlikely to suffer further similar fractures in any event. Dr Robinson accepted that. (E502C)

Thirdly, Dr Saggar, our highly-regarded genetics expert, spoke of the possibility of the "unknown unknown".

Of course, at that point we had not heard from Professor Offiah, but the picture had clearly changed sufficiently for the local authority to consider seriously the possibility that the evidence in relation to the fractures was going to fall away, and that the local authority would be left only with evidence of bruising. Miss Lee, having presumably discussed it with representatives of the local authority, said words to the effect that, in those circumstances, the local authority would be able to work with the parents.

Since that time, we have heard again from all the main experts. Miss Lee, in her closing submissions, appears to take the view that everything has fallen back into place (in terms of the evidence relating to fractures). I do not agree. Dr Olsen, a very experienced consultant paediatric radiologist from the highly-regarded Great Ormond Street Hospital for Children, was very clear that he saw "red flags" on the second skeletal survey, anomalies which caused him concern. He pointed, very astutely, to the fact that it was for the Applicant to prove that there was no underlying

abnormality and not the other way round (N146). He went on to say that there were a number of features of the appearances on the second skeletal survey which were "not the most typical", and that he was "very unhappy with concluding that all of these are just independent random rare findings." He went on to say (at N147) that "then the person who is the expert, Professor Offiah, says that, in her opinion, there is no known common denominator." A little later, he said: "it remains my opinion that the…22nd May skeletal survey is odd".

He later said that, despite having seen Professor Offiah's most recent report, (which effectively dismissed the appearances he was referring to as normal variations), "I do persistently believe that several appearances are rare or atypical."

Later, at N152, he said that "bone weakness can never be excluded by radiology alone."

At N161, Dr Olsen said: "…there were too many red flags for me to be entirely happy that there was not anything underlying."

At N180: "…it seems very unlikely that one should just have so many anomalous findings within the same child."

Overall, I was very impressed with Dr Olsen's evidence. He was keen to acknowledge the limits of his expertise, but at the same time, he stood firm as to what he had seen, and whether it was unusual. He remained clear, throughout his evidence, that the second skeletal survey threw up a number of "red flags" which left him concerned that Child S may have an underlying condition which may have a bearing on the fractures. Given that this is a child who, we know from Dr Saggar's evidence, has not one, but two, known genetic anomalies, Dr Olsen's evidence puts me firmly into territory where I have to seriously consider the possibility of the "unknown unknown" as Dr Saggar referred to it in the MDT meeting.

Professor Offiah

The main piece of evidence on which the local authority rely to counter that of Dr Olsen is the evidence of Professor Offiah. She was originally involved in the case as a treating clinician, but she is also acknowledged to be a leading expert in relation to

skeletal dysplasia. Professor Offiah was, unfortunately, unable to attend the MDT meeting at which all the other experts discussed the findings from the second skeletal survey. However she subsequently produced a report in which she dealt, individually, with the concerns raised by Dr Olsen (E546 – 588). She subsequently gave evidence (transcript at N343-N391). I have considered, in particular, two aspects of her evidence, relating to two of Dr Olsen's main "red flags".

Firstly in relation to the injury to Child S's right hip, Professor Offiah suggested that it could have been caused by forceful nappy-changing, although she said that was only a suggestion ("I'm not saying that's how it was sustained" (N358)). She also said that it could have been caused by only low to medium force. She referred (at N350) to a paper: "I think one of the papers I had submitted had described a cohort of young infants around Child S's age who had these sorts of fractures, as inflicted injuries, which would further support that low to medium force could cause these fractures."

Yet none of the other experts had seen fractures of this kind in an infant of Child S's age. The consultant orthopaedic surgeon, Mr Fernandes had referred to them as high velocity injuries, and "…it has to be extreme force" (E483B), and "if that child has normal bones and that hip has to fracture, it has to be enormous force" (E485H). He gave the example of car crashes. He later described more "oddities" on the skeletal survey (E503 F-G and E504D).

Even Professor Offiah herself did not claim to have seen such an injury (the hip injury) previously in an infant of Child S's age: "we see those types of injuries vey commonly in older children, young adolescents, but I don't recall seeing one. I may have seen one or two. If I have we're talking very small numbers. It's not a common fracture in that age group."

I note that one of the papers produced by Professor Offiah (atE552) was relied on by Miss Madderson in her cross-examination of Dr Saggar (at N421) as providing an example of "an abusive nappy change which caused a hip fracture". A closer reading of that report reveals that it was the alleged perpetrator, the boyfriend of the infant's mother, who attributed the fracture to a "frustrated diapering attempt". I do not attach any significant weight to that. It seems to me highly likely that the boyfriend would wish to minimise his responsibility for the baby's injuries, and may well have given a

false account of how the injury was caused. There is no reference in the report to any independent evidence of the causation of the injury.

Against that back-ground, I find that Professor Offiah's assertion that it could be an injury requiring low to medium force, perhaps during a nappy-change, defies common sense as well as the rest of the expert evidence. If Professor Offiah was right about that, then it would surely be a more common injury. Infants are very rarely subjected to high-velocity impacts; but they have their nappies changed very frequently, no doubt often by parents or other carers who are in a hurry, or tired and irritable, or otherwise less careful than they should be. I find that the fact that this kind of injury is so rare in children of Child S's age is more consistent with it being a high-velocity injury, (in children with normal bone-strength) as suggested by Mr Fernandes. I find that the fact that Professor Offiah was for saying that it could be inflicted with low to medium force suggests that she was trying too hard to say it was something relatively "normal". I am satisfied from the evidence of the other experts in relation to the severity of this injury that it was an extremely unusual injury, one which, on a balance of probabilities, would have required a high degree of force in a child with normal-strength bones.

