

IN THE FAMILY COURT AT WEST LONDON

West London Family Court,
Gloucester House, 4 Dukes Green Avenue
Feltham, TW14 0LR

Date: 17/09/2021

Before:

HIS HONOUR JUDGE WILLANS

Between:

**The London Borough of Richmond Upon
Thames**

Applicant

- and -

**(1) Mother
(2) Father
(3) BB and (4) AA (by their Children's
Guardian)**

Respondents

-and-

(5) Maternal Grandmother

Intervenor

Kate Mather (instructed by **Legal Department, Richmond upon Thames**) for the
Applicant
Philip Squire (instructed by **MB Law Limited Solicitors**) for the **First Respondent**
Jane Rayson (instructed by **TV Edwards Solicitors**) for the **Second Respondent**
Natasha Miller (instructed by **Owen White & Catlin LLP**) for the **Intervenor**
Christopher Archer (instructed by **Creighton & Partners Solicitors**) for the **Children**

Hearing dates: 7-16 September 2021

JUDGMENT

His Honour Judge Willans:

Introductory Remarks

1. Within this judgment I use labels to protect the privacy of the key participants (mother, father and grandmother in particular). No discourtesy is intended by the use of such labels. There is no need to

anonymise the judgment in respect of the expert witnesses. I refer to the relevant child in question by the initials AA and to his older sibling by the initials BB.

2. This case concerns what lawyers often refer to as a non-accidental injury (NAI) case. In simple terms I am asked to examine the circumstances surrounding identified injuries to a child and decide whether the case put by the Applicant, one in which an adult is held responsible for the injuries, explains what happened to the child.
3. This decision making is intended to inform the Court both as to (a) whether there is a need for a further welfare hearing (at which placement options for the children are considered), and if so (b) issues of risk within that hearing.
4. It should be obvious that these decisions are of prime importance for the children concerned and for their family. The task facing the Court is a challenging one and demands clear analysis and a rigorous assessment of the available evidence.
5. In this case I have the benefit of a digital hearing bundle¹ and a range of additional documents provided in the course of the hearing². I have read position documents provided for some of the parties and heard oral submissions made by counsel for each party at the conclusion of the evidence. Most importantly I have heard live evidence from the following witnesses (and in order): (i) Dr Patrick Cartlidge (Paediatrician); (ii) Mr Jeremy Brockelsby (Consultant in Obstetrics & Gynaecology and Feto-Maternal Medicine); (iii) Dr Melita Irving (Consultant in Clinical Genetics); (iv) the Mother; (v) the Father; (vi) Dr Oystein Olsen (Consultant Paediatric Radiologist); (vii) the Maternal Grandmother (“the Grandmother”).

¹ With a supplementary section containing some of the additional documents added prior to the commencement of the hearing

² I list these in annex A to the judgment

6. In the course of this judgment I will inevitably select and focus on certain aspects of the evidence. But it should not be thought I have not borne all of the evidence in mind when reaching my conclusions. I have, but it is simply neither practical nor necessary to deal with all points within this judgment.
7. This hearing was held on a hybrid basis. I heard all evidence remotely save for that of the parents, who attended Court in person to give their live evidence. I consider this hearing worked effectively and I consider there was no impairment of either access to justice or the individual's right to a fair hearing. No suggestion has been made to the contrary.

Findings Sought

8. The Applicant alleged as follows³:
 1. Upon admittance to hospital on 02/02/21, AA was suffering from the following injuries:
 - a. An undisplaced spiral fracture of the left upper humerus
 - b. A healing fracture of the right collar bone (clavicle)
 - c. A linear discontinuity in the left parietal bone representing either a skull fracture or an accessory suture.
 2. The fractures of the clavicle and skull occurred either as a result of birth trauma or in relation to the clavicle fracture occurred on or before 20 January 2021. The fracture of the humerus was acute but had been sustained no earlier than 24 January 2021.
 3. The injuries sustained by AA were inflicted and were non-accidental.
 4. The mother and father are within the list of possible perpetrators in relation to the clavicle injury as they had care of AA during the relevant period, and no other person was left unsupervised with AA. The mother, father and maternal grandmother are within the list of possible perpetrators in relation to the humerus injury as they had care of AA during the relevant period, and no other person was left unsupervised with AA.
 5. The humerus spiral fracture was caused by twisting of the left upper arm. The force required to cause this injury was greater than the magnitude of force resulting from normal handling by a reasonable carer; excessive force was applied. The fracture of the clavicle was caused by direct force over the clavicle, or a very forceful pulling of the ipsilateral arm.
 6. AA's injuries will have caused him pain and distress. Any person caring for AA following the humerus fracture when dressing or undressing would have found him in pain.]
 7. There is no satisfactory explanation offered by the parents or maternal grandmother, to explain how the injuries have been caused. The following explanations are implausible and unlikely:
 - a. Birth trauma
 - b. BB causing it- the "broken cup" incident
 - c. Mother 's evidence of AA having arm stuck between cot and bed on 31/01/21
 - d. A "rolling over" causing the arm fracture
 8. There is no pathological underlying organic or medical explanation for the injuries sustained by AA.

³ A146 – albeit modified following the evidence as noted below

9. The parents and maternal grandmother failed to protect AA from harm at a particularly vulnerable age.
 10. By virtue of the above, AA has suffered significant physical harm, and both children at the relevant time were at risk of physical harm due to the risk of further injuries being inflicted by either or both of their parents and/or the maternal grandmother.
9. At the conclusion of the evidence and in submissions the applicant substantially amended its allegations as follows:
- i) It no longer sought a finding against the grandmother
 - ii) It no longer sought any finding with respect to the skull 'fracture'.
10. For the avoidance of doubt no party sought to challenge this amendment. I will simply record at this stage that these were appropriate concessions to make. The clear evidence of Dr Olsen was that one simply could not establish to the necessary standard that the skull 'fracture' was anything other than a naturally occurring accessory suture. A state of affairs which is absolutely normal and does not speak of third-party misconduct. As regards the grandmother I can find no proper basis on which I could have made a finding against her were I asked to do so. I will in any event deal with her evidence, which remains important, below.

Legal Principles

11. **Establishing causation** This might be alternatively described as proving the allegations. This is for the Applicant to prove and to do so to the civil standard, the balance of probabilities. This standard is not flexible according to the gravity of the allegation⁴. Inherent probabilities as to an event taking place can be weighed in the assessment but are not to be taken to be determinative, they must be considered with all the other evidence in the case. The parents have no legal responsibility to disprove the allegations, but if they put forward a reasonable explanation then it falls on the Applicant to disprove that explanation⁵. Further the

⁴ Re B (Care Proceedings: Standard of Proof) [2008] UKHL 35, [2008] 2 FLR 141

⁵ S (Children) [2014] EWCA Civ 1447

failure of parents to explain an event cannot be relied upon to find an event proved⁶ but that is not to say the parents' lack of account in circumstances where the facts suggest they should be able to give valuable evidence may not be considered with all the other evidence.

