This judgment was given in private. The judge gives permission for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of this judgment the anonymity of the children and members of their family must be strictly preserved. If the judgment is to be reported or published, there is a requirement to ensure that no reporting restriction will be breached. This is particularly important in relation to any case involving a sexual offence, where the victim is guaranteed lifetime anonymity (Sexual Offences (Amendment) Act 1992), or where an order has been made in relation to a young person. All persons, including representatives of the media and legal bloggers must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Neutral citation: [2024] EWFC 238 (B)
Case No: CF23C50163

IN THE FAMILY COURT AT NEWPORT (SOUTH WALES)

Newport (South Wales) County Court and Family Court
5th Floor
Clarence House
Clarence Place
Newport
NP19 7AA

Date: 05/03/2024

BEFORE:

HIS HONOUR JUDGE JONATHAN HOLMES

BETWEEN:

A LOCAL AUTHORITY	**APPLICANT**
- and -	
M	**(1) RESPONDENT**
F	**(2) RESPONDENT**
THE CHILD (VIA THEIR GUARDIAN)	**(3-4) RESPONDENTS**

Legal Representation

Matthew Rees and Hayley Daniel on behalf of the Applicant Local Authority
Dorien Day and Grant Keyes on behalf of the First Respondent
Paul Storey KC and Alexa Storey-Rae on behalf of the Second Respondent
Harriet Edmondson and **Sophie Keegan** on behalf of the Third Respondent Child

Judgment

Before HHJ J Holmes:

Introduction

1. This matter was originally listed for a composite final hearing. It was listed for 11 days on 2nd February 2024 (due to the availability of two experts) and 12th - 23rd February 2024. Various issues, that I do not need to go into for the purposes of this judgment, arose on 12th February 2024 which resulted in a number of court days being lost. As a result a decision was made that the hearing would only proceed as a finding of fact hearing. Evidence and submissions concluded on 23rd February 2024.

2. The Child (hereinafter referred to as A) is the first child of the mother (M) and the father (F). F has two other children from a previous relationship with whom he has no contact.

3. For the purposes of this hearing I had a main bundle and four supplemental bundles amounting to nearly 4,000 pages. Further documents were produced during the course of the hearing.

4. I heard oral evidence from:

    i. Dr Oystein Olsen, Paediatric Radiologist;
    ii. Dr Anand Saggar, Consultant in Clinical Genetics;
    iii. Dr Shade Alu, Consultant Paediatrician;
    iv. Health Visitor;
    v. Social Worker;
    vi. Foster Carer;
    vii. General Practitioner;
    viii. Mother;
    ix. Father.

5. I have considered the evidence contained within the bundles together with my written notes of evidence in preparing this judgment. I do not intend on rehearsing the entirety of the evidence that I have read or heard.

Precipitating Event

6. On 18th April 2023 at approximately 9:15, M & F were visited at home by a health visitor for A's pre-arranged six-month review. M was not seen during this visit as F said she was in bed due to a disturbed night sleep from abdominal pain and anxiety. F said that he was concerned regarding M's mental health and requested a referral to other services. F was observed to be handling A appropriately and the review indicated that she was thriving in the care of her parents and was reaching her developmental milestones.

7. During the course of the review the health visitor observed, what is described in her statement, as a dark red mark to the inner left earlobe. F said that A had fallen from a sitting position on the floor approximately three days ago and had landed on a plug. F said that he had not sought any medical advice as he had an ambulance background and was monitoring

for any deterioration. F was informed that any injury to a non-mobile baby was of concern and that it was protocol to refer the matter to social services.

8. Following the visit, the health visitor made a referral which initiated a strategy discussion and joint section 47 investigation with the police.

9. Following the visit F took A to the GP. She was seen by the GP at 14:15 on 18th April 2023. F described how A had fallen onto a plug. F told the doctor that he had an ambulance background and he had personally assessed A and was not concerned. The GP examined A and noted that she appeared well-groomed and appropriately dressed. She conducted a full examination which raised no concerns. She noted a bruise measuring 0.5 cm on the concha of the left ear. She felt the injury was consistent with the explanation given by F at the time.