> As to the metaphyseal fractures, which had not resolved (and therefore disappeared on X-rays) within about 6 weeks, Professor Offiah suggested that they may be the result of "fracture upon fracture". In cross-examination by Miss Lee, (N356), Professor Offiah was asked about "the number of growth-plate fractures, which was unusual even for him (Dr Olsen)." Professor Offiah replied "I think he's right. I think that they are even unusual for me. …….all of his injuries, and we're also including the injury of his right femur, were actually quite severe, and I think that they represent recurrent injuries, so the rubbing wasn't on one occasion; and I think it may have been injury upon injury, rather than a single injury, so that they were severe, so that there was…growth plate damage.
>
> I find there are two difficulties with this piece of evidence. The first is that Professor Offiah moves from accepting that an appearance was unusual for her, to putting forward a hypothetical explanation ("….I think it *may have been* injury upon injury, rather than a single injury"). Since Dr Olsen had said that the great majority of Child S's fractures (he went through them individually) had that

unusual appearance, to a greater or lesser degree, it would follow that Professor Offiah's hypothetical explanation (fracture upon fracture) would have to apply to a large number of fractures. In my view that makes it less probable that that hypothetical explanation could be correct: how likely is it that a perpetrator of physical abuse would repeatedly cause fractures at a considerable number of different sites? Of course, that becomes much more probable if the child in question is prone to fractures when subjected to lesser force. If the fractures were caused during normal (or perhaps only slightly rougher than normal) handling, it might explain how there would be fracture upon fracture, if the same handling (e.g. nappy changes, placing into a car-seat, etc,) was repeated.

I therefore find that, in relation to this second aspect of Professor Offiah's evidence, it tends, if anything, to undermine the local authority's case: Professor Offiah has come up with an apparently unsupported hypothetical explanation for one of Dr Olsen's "red flags". Either I find it unconvincing, because it does appear purely hypothetical, and flies in the face of the wider picture of loving and caring parents who would be unlikely to serially abuse their child; alternatively, if I accept that it may be the explanation for the unusual appearances on the skeletal survey, it still suggests to me that there is something very unusual going on. Why, unless an abusive parent was also "moronic" (Mr Storey's word in his oral submissions) would he or she repeat actions which he/she must have known had caused an injury previously, thereby risking causing a similar injury again, and being caught on this occasion.

It seems to me that the more probable explanation is not the one for which Professor Offiah is contending. She is effectively suggesting that there are "normal" explanations for all of Dr Olsen's red flags, those explanations being consistent either with normal growth changes, or with physical abuse. I find, taking into account the wider picture (which of course is not part of Professor Offiah's remit) that the more probable explanation is that Child S has an underlying condition, perhaps connected with his other, known, genetic anomalies, which makes him prone to fracture with lesser force (not spontaneous fractures.) Of course, a parent would not be aware of such a problem unless or until it was diagnosed. He or she might be aware that the child sometimes whinged for no obvious reason. But if there had been no memorable event, because the child had been hurt by an amount of force which would not have

caused injury to a normal child, there would be no reason for the parent to deduce that the child had, in fact, been hurt.

Unfortunately, I find that Professor Offiah's response to those two, crucial issues, undermines the rest of her evidence: since I find that she was trying too hard to find a "normal" explanation on those issues, it makes me less prepared to accept her evidence that other matters Dr Olsen found were "atypical" were, in fact within the range of "normal" findings. My overall view was that she was trying to find "normal" explanations rather than giving any serious consideration to the possibility that this may be "the unknown unknown", to use Dr Saggar's words from the MDT meeting. The very fact that Professor Offiah was giving a variety of different explanations for findings which Dr Olsen, a very experienced consultant paediatric radiologist, considered to be "atypical", all in the same child, a child we know has genetic anomalies, rings alarm bells.

I therefore do not accept that Professor Offiah's evidence has moved us back from the position of uncertainty which existed at the end of the MDT meeting (which Professor Offiah did not attend), to a position where all the medical evidence points towards non-accidental injuries. Putting it another way, I am more convinced by Dr Olsen's "red flags", coupled with Dr Saggar's evidence relating to genetics and Mr Fernandes' evidence about the force required for the hip fracture, than I am by Professor Offiah's attempts to explain them away.

Before moving on, I should deal with one aspect of the medical evidence which does not appear to be in dispute. It appears to be agreed that X-rays are not capable of showing significant degrees of de-mineralisation of bones (possibly up to 40%), which would amount to osteopenia or osteoporosis. This could significantly weaken the affected bones, making them more prone to fracture. Thus, none of the medical experts are able to say, simply by looking at the X-ray images, whether or not Child S's bones were, in fact significantly de-mineralised (and therefore weakened) at the time of any of the skeletal surveys. That is one of the reasons why we have to look at the surrounding evidence to see whether there is any other evidence of bone fragility which may have played a part in the causation of Child S's fractures.

Also, it is significant that the great majority (13 out of 16) of fractures found in Child S were metaphyseal fractures. Dr Olsen described these (at E502E) as "fractures that are located at a …growth zone… and these are weak zones. So they're not fractures that require a large amount of force, but on the other hand, if you did not have an underlying bone abnormality, then it would be very, very unusual to see such a large number of fractures caused by…normal handling."

Dr Olsen went on to say: "Normal handling shouldn't normally give any fractures; of course, there can always be random events where you have a fairly low grade exposure to some force, and then unfortunately a fracture results, you know. These things happen but they wouldn't happen 13 times in the same child unless there was some underlying abnormality, I think. So if he doesn't have an underlying abnormality then each of the fractures must have been caused by force that is beyond what you would expect from normal handling, in my opinion."

Two points flow from that. Firstly, even if Child S was a normal child, with no underlying abnormality, the large majority of his fractures (all the metaphyseal fractures) could be accounted for by incidents involving a relatively low level of force, which may not necessarily be capable of being described as "abusive", or "non-accidental", or "inflicted". Those words all bear connotations of malicious or intentional or, at the very least reckless, causing of harm. I mentioned earlier Dr Robinson's reference to the "car-seat incident" on the 12th April 2019 as possibly accounting for a metaphyseal fracture. I ask myself, if there were evidence that that incident did, in fact, result in a metaphyseal fracture, would I make a finding of physical harm against the father, based on that incident? I think not: there is no evidence that he was even aware that he might be causing any harm, much less that he intended to do so. Yes, his handling of Child S was sub-optimal, somewhat rough, and yes, he probably used force "beyond what you would expect from normal handling" (Dr Olsen, above). But where does one draw the line between handling which is sub-optimal and slightly rough, or careless, and handling which amounts to abuse? There is a temptation to answer that question by saying that you cross the line if the child is injured. But that answer would clearly be wrong. Firstly, you would first have to know the answer to the question of whether the child had normal-strength bones (precisely the point in this case); and secondly, it may well be, from my understanding of all the evidence in this case, that many infants may suffer metaphyseal fractures which are never diagnosed because they

occur through somewhat rough or careless handling, and the child makes a full and rapid recovery without treatment. That would not, on my understanding of Dr Olsen's evidence, necessarily prove that those children had been physically abused; possibly only that they had been handled carelessly or a little roughly.