12. **Establishing an event on evidence:** The Court acts on evidence, not speculation or assumption. It acts on facts, not worries or concerns⁷. Evidence can include the absence of an explanation or account that might reasonably be expected on the facts. An allegation is either found to have occurred as a matter of fact or not to have happened. This is a binary system which allows no room for findings that events 'may have happened'. This binary principle is applicable to the conclusion as to the fact in issue not the value of the individual pieces of evidence which fall to be assessed in combination with each other.

13. **The wide canvas of evidence:** The evidence in cases of this sort can be far ranging. It is important the Court does not evaluate and assess each aspect of the evidence within a separate compartment from the other evidence as evidence may well have relevance outside of its own compartment⁸. It is important for the Court to carry out an overview in all cases, standing back and considering how the global evidence fits together. The evidence under consideration should not be thought to be restricted to those parts of evidence directly linked to the allegations in question. Instead a Court must have regard to the 'wide canvas' of available evidence including:

the history of members of the family, the state of relationships within a family, proposed changes within the membership family, parental attitudes, and omissions which might not reasonably have been expected, just as much as actual physical assaults. They include threats, and abnormal behaviour by a child, and unsatisfactory parental responses to complaints or allegations. And facts, which are minor or even trivial if considered in isolation, taken together

⁶ Re M (A Child) [2012] EWCA Civ 1580

⁷ Re BR (Proof of Facts) [2015] EWFC 41

⁸ Re T [2004] EWCA (Civ) 558

*may suffice to satisfy the court of the likelihood of future harm. The court will attach to all the relevant facts the appropriate weight when coming to an overall conclusion on the crucial issue*⁹

In Re BR Peter Jackson J. (as he then was) whilst commenting that ‘*Children can of course be well cared for in disadvantaged homes and abused in otherwise fortunate ones*’ noted the following risk and protective factors identified by the NSPCC¹⁰. Risk factors were: (a) Physical or mental disability in children that may increase caregiver burden; (b) Social isolation of families; (c) Parents' lack of understanding of children's needs and child development; (d) Parents' history of domestic abuse; (e) History of physical or sexual abuse (as a child); (f) Past physical or sexual abuse of a child; (g) Poverty and other socioeconomic disadvantage; (h) Family disorganization, dissolution, and violence, including intimate partner violence; (i) Lack of family cohesion; (j) Substance abuse in family; (k) Parental immaturity; (l) Single or non-biological parents; (m) Poor parent-child relationships and negative interactions; (n) Parental thoughts and emotions supporting maltreatment behaviours; (o) Parental stress and distress, including depression or other mental health conditions; (p) Community violence. Protective factors were: (a) Supportive family environment; (b) Nurturing parenting skills; (c) Stable family relationships; (d) Household rules and monitoring of the child; (f) Adequate parental finances; (g) Adequate housing; (h) Access to health care and social services; (i) Caring adults who can serve as role models or mentors; (j) Community support. He made clear ‘*that the presence or absence of a particular factor proves nothing...but that the analysis may nonetheless provide a helpful framework within which the evidence can be assessed, and the facts established*’¹¹.

14. **Parental (Carer) evidence:** The evidence of the parents and of any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must

⁹ Re H and R (Child Sexual Abuse: Standard of Proof) [1996] 1 FLR 80

¹⁰ In their Common Assessment Framework and the Patient UK Guidance for Health Professionals

¹¹ §19

have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them¹². Here the grandmother does not speak English and gave evidence with the assistance of an interpreter. This heightens the care the Court must take when assessing her evidence to avoid misunderstandings and the loss in translation of the nuances and shades of different meaning which may arise. That process also has the potential to focus on the expression of the interpreter who in using a neutral manner may rob the Court of an understanding of the emotion in the actual response¹³. I also bear in mind the observations of Leggatt LJ. (as was)¹⁴ as to the caution and humility the Court should show when seeking to draw conclusions as to witness credibility from the manner and demeanour of that witness (and particularly one giving evidence through interpretation). The valuable reminder is that the benefit of live evidence is not principally to assess demeanour of a witness but to test the plausibility, logical quality and inherent consistency of the evidence itself.

15. **Experts:** Expert evidence is important evidence but only part of the evidence. It is not for the expert to decide the case but for the *'expert to advise and the Judge to decide'*¹⁵. This means a Court can reach a conclusion as to causation contrary to that of the expert evidence¹⁶ and this is because the Court is required to assess the wide spectrum of evidence and is not constrained to an area of expertise (as is the case with a given expert). But this is not to suggest the Court can or should ignore expert evidence. A Judge who finds him/herself in disagreement with expert evidence should be able to identify the basis upon which he/she chooses not to follow the advice given. In considering expert evidence the Court will need to ensure a given expert confines

¹² Re W and another (Non-accidental injury) [2003] FCR 346

¹³ Swansea County Council v MB & Ors [2014] EWHC 2842 (Fam)

¹⁴ SS (Sri Lanka), R (On the Application of) v The Secretary of State for the Home Department [2018] EWCA Civ 1391

¹⁵ Re B (Care: Expert Witnesses) [1996] 1 FLR 667

¹⁶ A Local Authority v K, D and L [2005] EWHC 144 (Fam), [2005] 1 FLR 851

him/herself to their area of expertise¹⁷ and the Court will guard against a dogmatic expert and that today's medical certainty may be discarded in the future as scientific light is thrown on previously dark areas of understanding¹⁸.

16. **Unknown cause:** The Court is not precluded from making a finding that the cause of harm is unknown¹⁹ and must resist the temptation to believe that it is always possible to identify the cause of injury to a child²⁰. However, a Court should decide a case on the burden of proof alone only when driven to it and where no other course is open to the Court given the unsatisfactory state of the evidence²¹. In reaching this decision the Court of Appeal warned against reference to percentage possibilities or probabilities when deciding a case.
17. **Inherent probability:** The Court should take care in the application of this principle. This is not the same as asking for instance how commonly an event occurs. An event may be rare but on the facts of the case may, when taken with all the evidence, meet the test of being more likely than not. As Lord Hoffman observed²²:

There is only one rule of law, namely that the occurrence of the fact in issue must be proved to have been more probable than not. Common sense, not law, requires that in deciding this question, regard should be had, to whatever extent appropriate, to inherent probabilities. If a child alleges sexual abuse by a parent, it is common sense to start with the assumption that most parents do not abuse their children. But this assumption may be swiftly dispelled by other compelling evidence of the relationship between parent and child or parent and other children. It would be absurd to suggest that the tribunal must in all cases assume that serious conduct is unlikely to have occurred.

In BR the Court observed:

- (4) *Similarly, the frequency or infrequency with which an event generally occurs cannot divert attention from the question of whether it actually occurred. As Mr Rowley QC and Ms Bannon felicitously observe:*

¹⁷ Re S [2009] EWHC 2115 Fam).

¹⁸ Re U (Serious Injury: Standard of Proof); Re B [2004] 2 FLR 263

¹⁹ Re R (Care Proceedings: Causation) [2011] EWHC 1715 Fam; London Borough of Southwark v A Family [2020] EWHC 3117 (Fam)

²⁰ R v Henderson and Others [2010] EWCA Crim 1219

²¹ A (Children) [2018] EWCA Civ 1718

²² B (Children) [2008] UKHL 35

"Improbable events occur all the time. Probability itself is a weak prognosticator of occurrence in any given case. Unlikely, even highly unlikely things do happen. Somebody wins the lottery most weeks; children are struck by lightning. The individual probability of any given person enjoying or suffering either fate is extremely low."