10. The social worker and DC attended the home that afternoon and spoke to M and F. The initial social work statement says that both M and F gave an explanation that A had toppled onto a plug a few days previously. There were concerns about the location of the mark and the explanation given so arrangements were made for A to be examined at hospital. The social worker transported F and A to hospital with M remaining at home.

11. A Child Protection Medical took place on 18th April 2023 between 18:34 and 19:35. During this, F said about three days ago A had been sat on the floor when she fell and hit the side of her head on an extension cord cylindrical tower which had a phone charger plugged in. F said that he had an ambulance background. He said he checked A over and she was fine but a couple of days later he noticed a bruise in the ear. F also said that M later told him she had been cleaning A's ears with cotton buds and that may have done it. He said that this happened on the same day as the fall onto the plug. The CPM noted:

    i. Red mark to the back of the head 3cm x 2cm;
    ii. Fairly well circumscribed bruise to concha of left ear 0.5cm x 0.5 cm of reddish colour;
    iii. Blanching vascular mark to lower back 0.8 cm x 0.2cm

12. On 19th April 2023 a skeletal survey was undertaken of A. The initial report stated:

    a. There is a healing bucket-handle fracture in the proximal metaphysis of the right humerus with periosteal reaction in the proximal diaphysis;
    b. There is a metaphyseal fracture in the lateral cortex of proximal metaphysis of the left humerus with no evidence of periosteal reaction/healing.
    c. No other fractures are demonstrated.
    d. Bone density is within normal limits.
    e. No evidence of metabolic bone disease.

13. The survey was 2nd reported which agreed with the initial report in respect of the metaphyseal fractures to the left and right humerus but also raised concerns about the appearance of the left lateral seventh and eight ribs. The report said that healing rib fractures could not be excluded.

14. There was a follow up skeletal survey on 4th May 2023 which concluded that:

    a. The previously demonstrated healing right proximal humeral metaphysis fracture shows further evidence of healing on today's study.

b. The left proximal metaphysis fracture is no longer visualised and radiologically healed completely.
c. There is no evidence of a rib fracture. The appearance of the lateral seventh and eighth ribs is unchanged and is in keeping with a normal variant for this patient.
d. No further fractures.

15. The child protection medical process concluded:

i. *Bruise in the left ear - Two possible explanations were given by [F] for the bruise in the left ear. Systematic review on bruises published by RCPCH states 'it is very unusual for pre-mobile babies to sustain bruises accidentally and bruising in this age group raises significant concerns about physical abuse' and that numerous studies have shown that bruises on soft parts of the body such as the ears are rarely seen in non-abused children.*
ii. *Skeletal survey has shown healing fractures in both humeri for which no explanation has been offered by the family. Systematic review on fractures by RCPCH states that humeri fractures in those aged less than 18 months have a stronger association with abuse than humeral fractures in older children and that metaphyseal fractures are more commonly described in physical child abuse than non-abuse.*

The injuries on [A] are highly likely due to non-accidental injury.

16. Both M and F were arrested on 20th April 2023 and held in custody overnight before being interviewed under caution on 21st April 2023. A was taken into local authority foster care with M and F having provided consent under section 76 SSWA 2014. Care proceedings were issued on 25th April 2023. A has remained in foster care throughout these proceedings.

17. The final threshold document only relates to the injuries that A sustained prior to 18th April 2023 and issues that arise therefrom. Mr Rees has clarified the findings sought in his closing submissions. The Local Authority seek findings that:

a. The bruise to the left ear was sustained during an event separate from those that caused the fractures to the upper arm bones.
b. Even accounting for the more than 50% risk that A has inherited HSD from M, there is no evidence of any underlying haematological, bone or metabolic disorder that have caused or contributed to the child's injuries.
c. The parents have failed to provide any or any adequate explanation for any of the injuries.
d. The injuries were inflicted by M and/or F either during a momentary loss of self-control or out of frustration and/or irritability arising from poor mental health.
e. There is a real possibility that both M and F caused the injuries and it is not possible on the balance of probabilities to identify a sole perpetrator. (Mr Rees in his closing submissions details various factors that could lead to the identification of a sole perpetrator but submits that the Court is in some difficulty in making such a finding.)
f. The fractures sustained by the child most likely resulted from excessive pulling and/or twisting and/or bending and/or shaking of each arm with a magnitude of force more than that encountered with normal handling by a reasonable carer.
g. The parent who did not inflict the injuries has failed to protect the child from suffering and the risk of suffering further significant physical and emotional harm by

a lack of candour with professionals as to the circumstances in which the injuries were sustained to the child.

h. M and/or F failed to seek any adequate medical attention for the child in the aftermath of her suffering the injuries when it would have been apparent that she was in pain and distress.