It also seems to follow from this that, at least in respect of metaphyseal fractures, since they can be caused by relatively low force in normal infants (as discussed by Dr Olsen – see above), a child would not need to have a very serious underlying disorder to lower still further the amount of force required to cause such a fracture, to the point where such a fracture could be caused by normal handling.

Dr Saggar

The only other expert whose evidence bore directly on the question of possible bone fragility was Dr Saggar, our genetics expert (I will come to the more general and indirect points from the consultant paediatricians later). Dr Saggar is a highly respected expert, who lectures to judges at the Judicial College (I have attended one of his lectures there).

Dr Saggar's position, prior to the start of this hearing, was aligned with the other medical experts, namely that, in the absence of any medical evidence to support an underlying bone disorder, the likely explanation for Child S's fractures, as shown on the initial skeletal survey, was inflicted injury.

On the other hand, it was his evidence that Child S suffered from two genetic anomalies (COL9A1 and ANL5) and HSD (hypermobility spectrum disorder), and was therefore susceptible to easy bruising (as the parents have always said).

His position in relation to Child S's fractures appeared to shift during the MDT meeting, on the 8th June 2020, part-way through the hearing, when he heard of Dr Olsen's concerns about the unusual appearances on the new skeletal survey (transcript at E475 – 524). He did say, early in that meeting (at E479, G-H) that he thought it was going to be essential that Professor Offiah should look at the case (she not being present at that meeting). He later heard both Dr Olsen and Mr Fernandes say that there was something "odd", or "unusual"…"very unusual".

Later,(at E497 in the transcript), Dr Saggar said "Just from a genetic point of view, if clinicians tell me that lesions are persisting, and new ones are appearing,

and the wrist is also now a persistent feature that does give me more, as we've said before, a gut feeling that there's clearly some susceptibility here".

Later, (at E500E), Dr Saggar, when asked directly to comment on the possibility of an underlying bone abnormality, said: "…I don't think we know what this is, and if we don't know what it is, it's very hard to get a handle on what features you might see, what features might persist and what new features might occur. So it's a bit of the unknown unknown, but I would like Dr Offiah's opinion." He then went on to point out that he'd done a "clinical exome", of 12,000 genes, he thought, but not a "whole exome trio". "So without going over the top and doing a whole exome trio, which I don't recommend, I can't really take it any further from a genetic point of view. So it's either something to do with…like the vomiting we talked about the hyperemesis, or it's an unknown condition or a condition where we don't have any genes."

The clear inference was that Dr Saggar was considering the possibility of an underlying bony abnormality, either connected with Child S's known genetic anomalies, or with parts of Child S's genome which had not been checked and/or was not understood.

Later still in the MDT meeting, (at E519A), Dr Saggar said: "if we're now saying there's definitely something odd about the bones and it's an unknown unknown and we can't really then exclude the risk for fracture…"

By the time Dr Saggar was back giving evidence (10th July 2020 – N392-421), he had seen Professor Offiah's report of the 15th June (E546-588), and was deferring to her in respect of the possibility of skeletal dysplasia (even though, as I have indicated, I do not find her evidence persuasive in that regard).

He went on (at N395A) to discuss the possibility of people with hEDS suffering fractures with lesser force. "I have always said it's very controversial about the incidence of fractures in EDS, and how much force or whether you need lesser force. It's academically theoretically possible – there is evidence of reduced bone density". So Dr Saggar was not dismissing reduced bone density from hEDS as a possible cause, but he went on to explain why "I don't believe the mechanism is hypermobile EDS. Obviously it does not exclude what I said before about an unknown unknown, but that's just a….get-out clause, because there are many things that we don't know in genetics….." At N936A, he went on to discuss, at length, how much is still unknown in genetics, saying, for example, "we don't

pick up mutations in other conditions where there is an absolute barn-door diagnosis clinically". By that, I took Dr Saggar to mean that geneticists sometimes see very obvious genetic conditions for which they cannot locate any specific genetic mutations.

Dr Saggar did also say (at N396) …."if you have so many fractures at such a young age, if a child becomes more mobile and more active than you would expect, in such a short time-frame, for that susceptibility to continue, assuming the child isn't being so protected that they're not subjected to any of the same forces." This was a point which had also been made by Dr Robinson in the MDT meeting; but he had immediately conceded that it did not have the same validity in this case, where the great majority of Child S's fractures were metaphyseal fractures, and children over the age of one are far less likely to suffer metaphyseal fractures.

During his first spell giving evidence (on the 22nd June 2020) (N71), and again, during his final evidence (N4), Dr Saggar spoke of the fact that different people with the same genetic condition may show different symptoms, and how the symptoms may change over time. He likened it to an iceberg which can roll over, showing one set of features at one time, and a different set of features subsequently.

In his penultimate answer in cross-examination by Mr Storey, for the mother (at N417), Dr Saggar concluded by saying: …."I can't find anything" (meaning, as I understand it, any relevant genetic anomalies). "But there are red flags, I accept that; there are some unusual things." And in his final answer to Mr Storey, he said: "….this case seems so much more unusual than all the other cases where there have been metaphyseal fractures."

In re-examination, Dr Saggar said (at N418): "…..given there are these red flags which I've accepted, and we may be talking about something which is very odd, then there's no reason to suppose that you wouldn't get metaphyseal fractures as opposed to the more normal fractures."

Taken as a whole, Dr Saggar's evidence falls far short of excluding the possibility of Child S having a genetic susceptibility to fractures with lesser force – "the unknown unknown". It is, of course, for the local authority to exclude that possibility, not for the parents to prove it. On balance, I consider that Dr Saggar's evidence assists the parents more than the local authority.