I agree. It is exceptionally unusual for a baby to sustain so many fractures, but this baby did. The inherent improbability of a devoted parent inflicting such widespread, serious injuries is high, but then so is the inherent improbability of this being the first example of an as yet undiscovered medical condition. Clearly, in this and every case, the answer is not to be found in the inherent probabilities but in the evidence, and it is when analysing the evidence that the court takes account of the probabilities.

18. **Lies:** I will deal with this briefly and simply to acknowledge the need to approach with care the assessment of a witness who has been found to be untruthful in certain regards. One cannot simply read from this general untruthfulness. Rather a sophisticated approach is required if one is to draw probative value from the lie in question²³. Furthermore, this principle will not have traction in all cases and the Court can expect advocates to identify cases in which the Court is being asked to draw conclusions from lies²⁴.

19. **Pool of perpetrators:** This arises in circumstances in which an allegation is made but the identification of the alleged wrongdoer cannot be narrowed down to an identified individual. When seeking to identify the perpetrators of non-accidental injuries the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator²⁵. In order to make a finding that a particular person was the perpetrator of non-accidental injury the court must be satisfied on a balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interest of the child, although where it is impossible for a judge to find on the balance of probabilities, for example that Parent A rather than Parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to do so²⁶. However, the Court should keep in mind that an individual being placed into the pool makes them a possible perpetrator not a proven perpetrator and the Court must guard against

²³ H-C (Children) 2016 EWCA Civ 136

²⁴ A, B & C (Children) [2021] EWCA Civ 451

²⁵ North Yorkshire County Council v SA [2003] 2 FLR 849

²⁶ Re D (Children) [2009] 2 FLR 668, Re SB (Children) [2010] 1 FLR 1161

requiring evidence to exclude the individual from the pool²⁷. The Court should approach the issue as follows:

“The court should first consider whether there is a ‘list’ of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain to do so. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: “is there a likelihood or real possibility that A or B or C was the perpetrator of a perpetrator of the inflicted injuries?” Only if there is should A or B or C be placed into the ‘pool’.”

20. **Failure to Protect:** The court must have evidence of a factual basis from which to find a failure to protect and the Court should ask itself whether those facts justify the conclusion that the carer knew or ought to have known that injury would be inflicted?²⁸ Events post injury could not be relied upon to support a finding of failure to protect in respect of those injuries. A finding of failure to protect must not be a ‘bolt on’ to the central finding of perpetration and the Court must not assume that cohabitation will lead to an inevitable finding.

Relevant Background Material

21. On 2 February 2021 the mother took AA to hospital due to concerns surrounding his left arm. X-rays were taken and a humerus fracture noted²⁹. Concern arose as to how this injury had been occasioned. These proceedings flow from that initial attendance and diagnosis.
22. Prior to 2 February 2021 the family had occasioned no concerns as to their parenting or as to their home life. They were not on the local authority’s ‘radar’. Viewed through the prism of the NSPCC Framework referred to above³⁰ their day to day life ticked all of the positive protective features and none of the risk factors.
23. The parents are aged 37 (mother) and 34 (father) respectively. They commenced their relationship in 2014 and married in 2018. Their oldest

²⁷ B (Children: Uncertain Perpetrators) [2019] EWCA Civ 575

²⁸ Re L-W [2019] EWCA Civ 159

²⁹ E114 Fig. 1

³⁰ Ibid 10

child, BB was born in 2019, and was aged just under 2 years as at February 2021.

24. I do not intend to detail their life history in significant detail. I will summarise as follows: (1) they describe a wholly happy relationship; (2) there are no reports of, or grounds for believing the relationship to include any features of alcohol or substance abuse; domestic violence or mental health challenges; (3) both AA and BB were planned and much wanted children; (4) both parents are successful in their chosen careers and are financially secure; (5) there are broad community support network on both sides of the family and amongst friendship groups.
25. The mother was born in country Y (a European State) where her parents continue to live. The maternal grandparents have travelled to offer support for both the parents (previously with BB and then with AA) but also to their other daughter/daughter-in-law. The mother also has family who live full-time in this country. At the outset of her evidence the mother explained issues might arise as English was not her native tongue. This did not prove to be the case. I found her use and understanding of English to be substantial and she was articulate and fully comprehensible throughout her evidence. The father is British and has family both local and further afield in the country. As with his wife he was articulate and clear in his evidence.
26. The parents told me about the circumstances under which they have pursued their careers. For the purpose of this judgment I simply note they appear to have arranged their lives with care and on their evidence through discussion and agreement. At times this has led to them living out of the jurisdiction but by late 2020 their plans were to return to this jurisdiction to live, in anticipation of the birth of AA.
27. Unfortunately, Covid struck the family at just the worst time. At the point of AA's birth, the mother was suffering with Covid and indeed had to return to hospital after AA was discharged. The father could not attend the birth. It is clear Covid had a significant impact on the mother who

was discharged ultimately needing consistent oxygen whilst at home. It seems her reliance on oxygen continued into March 2021.

28. The father was able to obtain extended paternity leave in these circumstances and cared for the children when the mother had to return to hospital. Although wider family were available to help the family were required to isolate (the father had contracted Covid himself) and so could not be assisted fully. AA was born on 1 January 2021 and discharged with his mother on 2 January 2021. The mother then returned to hospital due to Covid on 5 January 2021 and remained there until 14 January 2021 when discharged home. The maternal grandparents had arrived in the country towards the end of December 2020. It seems they helped the father by caring for BB during the period when the mother was in hospital with Covid. Following her discharge and on 25 January 2021 the grandparents moved into the home with the mother, father and both children.
29. The evidence in the case largely focuses on the events of 31 January – 2 February 2021. I will summarise the events of this period in short order (although I will return to some detail later in this judgment) to allow an overview of this period.
 - i) The grandparents slept in a guest room on the first floor of the property. BB slept on the same floor. The living space comprised an open plan room on the ground floor. The parents' bedroom was on the second floor.
 - ii) On 31 January 2021 the mother reports waking in the night and discovering AA turned over in his bed-attached cot such that he was effectively on both the cot and her side of the main bed. She took this to have occurred due to him rolling.