Relevant Law

Threshold

18. Section 31(2) Children Act 1989 ("CA 1989) states:

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

19. To establish whether the cause of the significant harm is attributable to a lack of reasonable care, the test is an objective test – as is the establishment of the reasonable standard itself. It is not necessary that there should be culpability on the part of the carer, who may be trying his hardest yet failing to achieve the required standard of care and thereby causing significant harm.

20. Whilst the objective nature of the test arises from the need to consider the position of a reasonable parent, the test also has a subjective element in that the standard of care required must relate to the particular child before the court.

21. The questions for the court are:

    a. what would a reasonable parent do for the child in question? and
    b. if this child has suffered, or is likely to suffer, significant harm, is that as a result of a failure on the part of the child's carer to do what a reasonable parent would do for him?

22. In terms of the relevant time at which the threshold criteria should be considered, the relevant time is the date of the care order application or, if temporary protective arrangements have been continually in place from an earlier date, the date when those arrangements were initiated **Re. M (A Minor) (Care Order Threshold Conditions)** [1994] 2 FLR 577.

23. However, the Local Authority does not have to be in possession of all the information it wishes to rely upon at the date of the application. Evidence gathering continues after proceedings have begun and later acquired information as to the state of affairs at the relevant date can be taken into account. **Re G (Care Proceedings: Threshold Conditions)** [2001] EWCA Civ 968.

Burden of Proof

24. The Local Authority makes the allegations and therefore the burden of proving those matters rests with the Local Authority.

25. The court must be careful not to reverse the burden of proof if an explanation or hypothesis is put forward by or on behalf of a parent which is not accepted by the court. The failure to do so does not establish the local authority case. There is no obligation on a parent to provide an explanation.

26. Findings of fact must be based on evidence and not on suspicion or speculation. The court acts on facts, and not on worries or concerns. It is however legitimate to rely on inferences which may properly be drawn from the evidence (**Re A (Fact Finding: Disputed findings)** [2011] 1 FLR 1817).

Standard of Proof

27. The standard to which the Local Authority must satisfy the court is the simple balance of probabilities. In other words, they must persuade the court that it is more likely than not that a relevant disputed event occurred. If so, then that event is deemed to have occurred. The converse is equally true: if I find that something is more likely *not* to have occurred than to have occurred, then it is deemed not to have occurred. In that sense the law operates a binary system such that essential facts are either proved or they are not. In this context, there is no room for a finding by the court that something *might* have happened. The court must decide either that it did or that it did not (***Re B (Children) (Care Proceedings: Standard of Proof)*** [2008] UKHL 35 at paragraphs 2 and 4).

The totality of the evidence

28. I must consider each piece of evidence and assess it in its wider context. Evidence cannot be evaluated and assessed in separate compartments. I must form an overview of all of the evidence in order to decide whether the case put forward by the Local Authority has been made out on the balance of probabilities (**Re T (Abuse: Standard of Proof)** [2004] EWCA Civ 558, [2004] 2 FLR 838 at paragraph 33).

29. In this case a large part of the evidence before the Court by way of statement or oral evidence is that of M and F. Their evidence is of the utmost importance and it is essential that the court forms a clear assessment of their credibility and reliability. However, my assessment is not based solely on behaviour in the witness box during an emotionally charged contested family dispute. Demeanour and performance in court is just one aspect of the assessment (**Re M (Children)** [2013] EWCA Civ 1147, Macur LJ at paragraph 12).

Allegations of physical abuse/injury cases

30. In **Re S (A Child)** [2014] EWCA Civ 25, Lord Justice Ryder considered the use of the term 'non-accidental injury' stating:

> *"I make no criticism of its use but it is a 'catch-all' for everything that is not an accident. It is also a tautology: the true distinction is between an accident which is unexpected and unintentional and an injury which involves an element of wrong. That element of wrong may involve a lack of care and/or an intent of a greater or lesser degree that may amount to negligence, recklessness or deliberate infliction. While an analysis of that kind may be helpful to distinguish deliberate infliction from say negligence, it is unnecessary in any consideration of whether the threshold criteria are satisfied because what the statute requires is something different*

namely, findings of fact that at least satisfy the significant harm, attributability and objective standard of care elements of section 31(2)."