The Car-seat Incident

I remind myself of the incident described by Mrs L as happening on the 12th April 2019, when she had cause to "tell off" the father for not loosening the straps when he was putting Child S into the car-seat. The father was "doing it wrongly" and Child S was complaining that he did not like it. I doubt whether anybody observing that incident would have described it as abusive behaviour on the part of the father, or would have thought that Child S was being "hurt" by it. But, with the benefit of hindsight, I find that that is the kind of incident which could have caused an injury to Child S if he had an underlying condition. Indeed Dr Robinson, during the MDT meeting, (at E501G), said that …"pulling, twisting, gripping force during that procedure might well have accounted for a metaphyseal fracture."

Yet this was after injuries had been reported on Child S (the bruises discovered on the 8th April), at a time when there was already an investigation in progress. That demonstrates to me a number of points: firstly, this father is not one for handling children very delicately or sensitively. That had never been a problem with Child P, who presumably had been handled in a similar fashion.

Secondly, despite the fact that bruises had been reported on Child S, and there was an investigation under way, that did not prevent the father from acting, in public, in the manner observed and described by Mrs L. I draw two conclusions from that: firstly, that the father was unaware that he was doing anything inappropriate; and secondly, that he did not have a guilty conscience about anything that had happened to Child S in the past – or he would have been treating Child S with kid gloves to ensure there was no further evidence against him.

In response to the parents' suggestion that Child S has a propensity to fractures with lesser force, the local authority argue that, if that were the case, he would have continued to suffer fractures while in alternative care. This argument was dealt with in evidence by Dr Robinson, Dr Fonfe (both consultant paediatricians) and Dr Saggar (see above).

There are three major difficulties with that argument: firstly, most of Child S's fractures previously had been metaphyseal fractures. As Dr Robinson himself

conceded in the MDT meeting, such fractures were unlikely to recur given Child S's increasing age.

Secondly, we simply cannot say with any real confidence that he was being subjected to the same forces as previously, while in alternative care. For example, we know, from the car-seat incident witnessed by Mrs L on the 12th April, that the father is not the most gentle of baby-handlers. Dr Robinson said, in terms, that that incident could have accounted for a metaphyseal fracture. We know equally, from Mrs L's response to that incident, that she handles children more carefully than the father. So that difference alone could account for the absence of fractures in alternative care (particularly when coupled with the fact that Child S was now into an age-group when metaphyseal fractures would be far less likely). Also, despite Mrs L's assurance, in evidence, that she had tried to treat Child S as a normal child, I find that it must have been always in Mrs L's mind that the child she was caring for had previously suffered a large number of fractures. It would be a remarkable carer who could put that completely out of their mind and treat the child in a completely normal manner; it would always be a consideration, conscious or sub-conscious, that this child may fracture easily, and that the alternative carer would not wish to allow him to suffer any further fractures, or for themselves, to be responsible for any such fractures.

The local authority point to the fact that Child S was, by April 2019, becoming mobile, a boisterous, active child who would be more prone to fractures. They point, in particular, to two incidents, the fall on the stairs, and the fall in the park when walking with Mr S in ?September 2019. Yet these are very different incidents from the pulling/twisting actions which, we are told, are likely to be the cause of metaphyseal fractures. At the time of these incidents, Child S would still be small and light (I don't have his precise height and weight, but these incidents happened when he was no more than about 18 months old). He would therefore develop very little momentum in any fall, and the subsequent impact would be correspondingly far less than for an older, larger, heavier child. For example, in the fall in the park, when Child S was walking, his centre of gravity at the start of the fall would only have been about 30-40 centimetres off the ground. It follows that that was a very short fall (and therefore one in which the child would develop very little momentum), probably with none of the twisting and pulling forces which, we are told, would have caused most of Child S's previous injuries. I am

not satisfied that that could necessarily be expected to lead to a fracture, even in a child who fractured easily. I would certainly not expect it to lead to a fracture in a child with normal bone-strength (we've all had toddlers pitch over when starting to walk, with no significant adverse consequences). It would then be a matter of degree as to how easily Child S would have had to fracture in order to suffer a fracture in those, very innocuous, circumstances. It is not, as I understand it, being suggested that Child S was prone to suffering spontaneous fractures, merely that he fractured more easily than a child with normal bone-strength. How am I to say whether, in those circumstances, he could have been expected to suffer a fracture in such an apparently innocuous fall? I do not have the information to make that judgment. Since it is for the local authority to prove that Child S's injuries were non-accidental, I do not find this piece of evidence and reasoning particularly helpful, much less persuasive.

Similar considerations apply to the incident with the fall on the stairs. Although the fall would have started from slightly higher, it would not have been a vertical fall, since some of Child S's (limited) downward momentum would have been converted into forward movement to take him to the bottom of the stairs (a tumble, rather than a vertical fall). Again, I do not have sufficient information to draw conclusions adverse to the parents.

Thirdly, we cannot say with any certainty that Child S did not suffer further fractures in alternative care, as he was not (for obvious reasons), being routinely X-rayed. It could be that part of the unusual appearances seen on the repeat skeletal survey were due to re-fractures, which were simply not picked up at the time.

Taking Child S's fractures as a whole, I conclude, on a balance of probabilities, that the great majority of Child S's fractures were caused by a combination of two factors: firstly, an increased susceptibility to fractures with lesser force, either connected with HSD or with a genetic issue which is not yet understood (Dr Saggar's "unknown unknown"); and secondly, the fact that Child S's father, who was the primary carer through the relevant period, was not always the most gentle of child-handlers, as witnessed by Mrs L in the car-park on the 12th April 2019. I do not find that Child S's father was rough with Child S to the point of being abusive, or that he should have known that he was causing physical harm to Child

S. But, given my finding that Child S was prone to fractures with lesser force, (a fact of which the father could not have been expected to be aware), I find that his handling of Child S may have been sufficient, in some instances, to cause fractures. I find there were probably a number of occasions when Child S became distressed when being handled by his father, and his father interpreted it (as in the car-seat incident), as Child S "not liking" what was happening to him. We are told by the consultant paediatricians that a child may settle relatively rapidly after a metaphyseal fracture. I therefore find that there may have been a number of instances in which there was no "memorable event" (in the sense of something which a lay person would expect to cause significant harm to a child); yet, because of Child S's propensity to fractures with lesser force, he suffered metaphyseal fractures, from which he then rapidly settled. Dr Saggar said in evidence that a fracture in a child with reduced bone-strength would be just as painful as for a child with "normal" bones. It follows that Child S is likely to have shown significant distress; yet, without an event which a lay-person would expect to cause significant harm, a carer might well not appreciate what had happened, and simply allow the child to settle. It is of significance in this case that Child S was very visible throughout the period when his fractures must have been caused. In particular, he was attending frequently at The Childminders, being cared for by very experienced child-minders. Yet none of them appreciated that he had suffered any significant injury by way of fractures.