- iii) At about 1235hours on 1 February 2021 AA was photographed in his recliner seat³¹. He is positioned with his left arm raised to his face.
- iv) At about 1700hours on 1 February 2021 the grandmother dropped a mug in the kitchen³². The significance of this is considered below.
- v) At about 2200hours that night the father was caring for AA downstairs and AA was unsettled and crying. The grandmother came down and was given AA. She settled him and took him up to the parents' bedroom where she placed him into his cot. By this time both parents were in the bedroom. The grandmother went to bed. On the evidence this was the first night the mother was to be responsible for caring for AA at night. The father was due to return to work the next day (albeit working from home). Overnight the parents report AA crying. This will be considered in detail below.
- vi) At about 0800hours on 2 February 2021 the father brought AA downstairs and left him in the care of the grandmother whilst he returned upstairs. In the following period the grandmother found AA to be unsettled and in carrying out checks formed the view he was responding with pain to being touched in the region of his arm/shoulder on his left side. He then fell asleep. Later the mother came downstairs and the grandmother reported her concerns. The mother passed these concerns onto the father at about 1130hours by whatsapp as he was working upstairs.
- vii) Whilst there is no exactitude about these times the contents of the whatsapp messaging suggests the following. Following whatsapp messaging between the parents the mother asked when the father would be able to 'come down' [1159hours]. The evidence suggests he came down shortly after this and that a call was made

³¹ C71 and Annex A item 6

³² C111

to the family GP surgery. The evidence suggests the parents were told to call back for an appointment at 1400hours. During this first call the father was present and noted AA's arm appeared 'limp' to his side. By about 1330hours the mother was herself at the 'same day care unit' for a follow up on her covid pneumonia. She called the GP at 1400hours and obtained a telephone appointment for 1630hours. At that appointment the parents were advised to attend hospital and did so together (although only the mother could enter the hospital) around 1730-1800hours

- viii) I have a detailed medical chronology summarising the medical notes and meetings during the following period. Given I intend to deal with the expert evidence below I will not go into great detail at this time. But I have considered this in full and in passing note some points:
- a) It seems clear within 2 days of admission AA was using his left arm again
 - b) Consideration as to underlying bone fragility was raised by the clinicians
 - c) The potential for BB to have caused the humeral fracture was raised by the mother but discounted by the clinicians
 - d) The mother also raised the issue of AA moving in the night on 1 February 2021
 - e) It was plainly concerning to the clinicians that they were faced by three perceived fractures (skull / clavicle / humerus)
 - f) In general terms the parents' presentation was appropriate and the mother in particular was asking the right questions and searching for an explanation for what may have caused the injuries.

30. On 4 February 2021 an emergency protection order was made with respect to both children. Care proceedings followed and on discharge from hospital AA was placed with BB into the care of the maternal aunt and uncle pursuant to an interim care order and a clear working agreement.
31. I can see no benefit to setting out a full history of the proceedings. The children have remained with the family under an ICO and there have been generous contact arrangements permitting the parents daily contact. Appropriate experts have been instructed as can be seen within this judgment. Initially case managed by District Judge Hussein I have had care of the case since April 2021. A 10-day fact finding hearing was fixed at the earliest opportunity and despite some challenges along the way, with the hard work of the professionals/parties that fixture has been maintained. Fuller detail as to the proceedings can be found in section B of the bundle.

The Evidence

A. The Medical Evidence

The Skull 'Fracture' (Accessory Suture)

32. I will not detail the evidence with respect to the skull 'fracture' given the concession of the Applicant and the brief observations made earlier in this judgment.

The Clavicular Fracture

33. There is no argument as to the presence of a clavicular fracture³³ or as to the time frame for the same. Dr Olsen is best placed to advise as to likely timing and in his report dates the injury to between birth and 20 January 2021³⁴. In the light of evidence from Mr Brockelsby, Dr Olsen explained why his dating commenced at birth but told me that were it possible for the injury to have arisen in utero then the radiographic evidence would not challenge dating back to anything up to possibly 2 weeks prior to birth.
34. Dr Olsen deferred to others as to the likely forces required to cause such a fracture but noted (a) that the forces required would be in excess of those expected out of normal handling, and; (b) that the three typical mechanisms for such fractures are:
- i) Forceful, abrupt pulling of the arm on the same side as the fracture
 - ii) Sustained forceful loading (mechanism seen in birth related fractures)
 - iii) A direct forceful blow to the region of the collarbone/shoulder (with area hitting a non-giving object or being hit by some object).

As to dating the expert agreed that timing was in no way skewed towards either end of the window of opportunity and that each day within the window was equally plausible on the radiographic evidence alone.

35. Mr Brockelsby gave specific evidence as to the likelihood of the clavicular fracture arising from the birthing process. In this case a significant part of the birthing process had been filmed and the expert was clear that the procedure had been atraumatic (medically speaking)

³³ E114 Fig. 2

³⁴ E104 §7.7.2

and that he could see nothing on the video which would explain the fracture. He noted the physical contact was with the child's right arm area. He was also clear that the procedure within the womb cavity, which could not be seen on video, would not have included any likely manoeuvre that may have brought the clinician into contact with the injured area. He could see nothing to suggest the birth had caused the injury.

36. However, Mr Brockelsby went beyond this evidence in some important regards. He provided an article as part of his report³⁵ and was questioned as to the contents of the report. I summarise his evidence as follows. First, collar bone fractures are relatively common in the birthing process (Dr Olsen commented that clavicular fracture is not an uncommon birth related fracture³⁶ and Dr Cartlidge commented that clavicular fracture is the most common birth-related fracture³⁷). I appreciate this is 'common' in a clinical context with the incident rate being 0.4-2% (between 4-20/1000). Further he told me that such incidence skewed towards vaginal delivery due to the obvious pressures arising on the shoulder area through natural childbirth. As such c-section delivery was considered a protective factor in this regard. However, whilst it significantly reduced the likelihood of an identified fracture it did not fully remove the risk. Additionally in respect of those c-section clavicular fractures there was a lack of information as to cause and whilst the most likely cause would be birth-process related the expert considered there remained a group of cases in which no explanation could be identified and the potential for in utero injury could not be ruled out. The science simply could not explain the mechanism at play. He further accepted that given the nature of the fracture it would be the case that many would come to be undiagnosed and escape any data collection. Dr Cartlidge agreed as to the potential for this fracture to be

³⁵ *Neonatal Clavicle Fracture in Caesarean Delivery: Incidence and Risk Factors: E199*

³⁶ E106

³⁷ E139 §4.5.2

overlooked entirely, only being noted when separate investigations were later undertaken (as in this case)³⁸.

37. When giving his evidence Mr Brockelsby told me as to how on occasion, he had tried to break a clavicle to assist a traumatic birth but had been unable to do so due to the forces required and the room for manoeuvre. He commented as to his experience and limited experience of a birth related clavicular fracture. But this needs to be set against his clear evidence as to the incidence of the same in general and his wider evidence as noted above.
38. An important feature of the dating was to always exclude the grandmother from responsibility for the clavicular fracture. This meant that were I to find two inflicted fractures then I would need to find two separate perpetrators if the grandmother were to remain in the pool of perpetrators. All parties agreed this was an inherently implausible state of affairs.

The Humerus Fracture

39. As regards dating Dr Olsen was clear this was likely occasioned at any point between about 7-10 days prior to the first x-ray and up to the point of the x-ray. This suggested a 'window' of between 24 January – 2 February 2021. It was clear the two fracture periods did not overlap. The fracture was spiral in nature and this indicates there must have been some twisting element to the force which occasioned the fracture. The simplest explanation is of the lower arm acting as a lever with the shoulder accommodating the motion until it no longer can, at which point the torque travels through the upper arm causing the fracture. As to forces required, he considered that such fractures do not require immense force, but they do require forces not found in normal handling.
40. Dr Cartlidge accepted Dr Olsen's evidence. He commented that the clinical features of the fracture would have presented as a very painful

³⁸ E135

event for the child which would probably have persisted for about 10 minutes. There would then have been reduced movement of the injured limb with associated discomfort and distress each time the shoulder was substantially moved. In evidence Dr Cartlidge told me that the nature of the fracture (undisplaced) was such that AA would have been able to settle during periods when the site was not manipulated/moved and that to the objective bystander at these points nothing would be amiss. The signs would arise at the point of fracture and then during periods of manipulation/movement of the injured site.