31. In evaluating whether significant harm has occurred, and if so, who was the perpetrator, the roles of the medical expert and of the court are very different. Whilst appropriate attention must be paid to the opinion of experts, those opinions need to be considered in the context of all the other evidence. It is important to remember that the roles of the court and the expert are distinct, and it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision.

32. Cases involving allegations of this nature often involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others. When considering the medical evidence in cases where there is a disputed aetiology giving rise to significant harm, the court must bear in mind, to the extent appropriate in each case, the possibility of the unknown cause [**R v Henderson and Butler and Others** [2010] EWCA Crim 1269 and **Re R (Care Proceedings: Causation)** [2011] EWHC 1715 (Fam)]. As Per Hedley J **Re R** paragraph 10

> *"That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."*

33. I also remind myself of **Re U; Re B (Serious Injury: Standard of Proof)** [2004] EWCA 567: -

   a. *Particular caution is necessary where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause.*
   b. *The court must always be on guard against the over-dogmatic expert, or where the expert's reputation or amour propre is at stake, or where an expert has developed a scientific prejudice.*
   c. *The Judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts and that scientific research may throw light into corners that are at present dark.*

34. In cases of alleged injury, the Court should again be careful not inadvertently to reverse the burden of proof by requiring a parent to prove that the injuries in question have an innocent explanation as opposed to requiring the Local Authority to prove that they do not (**Re. M (fact finding hearing: Burden of Proof)** [2012] EWCA Civ 1580).

35. There is no requirement on the parents or the interveners to show that the injuries have an innocent explanation. Where a respondent parent seeks to prove an alternative explanation but does not prove that alternative explanation that does not of itself establish the Local Authority's case which must still be proved to the requisite standard. The fact that the Local Authority relies on the lack of a satisfactory explanation for the injuries does not amount to a reversal of the burden of proof (**Re. M-B (Children)** [2015] EWCA Civ 167).

36. In **Re X (Children) (No 3)** [2015] EWHC 3651 Munby P endorses what HHJ Bellamy had said in **Re FM** [2015] EWFC B26 , para 122:

> *"It is the local authority that seeks a finding that FM's injuries are non-accidental. It is for the local authority to prove its case. It is not for the mother to disprove it. In*

particular it is not for the mother to disprove it by proving how the injuries were in fact sustained. Neither is it for the court to determine how the injuries were sustained. The court's task is to determine whether the local authority has proved its case on the balance of probability. Where, as here, there is a degree of medical uncertainty and credible evidence of a possible alternative explanation to that contended for by the local authority, the question for the court is not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability' ."

<u>Perpetrator</u>

37. If the court is satisfied that there are inflicted injuries then it must consider whether it can identify a perpetrator of those injuries on the balance of probabilities.

38. The concept of a pool of perpetrators only arises where an allegation cannot be proved against a single individual on the balance of probabilities.

39. In **Re B (Children: Uncertain Perpetrator)** [2019] EWCA Civ 575 the Court of Appeal urged a change of terminology from 'pool' to 'list'. The following principles can be drawn from **Re B** when read alongside the 2008 **Re. B**:

a. The concept of a pool of perpetrators is one that seeks to strike a fair balance between the rights of the individual, including those of the child, and the imperatives of child protection;
b. A decision by a court to place a person in a 'pool' of possible perpetrators does not constitute a finding of fact in the conventional sense in that that person is not proven to be a perpetrator but is rather a possible perpetrator;
c. Where there are a number of people who might have caused the harm to the child, it is for the local authority to show that in relation to each of them there is a real possibility that they did so;
d. Within this context, the question is whether it has been demonstrated to the requisite standard that a person is a possible perpetrator.
e. Approaching the matter by considering who could be excluded from a 'pool' of possible perpetrators is to risk reversing the burden of proof. The court must consider the strength of the possibility that the person was involved as part of the overall circumstances of the case;
f. In doing so, in future the court should first consider whether there is a 'list' of people who had the opportunity to cause the injury;
g. The court should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so.
h. At this stage, the correct legal approach is to survey the evidence as a whole as it relates to each individual in order to arrive at a conclusion about whether the allegation has been made out in relation to one or other on a balance of probability. Evidentially, this will involve considering the individuals separately and together and comparing the probabilities in respect of each of them. Within this context, the right question is not 'who is the more likely?' but rather 'does the evidence establish that this individual probably caused this injury?' In a case where there are more than two possible perpetrators, the Court of Appeal highlighted a clear danger in identifying an individual simply because they are the likeliest candidate, as this can lead to an identification on evidence that falls short of a probability;