The Right Thigh-Bone Fracture

This stands out as being different from nearly all the other fractures which Child S suffered, in that it was a long-bone fracture rather than a metaphyseal fracture. I have discussed earlier the degree of force which the various experts have said would be required to cause such a fracture *in a baby with normal bone- strength.* Since I prefer the evidence of Mr Fernandes to that of Professor Offiah in that regard, it follows that, for a child with normal bone-strength, this injury would have required very considerable force. Dr Olsen, in his original report, which has not been challenged, suggested that this fracture was caused "no earlier than about 3 months before the 9th April 2019". One of the problems in this case is that we have no evidence of Child S being involved in any incident (e.g. a car-crash or

something similar), which would have been likely to cause such an injury in a child with normal bone-strength, during the relevant period. As I have already observed, Child S was very visible throughout that period. He was, among other things, at The Childminders, three times a week, having his nappy changed frequently by carers who would have been quite prepared (as they subsequently demonstrated) to "blow the whistle" if they had realised Child S had suffered any significant injury, much less a serious injury. In changing Child S's nappy, they must have been repeatedly manipulating the very bone which had been badly fractured. That leads me to the conclusion that there is something very unusual, not just about this fracture (which, effectively all the experts agreed), but also about Child S's response to it. That, again, supports the view that there is something very unusual about Child S's bones. In the circumstances, I find I am unable to draw any safe conclusions as to the amount of force which would have been required to cause this fracture in Child S, how he would have responded, and whether his carer at the time would necessarily have been aware that he had suffered a significant injury.

On balance, I am inclined to the view that, if either of the parents had had any idea that they had caused a significant injury to Child S's thigh-bone, they would have tried to ensure that he did not attend at The Childminders; even if he was comfortable sitting (being then immobile), there would be a continuing risk that Child S might show acute distress when his leg was manipulated during nappy-changes.

I have considered whether to attach any weight to the offer made by the father to the mother to "take the blame" for the injuries to Child S. The local authority suggest that was an admission of guilt, which supports their case that the father had knowingly caused the injuries. From the outset, I was wary of that conclusion, even though, at that point, all the medical evidence appeared to be pointing in that direction: I was mindful that parents are sometimes led to believe that the only way of getting their child or children back is for one of them to take responsibility; and that, in the circumstances, it may be tempting for a caring parent to make a false admission rather than face the possibility of their child/children being removed permanently from their home.

Subsequently, it occurred to me that there is another interpretation, which would not be consistent with the father being a perpetrator in the normal sense: it may have occurred to the father that Child S had suffered his injuries on the father's watch (since he was the main carer), so he must be "responsible" for those injuries, even if he had not realised it at the time.

For both those reasons, and having regard to all the other evidence in the case, I conclude that I could not safely place any reliance on this aspect of the evidence.

The Bruising

On the 8th April 2019, Child S was seen to have a considerable number of bruises on his torso. Those bruises caught the attention of Childminder 3 at The Childminders when she was changing a nappy (as was bound to happen at some point during the day), and led to the investigation which ultimately revealed the numerous fractures to which I have referred. Since that time, the local authority have looked back in time, and now say that there was evidence of bruising much earlier, starting when Child S was 4 weeks old (the jaw-line bruising). The local authority now say that that was early evidence of a pattern of physical abuse which culminated in the findings in early April 2019. There are a number of difficulties with that line of reasoning.

Photos of Bruising

As Dr Robinson pointed out in the MDT meeting (E512A), the Royal College (presumably of Paediatricians) advises paediatricians not to draw conclusions from a photograph which is not associated with a clinical exam or a child protection medical. Dr Robinson went on to comment, as did Dr Fonfe, (since they were both asked to do so) upon a number of photographs which did not fall into those very limited categories. Both said they were very uncomfortable doing so. Dr Fonfe made the point that she could not really tell whether the marks shown were actually bruises, but would have to act on the assumption that they were.

Of course, even if one assumes that the parents would not have produced the photographs they did unless they did show bruises, it still leaves open the question of how accurately the photographs showed the bruises, in terms of size, depth and colouration.

Looking at it from a slightly different perspective, the parents may have produced those photographs without having any clear recollection as to whether they actually showed bruises, or merely marks of a transient nature (see Dr Saggar's evidence (below).

How can I safely place any reliance on these photographs, when the paediatricians' own professional guidance tells them not to do so?

Secondly, I find it very significant that it was the parents themselves who produced many of the photographs on which the local authority now rely to prove their case of inflicted bruising. Of course, the parents produced those photographs to support their own case that Child S bruised easily. There is nothing in law to prevent the local authority from turning the parents' own evidence against them. Yet I have to consider whether those photographs would ever have been disclosed by the parents if they did not genuinely believe that these were bruises which had appeared because Child S bruised easily, rather than bruises which one or both of them had inflicted. Surely if either or both of them had inflicted any of those bruises, they would have ensured that the photographs were not disclosed? I find, on a balance of probabilities, that the very fact that the parents produced these photographs supports their case.

Next, I find that Dr Saggar's evidence undermines the local authority's case that these were all inflicted bruises.

Dr Saggar (at E516H) said that "red marks, blotchiness and transient markings are quite common in children with hypermobility syndromes, and I often see that when I examine them, they get red blotchy marks." That is an additional reason for being cautious about relying on photographs of doubtful quality; even if marks on the photographs look like bruises, they may just be the type of "transient markings" referred to by Dr Saggar (above), to which children with Child S's condition are prone. One example of that is the linear mark on the ear which was photographed, and which, for a time was thought to be a bruise. I heard a significant amount of evidence about that, yet it has now fallen out of the picture: other evidence showed that it had disappeared rapidly, and it is now accepted that it was just a transient mark, of a type to which Child S would be prone. How, then, can I safely draw conclusions adverse to the parents about other marks/bruises, based on photographs which do not meet the required standards?

Dr Saggar was also very clear that "there's definitely an increased susceptibility or propensity to bruise." (E517G).