41. In the course of evidence, the experts were asked to consider the potential for a rolling mechanism to have occasioned the fracture. This largely flowed from the mother's account of the night of 31 January/1 February and finding AA turned over. I should make clear that by the conclusion of the evidence all parties accepted this event fell outside of the likely time frame for the injury (see further below). However, the evidence was of interest. The experts accepted the potential for a roll to cause a fracture in an infant in circumstances where the relevant arm was trapped, and the manoeuvre mimicked the twisting motion noted above. However, Dr Cartlidge doubted a 1-month old child could roll and perhaps most importantly Dr Olsen made clear that the roll in question would not be a gentle and slow process but would require a more abrupt 'flipping' type turn over. He could not agree that the video of AA rolling shown to the Court was demonstrative of the type of rolling that might explain a fracture.
42. Discussion was also had as to the potential for a third party (child or adult) to intervene and assist the roll thus causing the fracture. For my part I did not understand this to really be a rolling-based explanation. In reality in such cases it is difficult to extract from the process the forces applied by the third party to the child and whether these forces could be causative of fracture irrespective of whether there was an associated roll (or perhaps forced roll).

43. Dr Cartlidge was interested to understand whether it was being suggested the mug incident was possibly associated with the fracture. In his report he had discounted the likelihood of BB having caused the fracture. It was clear he did not rule out the potential in this regard and was open to the possibility for a sibling interaction to be linked to a fracture. He was asked to consider the adult response were I to find that the mug incident was linked to the fracture. His answer I consider important. He told me that were the fracture to have occurred at this time and had not been witnessed, and had this been followed by the child being unsettled with the problem only being fully noted the next morning then were this to have been the history presented to him as the treating clinician he would not have found this troubling. This followed from earlier evidence when he was troubled by the notion of the fracture being caused by the 'rolling incident' on the night of 31 January 2021. As he commented this would be a period of 30 hours or so without the cause being found, whereas a period of a few hours could be understood.
44. Dr Cartlidge also considered the photograph of AA in his recliner chair. He observed that if this was not a posed picture then it was inconsistent with being taken at a time when the child had suffered the fracture. This was because it was unlikely the child would raise his arm in the manner seen in the picture if he had a fractured humerus. Dr Cartlidge also commented that the evidence of the grandmother as to AA responding with pain when touched on the morning of 2 February 2021 indicated the fracture had been inflicted by that point. The impact of this evidence (accepted by all) was that the window in which the fracture was likely experienced was between 1235 hours on 1 February 2021 and a point shortly after 0800hours on 2 February 2021.

Osteogenesis Imperfecta (OI)

45. Dr Cartlidge properly considered and excluded a range of organic explanations for the fracture(s). He was though troubled as to whether the fullest enquiries should be made in respect of OI. He remained of this view at the end of his evidence and was an advocate for OI testing.

It was Dr Cartlidge's appropriate professional caution which led to the instruction of Dr Irving. In summary she was not of the view that the clinical features identified suggested OI. Further she did not support testing for OI in the absence of good clinical grounds. She explained that the test results would be unlikely to produce a binary yes or no answer and would likely leave us in a continuing unclear position.

46. This issue caused significant pause for reflection and at the outset of the case I indicated I would keep the matter under review through to this judgment. It is right to note that no party now suggests I should delay the proceedings to obtain test results. For reasons given below I see no need to obtain test results before resolving this case. Whether the parents wish to pursue this avenue will be a matter for them. But I appreciate obtaining detailed genetic information about any individual requires significant pause for thought before it is pursued.
47. I do though wish to make it clear that this feature of the case illustrates the high level of professional skill and care that has been provided in this case. All of my experts gave clear and lucid evidence. They were focused in their evidence and were plainly doing their best to help the Court come to the right decision. None of the witnesses were dogmatic in their approach or defensive of their professional position. They properly understood the boundaries of their expertise and deferred where appropriate. Where they disagreed, they did so for good reason and explained the logic of their position. I am grateful for their assistance. **I require the local authority to provide an anonymised copy of this judgment to each of the experts on the basis that the same will be kept confidential and not used as a teaching tool.** Experts in general and these experts in particular are entitled to see how the Court works through its investigative process and should be informed as to the gratitude the Court has for their assistance they offer in this regard.

B. The Non-Medical Evidence

48. I heard from the parents and the grandmother. I have read their statements and the interviews with them conducted by the Metropolitan Police Service.
49. I do not intend to summarise the background history they gave me. I have referred in passing to much of it above. I should note the evidence of the grandmother's experience in family life and with children. The impression given was of a matriarchal figure who is self-sacrificing and wholly dedicated to her family. She enjoys a strong relationship with her daughter and despite language issues has formed a good relationship with her son-in-law.
50. I will focus on the key evidence of the parents and with a particular focus on the period between 31 January 2021 and admission to hospital on 2 February 2021.
51. I heard the evidence of the parents as to the events of the night of 31 January 2021 and with particular regard to AA rolling. I have to say I am not assisted by this evidence and make no findings as to whether in fact AA could or could not roll. The 'roll' was not witnessed and in any event, it is agreed could not explain the fracture. In this regard I accept the evidence of Dr Olsen as to the need for a more developed process than a gentle motion. In making these observations I have drawn no adverse conclusion against the parents who stand by their evidence of seeing AA roll subsequent to this date. They point to raising this at hospital and are entitled to point to the video which at least suggests AA was rolling at an early age. They may be correct, and AA may be a child who falls outside of Dr Cartlidge's considerable experience. Alternatively, there may be factors at play such as the angle of the surface on which AA has 'rolled' which may explain the disagreement.
52. I also heard evidence from the parents as to their mindset at this point in time. Quite understandably the applicant suggested there must have been significant stresses in play in the light of the mother's poor health on her return home. The applicant hinted at the potential for this to be a

relevant feature which may explain out of character parental misconduct. Viewed objectively the mother was still very unwell and needing oxygen almost constantly. On top of this the parents now had two young children and the father was about to return to work. One can readily see how pressure might arise. However, the parents scotched this suggestion. From their perspective the opposite was true. They had been deeply worried when the mother was in hospital as to what might happen to her but now, she was out and, on the mend, (albeit gradually). Further, she was stressed when in hospital to be away from her family and new baby and she now had the chance to mother him. Finally, they had support to hand which was not only available but willing to help.