i. Only if the court cannot identify the perpetrator to the civil standard of proof should it then go on to ask of each of those on the list whether there was a likelihood or real possibility that they caused the injuries. Only if there is, should that person be considered a possible perpetrator;

40. I remind myself also of paragraph 34 of the judgment of Lady Justice King in **Re A (Children) (Pool of perpetrators)** [2022] EWCA Civ 1348 when she said after consideration the origin of the phrase straining to identify a perpetrator said:

> *"I suggest, therefore, that in future cases judges should no longer direct themselves on the necessity of avoiding "straining to identify a perpetrator". The unvarnished test is clear: following a consideration of all the available evidence and applying the simple balance of probabilities, a judge either can, or cannot, identify a perpetrator. If he or she cannot do so, then, in accordance with Re B (2019), he or she should consider whether there is a real possibility that each individual on the list inflicted the injury in question."*

<u>Failure to protect</u>

41. In **Re L-W (Children)** (2019) EWCA Civ 159, it was held that the family court should be alert to the danger that a finding that a mother had failed to protect her child could become a '*bolt on*' to the central issue as to who had caused non-accidental injuries to a child. Courts should not assume too easily that if a person was living in the same household as the perpetrator, a failure to protect finding was almost inevitable.

<u>The Approach to Lies</u>

42. It is not uncommon for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for various reasons, such as shame, misplaced loyalty, panic, fear, distress. The fact that a witness may have lied about some matters does not necessarily mean that he or she has lied about everything: see **R v Lucas** [1981] QB 720 .

43. In **H-C (Children)** 2016 EWCA Civ 136 Lord Justice McFarlane said:

> *"100. One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of **R v Middleton** [2001] Crim.L.R. 251.*
>
> *In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt".*

44. There is danger in placing too much weight on inconsistencies which may emerge from the giving of multiple accounts over time. In **Lancashire County Council v The Children** [2014] EWFC 3 (Fam), Jackson J (as he then was) said:

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

Factors Relevant to Factual Framework

45. In BR (Proof of Facts), Re [2015] EWFC 41 Peter Jackson J (as he then was), whilst acknowledging that each case turns on its own facts, endorsed an analysis of relevant factors to be considered by the court which had been prepared by counsel for the Children's Guardian from material produced by the NSPCC, the Common Assessment Framework and the Patient UK Guidance for Health Professionals.

The 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

The protective factors were:

q. Supportive family environment
r. Nurturing parenting skills
s. Stable family relationships
t. Household rules and monitoring of the child
u. Adequate parental finances
v. Adequate housing
w. Access to health care and social services
x. Caring adults who can serve as role models or mentors

y. Community support

Background

46. M is 34 years old. She was diagnosed with ME in 2012 which affects her joints and restricts her mobility. She suffers from an anxiety disorder and has a number of health conditions including POTS and hyperthyroidism. The pregnancy with A was not an easy one due to sickness and the impact on medication M takes for her various conditions.

47. M had a relatively unremarkable childhood. Her father sadly passed away when she was 12 years of age and she has suffered with anxiety ever since. She attended University and obtained a BA degree.

48. F is 39 years old. His initial statement describes a stable family background but more recently he has alleged that his parents were physically and verbally abusive to him. He struggled in school but did leave with some qualifications. He spent some time working in catering before training in emergency services. He worked in this role until 2013.

49. F was involved in private law proceedings over a decade ago. It was determined by HHJ Wildblood KC in 2012 that F had knowingly engaged in sexual activity with a child under the age of 16 and breached an abduction warning notice on two occasions . The matter did not proceed to a criminal trial although the complaint has never been withdrawn. Since then, F completed the AHIMSA treatment programme in June 2013. His contact with his daughter continued to be supervised until F disengaged with contact in approximately 2014/15.