Later, when being asked about the bruising, Dr Saggar said (N398A)…."I don't have a problem with lesser force being applicable. I'm not saying that lesser force was appropriate. That's a matter for my lordship – but I'm just saying that bruising can occur, and I've certainly seen fingertip bruising…."

Later, at 398A, Dr Saggar said that some of his adult patients (with this condition) sometimes say: "I'll wake up with a bruise and I don't know where it's come from". So, said Dr Saggar, "I think things which can otherwise seem innocuous can certainly lead to bruising."

I find that the paediatricians, who said that, for any of these injuries, there would have to be a "memorable event" and an "aftermath", have failed to factor in sufficiently Dr Saggar's evidence about Child S's susceptibility to bruising. It follows from Dr Saggar's evidence (above) that it would not require a "memorable event" to cause small bruises; they could be caused by "things which would otherwise seem innocuous".

One example of that, in my view, is the evidence of bruising to Child S's jaw-line. Dr Robinson said, more than once, that he thought that would be the result of a "grabbing" action, and he had no doubt that would be abusive. The parents, when asked, said they thought the bruising may have resulted from propping up Child S's head when winding him. Given Dr Saggar's evidence about Child S's propensity to bruise easily, I cannot see why the parents' suggestion is inconsistent with Dr Saggar's evidence; if a baby is being held on his front to be "winded", and his head is supported on either side of the jaw, there will be some force exerted on the jaw-line, if only the weight of the baby's head being drawn down by gravity onto the thumb and finger, perhaps amplified to some extent by the motion of winding him. That would not, of course, be enough to cause bruising on a child with a normal bruising re-action. For such a child, I would accept Dr Robinson's evidence that there would have to be a "grabbing" action, involving significantly more force. But Dr Saggar said that, in a child with Child S's condition, "things which can otherwise seem innocuous can certainly lead to bruising". In the light of that evidence, how could I safely conclude, even on a

balance of probabilities, that Child S's jaw-line bruising was caused by a forceful, and therefore abusive, "grabbing" action. I find I cannot.

The same arguments apply in relation to all the other, smaller bruises which pre-dated the bruises discovered on the 9th April 2019.

With all those bruises, I also find it concerning that the parents are having to meet a case which was built against them long after the events concerned. I remind myself of the "delay" direction frequently given to juries in criminal cases, the object of which is to remind the jury to be fair when considering a Defendant's account of events. Part of that direction involves reminding the jury that "with the passage of time, memories fade". The jury are invited to put themselves in the position of a person having to answer questions about events which happened a long time ago, and to consider how difficult it would be. The same applies to the parents in this case. Of course, it may be tempting to think that the parents must remember these events, because they would have been "memorable events". But that would be pre-judging one of the real issues in this case: were these, in fact, memorable events? If not, then why should the parents have a clear recollection of them? They may now think they have (as did Childminder 1 about the events on the 9th April 2019 when the police arrived – she was wrong).

How can I safely rely on photographic evidence of uncertain quality, and the parents' attempts to remember events which happened a considerable time ago, and which were not investigated until much later?

It is right that I should deal also with the argument, raised on behalf of the local authority, that there is no evidence of suspicious bruising seen on Child S while he has been in alternative care. They suggest that makes it more likely that the bruises Child S suffered in the care of his parents were non-accidental , that is to say, inflicted injuries. On behalf of the parents it is argued that, on the contrary, Child S has been seen with bruising in a wide range of different settings. The paediatricians agree that, the more settings in which bruises are seen, the less likely it becomes that any particular bruise is non-accidental.

That argument and counter-argument are bedevilled by the fact that, as I remarked previously, Child S has probably not been handled in the same way since he has been in alternative care. Thus, a comparison of bruises before, and bruises after, the move, is unlikely to produce a fair, or reliable, result. Accordingly I find I cannot draw any safe conclusions from that line of argument.

I also take into account the positive evidence about these parents.

I find that, taking into account Dr Saggar's evidence, the dubious photographic evidence, the passage of time, and the positive evidence about these parents the local authority have failed to discharge the burden of proof in relation to all the earlier bruising (before that found on the 8th April).

The Bruising seen on the 8th April

This bruising was clearly more substantial and serious than any of the earlier bruising which has been referred to during the case. I have heard much evidence about it. One possible explanation was the incident on the water-slide at Flamingoland the previous weekend, when the parents say Child S was grasped firmly by the torso to stop him going underwater. Dr Saggar accepted that, given Child S's propensity to bruise with lesser force, that would be a reasonable explanation of this bruising, if the incident was sufficiently close in time to the discovery of the bruising. On the other hand, we have evidence (e.g. from Mr S), that, when Child S suffers a bruise, it appears very rapidly. The local authority therefore argue that the Flamingoland incident cannot be the explanation for the bruising seen on the 8th April; that incident had occurred over a week previously, so, say the local authority, the bruises would have come out sooner.

One aspect which was not investigated during the evidence, so far as I can recall, was whether "deeper" bruising would come out as rapidly. Most of us have probably had experience of suffering "deeper" bruising, and that bruising taking longer to develop.

I also remind myself that I have been repeatedly told by paediatricians in other cases that it is no longer regarded as possible to "age" bruises by their appearance, since different bruises develop at different rates.

Another possible explanation for this bruising was Child S being thrown up in the air and caught, which is something the father was in the habit of doing. It was pointed out that, for that to account for this bruising, Child S would probably have had to be thrown up while facing away from the adult, rather than towards him/her (to account for the apparent finger-tip bruises on his chest).

The Credibility of the Witnesses

The local authority make much of the fact that the parents have not come up with a clear account of discussions between them concerning the bruising on Child S. The parents both say it had been seen on the Sunday before it was seen at The Childminders the following day. But there is not a clear account of any discussions surrounding it, either when the parents say they first saw it, or the following morning when it became apparent that the child-minders were not going to simply return the children in the usual way. The local authority say that is highly suspicious, and suggests that they are lying, because there must have been such discussions, and they would remember and be able to recount them. I do not accept that. Firstly, I am mindful of a lecture I attended at the Judicial College from a psychologist speaking about the damaging effects of trauma on memory (in the context, as it happens, of rape victims). Her theme was that people who are traumatised do *not* have clear memories of events surrounding the trauma. The brain, perhaps as a defence mechanism, tends to block out the memories. They often emerge either in a disjointed fashion, or not at all. That is, of course, directly contrary to what defence counsel have been putting to complainants in rape and similar cases for decades, perhaps centuries: "if you had been raped, you would remember it, and you would give us a clear account of it". That, apparently, is simply wrong. Since hearing that lecture, I have been directing juries in rape cases that they cannot necessarily expect a genuine victim to have a clear recollection and to give a clear account.