53. In the context of this case and on the evidence, little needs to be said as to the period through to 12 noon on 1 February 2021. There was little examination of the parents relating to the clavicular fracture save that each denied occasioning the same or being aware of its presence. It seems clear the mother considered her c-section a more traumatic experience that was warranted on a medical view, but this is it seems to me entirely understandable. I did hear about the constraint the need for oxygen placed on the mother and she does appear to have been largely sedentary when at home (if not travelling between floors or visiting the toilet) and did not leave the home. I was shown both a plan and some marketing shots of the home to gain a better insight into the property and its layout.
54. As to the photograph of AA in his recliner it was confirmed this was not a posed shot and this was not challenged. It seems to me on the evidence that were the shot posed then this would in any event have likely caused pain to AA and there is no sign of the same in the photograph. I agree that this indicates the earliest point at which the fracture might have occurred.
55. I turn next to the 'mug incident'. At about 1700hours on 1 February 2021 the grandmother was on the ground floor of the property. Present were AA in his Moses basket and BB (who I understand was playing with toys).

The mother had been present but was visiting the toilet. The plan shows this to be on the first floor. The ground floor is an open plan area with a kitchen at one end and living room/seating at the other with a staircase towards the middle of the living room. The evidence suggests the journey to the bathroom might take 10 minutes due to the mother's condition. The Moses basket would appear to have been against the wall in the living space and close to where the mother had been sitting.

56. The grandmother reports taking a plate from a cupboard and inadvertently causing a mug to fall to the floor and break. BB came towards her, but she told him to stay in the living space due to the broken mug pieces on the floor. She then proceeded to pick up the pieces before hoovering to clear away any shards or smaller debris. Whilst hoovering she heard AA crying loudly and stopped. She ran over to the basket and BB was next to it saying "baby, baby, baby". She picked AA up and soothed him for '6-7 minutes' before he fell to sleep. The grandmother didn't know what had caused him to cry and, in her statement, queried whether it was the mug breaking or the hoovering or something else.
57. In her evidence I asked her about the process she followed. She told me she picked up the pieces first before hoovering. She told me if she had heard the cry when she was doing this then she would have immediately stopped to check on AA. She then took the hoover which was to hand and proceeded to clear the floor. She told me she did not finish, and it was not on finishing that she heard the crying. Rather it was whilst hoovering that she heard the noise and stopped as a result. I didn't understand anyone to question the truthfulness of this account.
58. Neither the mother nor father were present. Initially the evidence suggested that AA was in the recliner seat noted above. However, during the evidence this was clarified as being incorrect. In considering this change in evidence I bear in mind that the grandmother in her first

account to the police³⁹ described this event and referred to AA being in his 'basket'. At no point has she suggested he was in the seat.

59. I move onto later that night and the evidence of the grandmother surrounding putting AA to bed. The applicant points to the following line in her written evidence as being important:

When I put him down to sleep the night before he did not wake up or respond in the way that he did that morning (i.e. 2 February 2021)

I understand the applicant to suggest this comparative evidence points against AA having a fracture at this point. Indeed, the applicant consequently restricts the window of opportunity to between this point and 0800hours the next morning. The applicant also seeks to point to a change in presentation on the part of AA after this point as being probative. I do though note the grandmother only went downstairs to offer help because AA was crying on and off and she wondered why this was the case. She also noted him being a little unsettled after dinner that evening. The picture is therefore not entirely clear in this regard.

60. As to the overnight period the parents gave cumulative evidence as follows. AA was on the mother's side of the bed as it was going to be her first night to care for him. It is clear he was unsettled overnight although the parents offer a different description of the level of disquiet. Certainly, the father comments in stronger terms and at one point in police interview spoke of AA 'screaming'. The mother agrees he was unsettled but characterises the crying at a lower level. They each explain this discrepancy by reason of their different reference points. The father had been caring for AA throughout and this was a more unsettled period whereas the mother had less experience of AA and compared to BB the baby was a calmer and quieter child. But the mother accepts AA was unsettled overnight. The father was questioned but could provide only a vague account of the night. The mother gave more detail but also gave a more general than detailed account. The substance of her case was

³⁹ 12 February 2021: I47

that nothing remarkable happened save that AA was unsettled, which she put down to trapped wind or reflux. She accepted she would have moved AA during the night and likely changed him up to two times but there was no problem in being able to move or change him.

61. There was some discussion as to the bedding/clothing AA wore at night. Ultimately the parental evidence was that he probably was in a sleepsuit of some type on a sheeted mattress. He did not have an oversheet and they did not think they were using a baby-duvet at that time. Whilst the grandmother said she had moved AA's bedding when placing him in bed, when examined she could not explain this as there had been no bedding to move.
62. The parents are in agreement as to the father taking AA down the next morning. On their evidence neither saw or heard or did anything that night which would fit the required mechanism for a fractured humerus.
63. The grandmother then cared for AA and came to discover AA was in pain linked to his left arm area. She explained how she worked this out. No party challenged her evidence. I have set out above the process under which AA then came to travel to hospital.
64. There was examination as to whether the father demonstrated some level of indifference to the developing issue. He was asked why he had not interrupted his work when the suggestion (made by the grandmother of a possible break or dislocation (popping out)) was raised. The parents were questioned as to the content of some limited whatsapp messaging between themselves during this period and whether this undermined their account of events. They were questioned as to why it took the grandmother to identify what was wrong and why more urgent medical care was not sought. They were asked why AA was not taken by the mother to the 'same day care unit' when she went there at about 1300hours. In short, they were questioned as to their response to the developing picture and what this might suggest about their state of

knowledge and motivations. I will deal with all these points in my analysis below.

65. This is perhaps a slightly unusual case in which there was no material questioning as to the events which took place after admission. Often parental responses are said to have relevance when considering causation. In this case whilst it is clear the father was somewhat unhappy with what was taking place, the overarching picture is of co-operative parents who were expressing appropriate concern as to the unfolding story.

Submissions

66. In closing the applicant asked me to find that both parents were in a pool of perpetrators responsible for inflicting both the clavicular and humerus fractures. Further they argued that there had been a failure to protect. They argued the medical evidence was clear and that the probabilities associated with the alternative basis for the clavicle fracture ruled out any conclusion to such effect on the balance of probabilities. As to the humerus they argued the window of opportunity was simply the night of 1/2 February 2021; that AA was in the care of the parents; that something which has not been revealed must have happened during this period, and that absent admission one cannot determine who of the parents was responsible for the same. They reject the 'mug' incident as it was an 'unwitnessed event' and in any event the child's presentation thereafter rules out having suffered a fracture.
67. The parents take a common position. The evidence of Mr Brockelsby as to pre-birth or birth related clavicular fractures creates sufficient doubt as to mean the applicant has not met the test required. As to the humerus fracture the mug event is an explanatory event which equally means the burden has not been met. In considering this the wide canvas is strongly supportive of the parents' case and when weighed in the balance supports the conclusions advanced on their behalf.

68. The guardian agrees with the parents with respect to the clavicular fracture and agrees the burden has not been met in that regard. The picture with respect to the humerus fracture is more complex and whilst the guardian does not seek to argue for an outcome, I was taken to factors which I might consider relevant when reaching my own conclusions. These factors were balanced in both directions.
69. The grandmother did not have a case to meet but was supportive of the parents' case.