50. F's engagement with AHIMSA concluded that:

> *"[F's] dynamic risk has continued to reduce… [F] does not pose a risk to strangers, infants or pre–pubescent female children or male children of any age, and there is no evidence that [F] poses a risk to his daughter [] or to his son [] at this time."*

51. M and F met online through a dating website. They exchanged online messages before meeting in December 2018. M proposed to F in early 2020 and they married in August 2022.

52. M and F tried to conceive for 1 ½ years but experienced difficulties. M has described A as a miracle. A was born in 2022. For a period of about six weeks after A was born M was required to supervise all time that F spent with A whilst assessments were undertaken in respect of the findings previously made against F.

53. There is a wealth of evidence of both M and F's close and loving relationship with A. At the 6 month check the health visitor described her as thriving in her parent's care and meeting all of her milestones.

54. Apart from the circumstances which led to these proceedings, the main significant contentious event occurred in March 2023 when F attended at hospital with a wound to his head. He was triaged at 14:00. The triage notes say:

> *"during argument with wife today at home patient's wife threw drill at patient hitting right side forehead, would 1 inch not bleeding…. Patient's daughter in property at time, will complete MARF (patient aware)…"*

55. F was seen again at 16:37; 22:45 and 23:30. The entry for 22:45 records:

> *"At 1pm today had argument with his wife at home wife then threw a large impact drill down full flight of stairs and hit him on right side of face - temple bled a lot at scene"*.

56. Four days later at 13:57 social services telephoned F as a result of the MARF raised following his attendance at hospital. During this call F gave an entirely different account of the March 2023 incident. We know exactly what F said during this call as he has an app on his phone which automatically records conversations and therefore a transcript of that call is available. F was asked about the incident and he replied:

> *"There was a misunderstanding with them. They wrote down in my notes that my wife threw a drill at me but what actually happened was that I was at the bottom of the stairs, I was doing some work on the house at the bottom of the stairs and my wife was on the middle floor. I needed my drill and I asked my wife to chuck it down to me. She chucked it down to me and I missed it. It was a complete accident and I got caught in the head."*

57. F went on to say that there was no argument and it was a complete accident. The caller then asked to speak to M. After a 30 second pause, when it sounds like the call has been muted, M came onto the phone and also said that F had asked her to 'chuck' him the drill and it was a stupid accident.

58. That same day at 14:14 F returned a call to the health visitor. During this call F raised the March 2023 incident and explained that social services had been in contact. He again said that he had asked M to throw the drill and the injury was an accident.

59. F subsequently repeated this accident account on various occasions including during the Child Protection Medical, interview under caution and in a telephone conversation with his Father on 19th April 2023.

60. This remained the account until M filed a statement on 2nd June 2023 in which she accepted lying about the incident. The statement detailed that during the March 2023 incident they had been arguing over F spending money at Starbucks and M's concerns that he was being unfaithful. During this argument M said she pushed F's keyboard down the stairs following which there was a physical struggle between them. She says during this she was struck to the face. She said at first, she thought he had hit her to the face but was later told she had hit herself with her hand during the struggle. She said she ran upstairs in a panic and threw the first thing to hand to prevent him from following her. This happened to be the drill which hit F to the head causing the injury. She accepted that A was in the property at the time but said she was upstairs asleep.

61. F filed a statement on 2nd August 2023 in which he largely accepted the statement of M. He accepted that there had been an argument. He said M pushed his keyboard down the stairs causing it to be damaged. He said both he and M were shouting and angry. He thought M was going to cause further damage to the keyboard so he grabbed her arms to stop her. M continued to thrash around and F said during this struggle M hit herself to the face with one of her hands. F said he then bent to pick up parts of the keyboard. Whilst doing this he was hit to the head by the drill.

62. The events of March 2023 and the accepted dishonesty of M and F are now relied upon by the local authority. They seek a specific finding that F punched M to the face during that incident. The local authority contend that the deliberate lies and minimisation of matters are inextricably linked to important wider canvas issues and are designed to prevent professionals from viewing how the injuries to A were sustained in their full context. I will return to the oral evidence of M and F in due course in this judgment.