I mention that because, in my view, the Cs were traumatised by what happened that morning. They had not seen it coming. (If they had, as is suggested on their behalf, they could easily have avoided taking Child S to nursery that day). The description of the mother's behaviour on arrival at the setting makes it clear that she was distraught. That is hardly surprising. I am satisfied that the parents had not attached any great significance to what they saw the previous evening. Perhaps they should have, but they didn't. In the circumstances I am not surprised that they were unable to produce a coherent account, indeed matching accounts, of the events of the previous 24 hours.

Secondly, I am wary, in any event, of witnesses who give clear, coherent, plausible accounts of events. The fact that they do so does not mean that their

evidence can be relied upon, even if they appear to be otherwise honest and dependable witnesses, with no axe to grind. That statement may seem curious, even perverse. Surely honest witnesses will generally be able to provide clear, truthful and reliable accounts? Well, no, not necessarily. In this case, we have a classic example of a patently honest witness, with no axe to grind, who gave a clear and plausible account which turned out to be badly wrong. I am referring, of course, to Childminder 1, and her description of Mr C's behaviour when the police attended The Childminders at about lunch-time on the 8th April 2019. Childminder 1's account made Mr C's behaviour sound very suspicious. That could, of course, have been very important evidence in the context of serious alleged non-accidental injuries. Fortunately, we have irrefutable evidence which directly contradicts the evidence of Childminder 1 – the police body-cam footage. It is not disputed (even by Childminder 1), that her account was simply wrong! I do not say that as any criticism of Childminder 1: I have no reason to doubt that she was doing her best to give an accurate and truthful account. But it does demonstrate, as Crown Court judges sometimes remind juries, that even an honest and truthful witness can be mistaken.

It also reminds me how fallible human memory can be. That becomes particularly relevant when I am being asked to make findings about events which happened a very long time ago (some going back 2 years and more). If Childminder 1 could be badly mistaken about relatively recent events about which she was certainly not lying, how can I expect to rely upon evidence about events which happened much longer ago, which were not investigated until much later?

For those reasons I have to be very wary of looking for an apparently coherent and consistent account, and relying on it; or conversely, dismissing the parents' account on the basis that it is not clear or coherent or consistent.

Indeed, I am inclined to the view, contended for on behalf of the parents, that the very fact that the parents presented Child S at The Childminders that morning, with obvious bruising, and did not have a coherent explanation, tends to suggest that they are being truthful in saying that they had not (knowingly) caused the bruises. These are two intelligent adults who could certainly have avoided producing Child S at The Childminders until the bruising had disappeared; or, if for any reason he had to go to The Childminders, there would likely have been some carefully thought-out and agreed explanation for the bruising. The absence

of such an explanation tends to support their account, that they were completely taken by surprise by the events of the 8th April. That, in turn, tends to suggest that neither of them had knowingly caused the bruising.

I have dealt, earlier, with the local authority's argument about the relative lack of bruising seen on Child S while in alternative care. My views on that apply equally in relation to this bruising.

In the circumstances, I find the local authority have failed to discharge the burden of proof in relation to any of the bruising seen on Child S at different times.

The "Problem" with Child S being carried on the hip

The local authority now seek a finding that the parents failed to seek medical attention for Child S in the light of the fact that he objected to being carried on an adult's hip (1A at A339 in the final threshold document).

The particulars of this allegation start with the assertion (at 1.A.a) that Child S suffered "an injury to his legs and/or hips". The local authority then go on to allege that the parents failed to seek medical treatment for that injury.

The fundamental difficulty with this allegation is that there is no real evidence to support it. There is certainly no medical evidence to show what caused Child S's complaints when he was placed on the hip. There are no X-rays showing an injury and no evidence from any medically qualified person saying that they examined Child S and diagnosed any such injury. Of course, the local authority say that is precisely because the parents failed to seek any treatment for any such injury.

Yet the result of that is that I am, in effect, being invited to speculate about an injury relying only on evidence about the noises that Child S made when placed on an adult's hip, and what people said about them.

The parents say that Child S didn't like being placed on the hip. Others have given different descriptions. This allegation is again bedevilled by the fact that whatever did happen, it had happened many months before the investigation started, and before any statements were taken. I have already remarked on the unfairness which can arise from investigating an event long after it happened, and how decent, respectable, honest witnesses can be mistaken in their description of events.

The parents are effectively saying that they made a judgment call that there was nothing of substance underlying Child S's dislike of, and his response to, being placed on an adult's hip. Sensible parents frequently make such judgment calls. They may be right, and they may not. It could be that, because of his underlying condition, Child S had suffered a metaphyseal fracture because of an apparently innocuous event. If that was right, then there would have been no "memorable event". If that were the explanation, I find that the parents cannot be seriously criticised: they would not have seen anything happen to Child S (an immobile baby) which should have led them to realise that he had suffered a significant injury. And if the same thing happened again subsequently when he was placed on the hip without excessive force, one interpretation could be that he "didn't like it".

Given the very positive things which are said about these parents; given the lapse of time and the difficulty in carrying out a fair and reliable investigation, and the fact that Child S was always visible through this period, and was seen and examined by a number of health professionals, I conclude that the local authority have not discharged the burden of proof. I am therefore not going to make any finding.

The "Pulled Elbows" (1B in the threshold document at A339)

This allegation is subject to the same criticisms as the last, but more so: here, the local authority accept that the parents sought appropriate medical attention; their criticism is that, whatever had happened to Child S to cause the first pulled elbow, the parents allowed it to happen again to the other elbow. That might be a reasonable criticism if Child S had a medical condition which was known and understood, and if the parents had been told that they must treat Child S very gently to avoid a recurrence. So far as I am aware, they were not told that. So far as they were aware, Child S was a normal baby who did not have to be treated particularly carefully. In the circumstances, I find it unsurprising that there was a recurrence (albeit on Child S's other side).