Discussion

70. I am asked to form the view of the parents as being unreliable witnesses. Both are described by the applicant as having given evidence in a manner which justifies criticism. At one point the mother's account of the night of 1 February 2021 was described as 'incredible'. I have to say I struggle with this characterisation of the parent's evidence. It is fair to say that I had the benefit of seeing them in person and from only feet away with non-related counsel appearing remotely. Yet I formed a very different impression. Insofar as their evidence was concerned it seemed to me, they gave evidence which was internally consistent and consistent over time. Their evidence did not appear exaggerated and was not given in a manner that suggested evasion. At no point were they tripped up or caught in a lie. Other than the recliner seat clarification I am not sure either at any point sought to modify their account. True they differed to some extent in their evidence, but this was on subjective matters (the description of a cry) rather than objective points. They were open and direct in their answers and a measure of this is in the relatively short time taken with both.
71. I would particularly wish to comment on the suggestion that there was a concerning lack of detail with respect to the night of 1 February 2021. The applicant says this is significant and I understand this is to suggest that this reflects something perhaps being hidden or disguised. Of course, a Court will always be alert to the apparent gap in account when

one is to be expected or the witness who develops an inexplicable mind block in just the area of examination where assistance is required. The Court can and often does draw inferences in such cases. But this is markedly different from the case of a father being unable to give a detailed account of the night events on the first night he has not had overnight care for his new baby. Any realistic assessment must allow for such recollection to be shaped and limited by the impact of sleep on memory. Everyone has their own experience of an interrupted sleep and how in the morning the detail may be difficult to recall. To utilise this natural state of affairs as a basis on which to build a case against the father seems to me to be unrealistic in the extreme. I accept the mother would likely have a better account as she was awoken to care from time to time. But I did not find her evidence lacking, rather it was lacking in detail because on her account there was really nothing of note other than an unsettled child and routine care.

72. I have cautioned myself against placing too much weight on demeanour. However, in this case there really wasn't anything in the demeanour of either parent that might suggest anything untoward. For what it is worth I sensed in the mother real distress underlying her evidence. In the father I sensed real frustration and a degree of controlled anger. But these are not surprising emotions if, as they say, they have done nothing wrong. They are certainly not mannerisms which are probative of guilt or culpability.
73. Having said all of this it is the actual evidence, and all the evidence, that should guide me to an appropriate conclusion. It is to this which I now turn.
74. It is logical to start with the humerus fracture as this is where the evidence was focused. By its nature a judgment must be linear in character, but I want to make it clear I have reviewed all the matters in the round and considered how they interact before setting out this analysis.

75. In my assessment it is clear there are two explanatory approaches to this injury. On one side I have the mug incident and on the other the applicant's case of the hidden event during the night. Given the limited time frame and the evidence received it is difficult to identify any other potential cause.
76. For the avoidance of doubt the mug incident is an explanation put forward by the parents (although they put it forward with reluctance it seems to me because they perceive it places blame on BB ~ for my part this is not how I approach the incident) and as such it falls on the applicant to deal with it. It is clearly signposted within the applicant's schedule of findings⁴⁰ as a matter for consideration and Dr Cartlidge considers it within his report.
77. I have considered this evidence with care. I accept the grandmother's account of the event in its entirety. It was a simple event and there is no reason to doubt her account. The key points I note are the following:
- i) It is within the timeframe for the fracture
 - ii) The grandmother clearly described a noteworthy cry. On the evidence I have heard this was in fact the only noteworthy cry (albeit the child cried differently when his arm was touched). It was loud enough to be heard over the hoover and insistent enough to cause her to stop immediately and in her words 'run' over to the child.
 - iii) I am in no doubt it is not explained by the mug breaking. On examination there was obviously too much time between the two for this to be a delayed response.
 - iv) It is clear BB was in close proximity to AA and was showing interest in his brother.

⁴⁰ Ibid §8(7) above

- v) Other evidence shows he was tall enough at the time to be able to look and likely reach into the basket. Contemporary evidence shows he was 3 feet tall whereas the midpoint of the basket was likely under 2 feet high.
 - vi) Whilst this is characterised as an unwitnessed event, I am not sure this is accurate. True nothing was seen to happen to AA, but the circumstances were witnessed, first in an auditory way and then visually. If the point is that the grandmother did not see the child touched, then this is of course true.
 - vii) I am not particularly impressed by questioning as to the ability for BB to have rolled or assisted AA to roll. I consider rolling is not a necessary feature of this injury. In principle BB could occasion the injury by the abrupt pull described by Dr Olsen. A roll is an explanation (in certain circumstances) but not the only explanation. The fact that the grandmother seemed to doubt AA had turned over in any way is neither here nor there.
 - viii) It is important to note this account was not given after the receipt of expert evidence. It was given at a very early stage and has remained consistent throughout.
78. But what of the evidence as to a lack of expressed discomfort or pain that evening showing there was no fracture? I accept one does not have anything akin to the response to the grandmother the next morning but equally there is no evidence that anything was done to obtain such a response. The grandmother received her response on a body examination not on general holding. And this is where I struggle with the applicant's argument in this regard. I note the following:
- i) Factually if one is looking for evidence of disquiet it is there to be found. The grandmother comments as to wondering why the child was crying prior to putting him to bed. She is sufficiently interested to go downstairs to assist the father. For my part I struggle to understand why the applicant does not recognise this evidence.

- ii) Secondly, I consider the sentence extracted from the grandmother's statement does not say exactly what it is taken to say. The applicant suggests the sentence clearly rules out a fracture at that point in time as the grandmother contrasts AA's presentation with the later presentation the next morning. But on my reading, she is simply stating he was settled when put to bed and no more and the evidence tells me this was entirely possible, indeed likely.
- iii) Thirdly, and following on from this Dr Cartlidge supports the point just made of an injured child being settled and in no obvious pain. I fear the applicant has fallen into error in interpreting the evidence of 'movement' (of the injured) site to include any movement of the child (and thus of the injured site as part of the greater body). This is not what can be inferred from the evidence of the expert when he talked about himself not being troubled if he had come to be presented with this account ~ unless of course it is assumed Dr Cartlidge was saying only if I had been told the child had not been moved at all during this period. This is plainly not what he meant. So, I accept that movement per se of the child might be undertaken without the response seen the next day.

79. But should I not rule it out because Dr Cartlidge has considered and discounted it as a possibility in his report⁴¹? Whilst this does not answer the substantive point, I do not consider this to be the case. I say this because Dr Cartlidge worked on the premise that no carer had heard AA suddenly cry. But as noted above by the end of the evidence this was not the case. Indeed (and Dr Cartlidge cannot be criticised in the regard given the evidence was received after his own evidence) it became apparent that the actual word used by the grandmother in her statement in her own language for the relevant cry was 'violent' (but in any event translated as 'severe'). Interestingly Dr Cartlidge at his bullet point 4 confirms my view at 78(iii) above. One is then left with the speculation of

⁴¹ E140

how BB might have come into contact with AA which in any event simply does not fit with the suggestion in this case. Again I should say this reflects the manner in which the evidence came to be understood as Dr Cartlidge gave evidence at a point where it was felt AA was in the recliner rather than the basket and so the logical form of contact would have been a downwards force. Notwithstanding all of this I sensed Dr Cartlidge had some reservations about unequivocally ruling out BB as cause of the injury ~ see his enquiry as to whether he could help with this issue.