Again, I find on a balance of probabilities that the primary cause of Child S's difficulties was his underlying condition, rather than his treatment by his parents. In the circumstances I will not make a finding.

The Father's Involvement

While I have found that the father's less-than-gentle handling of Child S may have contributed to the causation of some of Child S's fractures and/or bruises, I do not make any finding against him in respect of that: he was not to know that Child S had a propensity to fracture; he could therefore not be expected to handle Child S with special care; his handling of Child P had apparently never been a problem. He is not to blame for what happened to Child S. Nevertheless, I anticipate that, now he knows more, he will handle Child S more carefully in the future, while avoiding "wrapping him in cotton wool".

Summary and Conclusions

The outcome of this hearing depends on the interplay between the positive evidence about the parents, on the one hand, and any medical evidence which might prove that Child S's numerous injuries were inflicted. There is no eye-witness evidence to support the allegations of non-accidental injury inflicted by the parents (except, arguably, the evidence of Mrs L about "the car-seat incident").

As to the medical evidence, I prefer the evidence of Dr Olsen, Dr Saggar and Dr Fernandes to that of Professor Offiah and the consultant paediatricians. Accordingly, I find, without hesitation, that Child S has genetic anomalies, some of which may still be un-identified and not properly understood (Dr Saggar, supported by the evidence of Dr Olsen's "red flags"). Those genetic anomalies lead to bruising with lesser force, and may lead to fractures with lesser force (Dr Saggar).

Taking the medical evidence in isolation, I find that the local authority have not discharged the burden of proof in relation to any of Child S's injuries, since they may all be accounted for by known genetic anomalies and possible unknown anomalies.

Once the positive evidence about these parents is factored in (the wider picture), and the fact that Child S's older sister, Child P, has never come to any harm, I find

the local authority have fallen well short of proving their case. I accordingly make no findings.

I trust that this will result in a planned but rapid return of Child P and Child S to their parents and their home. It is fortunate that they have been kept within the extended family in the interim, and I have no doubt that the parents are very grateful to Mrs L for caring for them.

Exoneration of the Intervenors

When these proceedings started, there was no suggestion that the intervenors were responsible for causing any injuries to Child S. It was, after all, they who had started safeguarding measures by reporting the bruising seen on Child S. They would have been very unlikely to do that if any of them had been responsible for Child S's injuries, at least those which were apparent at the time, namely the bruising.

Fairly late in the proceedings, the local authority amended the threshold document to include possible findings against the intervenors. As I understand it, that was only ever a long-stop, in case the local authority failed to obtain findings against the parents. In the event, the possible findings against the intervenors have not been actively pursued; the intervenors have appeared as witnesses during the proceedings, although they have also attended the hearing, as they were entitled to do.

I can well understand that these proceedings have caused great concern to the intervenors, particularly during the period when the local authority were (even if only half-heartedly) seeking findings against them. The intervenors are all child-care professionals, for whom these proceedings could, under very different circumstances, have had extremely serious consequences.

In the present circumstances, in the absence of any evidence against Childminder 1, Childminder 2, and Childminder 3, I have no hesitation in exonerating them

from any responsibility for any of Child S's injuries. They should be treated by all external parties as they would if no findings had ever been sought against them.

Zoom

This hearing was conducted throughout on the on-line conferencing platform, Zoom. Fortunately, that had been arranged, and preparations made, before the judiciary were told that we could not use Zoom. In the circumstances, I was told we could continue with the existing arrangements. I am very grateful that that was allowed: ever since, I have been hearing reports of problems associated with hearing the more complex cases on CVP. The general view seems to be that, once there are more than a fairly limited number of participants in a CVP hearing, the problems proliferate, with a resulting waste of time and an increase in stress for all concerned. I have also been told that, if one party has a bad connection, it appears to affect the functioning of the whole hearing.

By contrast, this hearing, with upwards of twenty people joining most of the time, has been largely trouble-free. The only significant problems we experienced appeared to be the result of individual participants having difficulties with their home wi-fi connections, rather than problems arising from the platform itself.

Those of us who participated in the hearing are all indebted to Miss Lee QC, Leading Counsel for the local authority. She kindly took it upon herself to manage the Zoom aspect of the hearings, sending out invitations, taking responsibility for recording the hearing, and forwarding the recordings to the court. Those were tasks which would normally have to be performed by a member or members of court staff. I do not suggest, for a moment, that that is something which should normally be expected of counsel. Certainly in this instance, Miss Lee had more than enough on her hands running a complicated case for the local authority. However, she took on the additional burden I have mentioned and, by doing so, enabled the hearing to proceed smoothly on a platform which worked well. She thereby assisted us all.

Caselines

The case was heard using Caselines, an online system of electronic bundles rather than paper bundles. This is the second long case I have heard using Caselines (the first would, I am told, have involved 47 lever-arch files of papers). I have found it invaluable in both cases. It makes the judge's task much easier, primarily because it completely removes the need for the judge to physically organise and manhandle vast quantities of papers, and locate page references. That is all done by the advocates (or their junior or solicitor) taking witnesses (and everyone else involved in the case) to a particular page by issuing a page-direction which is sent to every computer logged on to that particular case. By the same token, the witness does not have to find page references, nor does there need to be a member of court staff assisting the witness to do so. Witnesses giving evidence remotely can be directed to documents which are not physically present at their location. The list of benefits goes on. I found it speeded up the proceedings significantly, and reduced considerably the stress on me, as the judge. I found it speeded up the evidence, in particular, because I was relieved of the tasks of bundle-management and page-finding. I also found it made it far easier to write the judgment: I did not have to take large numbers of lever-arch files to wherever I wanted to work; I only needed my laptop, and the ability to log on to Caselines. I imagine the same is true for advocates preparing the case or preparing written submissions.

For any judge or advocate facing, for the first time, a hearing using electronic bundles (at least, if they are on Caselines, the only system with which I am familiar), I thoroughly recommend the experience. Embrace it: it will make your life easier. In case you are thinking that I am some young computer-whizz, that is certainly not the case: I am fast approaching compulsory retirement age, and am only moderately technologically aware. The system is very user-friendly, and saves time and effort.

HHJ Simon Jack

(sitting in the High Court)

28th August 2020