80. What about the parental messaging? Is there something in this to raise concern and to question their account of the evening. I do not consider this to be the case. I am very wary as to over interpreting messaging of this nature. Judges have become very accustomed to being asked to consider shorthand messaging as probative evidence and often it will shed real light on the issues in the case. But one must not lose sight of the fact that this is instant conversation and often in an abbreviated form. Consequently, as here the father may be unfairly criticised for an unsympathetic response to the mother where in fact this simply reflects a short opportunity to respond and the knowledge that he can respond in greater detail later. Elsewhere it is suggested I might glean insight from the mother describing AA as being 'difficult' the night before. I think it is suggested this is an odd turn of phrase to describe a baby ~ how can he be difficult? Yet in my experience this is the sort of language that parents deploy without any intention to suggest blame. A child is not eating their food and is described as being 'difficult'. But I really can't use points such as this to leap to the conclusion that this parent inflicted a fracture on their child. This is again shorthand language thrown into conversations without forensic consideration. It can inform but is often of no real assistance.
81. Turning to the perceived delay in seeking medical care. I have considered this and note the suggestion that based on the grandmother's suggestion (arm may be broken or popped out) one might

have expected a more urgent response. But this only goes so far. On the evidence the grandmother was far more hesitant as to what had happened. Second, in these Covid times the process of obtaining medical care was perhaps viewed slightly differently. Third, on the evidence AA did settle and seemed not to be in pain. Fourth, on any case the parents did seek and pursue medical care. The issue is why they delayed by no more than about 4 hours or so. That being the case I wonder what probative light this limited delay could reasonably shed. I gain no assistance from the fact the mother did not take AA to her appointment. By this time the family had decided to pursue the GP route. I consider that was a reasonable response and within reasonable bounds of response whether or not all parents would have acted equivalently.

82. I turn to the events of the night. I have commented generally on the parents' evidence in this regard, but I wish to pause to consider the likely reality if the applicant is correct in this regard. On the evidence one would need an event involving the twisting motion described by Dr Olsen. One would secondly, expect the sharp response from the child and a sustained period of crying. In context I struggle to see how such an event could have occurred during the night without both parents becoming aware of the same. This is not to say both would have known the event which caused the cry (e.g. the father could have been awoken by a cry), but both would have experienced the fallout from the same. I consider it is therefore realistic to conclude that were this to be the case then both parents should be able to give some account of a particular period during the night in which the child was deeply affected. Yet this is not the case. Whilst the father talks of AA 'screaming' this is not a scream but generalised behaviour. It is a description of the crying. It does therefore seem to me that if the applicant is correct the following are likely to hold:
- i) One of the parents is aware they were at best heavy handed with the child

ii) The other parent is aware of this or at least aware of the fact there was an event during the night

iii) Both have chosen to downplay and/or cover this up

I will have to assess the likelihood of this.

Conclusions

83. Insofar as the clavicular fracture is concerned, I am not persuaded on balance that this was caused by either parent. There is a realistic likelihood that the same arose out of the birth process or pre-birth. In reaching this conclusion I have had regard to the evidence of Brockelsby/Cartlidge and Olsen. I accept that incidence of such fractures is in % terms low but this is not the point. I fear the applicant has confused itself between the chance of an event happening and the balance of probabilities. These are two different things. I have regard to the potential for something to happen but weigh this with the absence of any real evidence to support culpability on the part of either parent; the wide canvas which points against such conduct; the timelines which in the case of the mother would limit her to a matter of days and require her to have injured her child as alleged after just being discharged from hospital in poor health; the unlikelihood of mixed perpetrators (on the facts and given their roles and health one might consider the father to have greatest opportunity re the clavicular fracture and the mother greater re the humerus), and; my assessment re the humerus. The local authority has not persuaded me that either of these parents caused the fracture. The medical evidence does not justify a finding that it is likely they did.

84. I have reached a similar view on the humerus but in that case on the basis of more detailed evidence. In short, I am satisfied the mug incident provides a plausible explanation for the injury. All the surrounding circumstances bar one fit with this conclusion. The only gap is that BB was not seen to interfere with AA. I do not consider this to be an

insurmountable obstacle though, and particularly where the alternative theory of causation is itself surrounded by real question marks. As was pointed out both 'theories' require the Court to trade in inferences as to what took place. It is clear to me that BB had the opportunity to pull at AA; was proximate to him when the 'violent' cry was heard and had the capacity to do that which Dr Olsen said was required. The forces required are not immense. What one needs is an abrupt motion. It seems to me this is a plausible account of how a child might engage with a sibling without any intention to harm. I recognise that I cannot go beyond this. But this is not in my judgment a case with a strong pull towards the theory of an overnight infliction. There is evidence of AA being unsettled before being put down; I bear in mind the wide canvas; there is no obvious basis for understanding a loss of control or care by either parent (and one would have thought most likely the mother giving the sleeping arrangements); there is no obvious reason for a cover up as the impact on the child was not appreciated; there is no obvious reason for the father to go along with this even were this the case. If this did happen then it is far more plausible that one or other parent would have explained it in the context of a night-time error of handling. I note the grandparents did not hear a cry during the night although I accept this would not have been a necessary requirement. Thereafter the parents have acted exactly as one might expect parents to act who have no comprehension of anything being wrong with their child.

85. I should say I would have struggled in any event with the notion of failure to protect on the facts of the case absent established collusion. The evidence made clear that the clavicle fracture need not have been noted. If the humerus was inflicted by parent A whilst B was asleep then it is not entirely clear the existing state of knowledge which would have justified a failure to protect. Given both were agreed on seeking medical treatment within 12 hours I simply do not understand how this could have been established (short of active collusion). So, I have reached the conclusion that the findings have not been established and, on that basis, there is no justification for this applicant seeking to intervene in

the life of this family. Absent further application these proceedings will come to an end. I have already arranged to hand this matter down at 9am on Wednesday 22 September 2021. Can I have any corrections/requests for clarification by close on Monday. This judgment can be shared with professional and lay clients.

86. It is of course a matter of regret that this family has been separated during the course of the proceedings. But this is a view which has the benefit of hindsight. I have read the interim report of the ISW and can see the parents have tempered their frustration with an understanding of the objective need for safeguarding. I give them credit for that acceptance. It is a reality of this case that family life has been maintained at a quite unusually high level. I am sure that this feature taken with the parental commitment to their children will make the transition a success. I am sure the parents share my gratitude to the aunt/uncle in stepping in to allow these children to maintain family life. I do therefore wish the children and the family the best for the future. I trust in time they will find a way to put this experience behind them.

His Honour Judge Willans

ANNEX A: DOCUMENT RECEIVED

1. Statement of Maternal Grandfather: 8 September 2021
2. Extract from article headed "*Abusive Spiral Fractures of the Humerus: A Videotaped Exception*" (provided by Dr Cartlidge)
3. Letter of Instruction for Dr Brocklesby
4. Video of AA rolling
5. Meta data of (4) above
6. Meta data of photograph at page C71 of bundle
7. Photos of Moses Basket
8. Video documenting 'whatsapp' messaging between the parents on 2 February 2021
9. 2 x video clips of birth of AA