Expert Evidence

63. During the course of the proceedings a number of medical experts were instructed. There was an experts meeting on 30th November 2023. There were no areas of disagreement arising from that meeting.

64. Dr Russell Keenan, Consultant Paediatric Haematologist, provided reports dated 5th July 2023 and 26th August 2023 together with a response to questions dated 25th January 2024. He concluded that no blood clotting disorders had been identified and that any bruising to A should be considered on balance of probabilities to have occurred in a child with a normal blood clotting system.

65. Dr Oystein Olsen, Consultant Paediatric Radiologist, reported on 22nd July. His report said:

i. A had suffered two fractures (breaks in bones), namely at the metaphysis (the part of a long bone that joins the shaft to the knuckle) at the upper end of the left and right upper-arm bones, respectively.
ii. The right sided fracture showed sub-periosteal new-bone formation on 19th April 2023 and more consolidated, denser such formation on 4th May 2023. These observations would place the fracture at about ½ to 1 month prior to 19th April 2023.
iii. The left sided fracture did not display the typical fracture-healing signs which is not unusual for metaphyseal fractures. The upper limit of age for both was roughly the same but the left-sided fracture may be slightly more recent by a week or so.
iv. The fractures cannot be separated by time of occurrence.
v. There is no radiological sign of any underlying abnormality.
vi. The most likely mechanism causing metaphyseal fractures was unnatural, forceful bending; pulling rotation or a combination thereof.
vii. Each fracture most likely resulted from excessive pulling and/or twisting of the respective arm.
viii. The magnitude of force required to cause a metaphyseal fracture while in excess of what one would expect from normal handling, is not necessarily as great as what is required to cause a fracture of the shaft of a bone.
ix. F throwing A in the air and catching her is of no relevance had the impact been to the chest wall.
x. If F gripped both upper arms as A descended and there was significant momentum then that could fit with the causation. However, to sustain two fractures as a result of one fairly low-energy, domestic event would be highly unusual.
xi. He had not identified any clear causative event in the papers available at the time of writing.

66. Dr Olsen responded to questions on 25th August 2023 having been provided with statements from M and F and a number of videos. His response was:

i. He had three principal reservations in accepting that any fracturing event was demonstrated in the video clips. They were:
   - That self-inflicted fractures in infants are, as far as he knew, exceedingly rare;
   - That the potential self-inflicted upper-arm fractures described in the literature were to the mid/lower forearm while A's fractures were at the very upper aspects of her upper-arm bones; and
   - That self-inflected metaphyseal fractures at the shoulder have not previously been plausibly described, as far as he was aware.

ii. Having significant reservations did not mean that he could completely dismiss the possibility but that most of the movements or manoeuvres demonstrated in the videos (e. g., `folding the arms' under her, the arm being `tucked' under the front, and similar) would not plausibly generate any noteworthy tensile force.

iii. The only movement that, in his view, perhaps might be considered, was seen in the video clip FT1.mp4 at between 19 and 23 seconds, namely relative rotation of the arm around the back. That is the mechanism proposed (by some) for fractures further down the upper-arm bone.

67. In evidence he agreed the Areas of Agreement document from 30th November 2023 save that from a radiological perspective he said he had no opinion about the bruising. He also said in evidence that it was not his conclusion that the injuries were highly likely to be NAI simply because NAI is not a medical diagnosis.

68. In relation to the age of the fractures he would not be drawn into specific dates. He said he wanted to alert the court to the fact that there is no high granularity or high precision. The age given is a rough estimate of about ½ to about 1 month prior to 19th April 2023. He said that range is the best fit radiologically and he could be fairly granular as there were classic signs of healing. He said that the fractures looked pretty similar so it would be no surprise if the fractures occurred on same day or at least close in time.

69. He did not agree with the opinion of Dr Alu that a metaphyseal fracture is more commonly described in physical abuse than in non-abuse. He said that, for example, Kemp & Co 2008 did not arrive at that conclusion in respect of a single metaphyseal fracture so it is not straight forward. He said that the important point to him was that it does not make a good diagnosis just because there might be an over presentation of one or other alternative of aetiological groups. That does not make a good diagnostic criteria as if 60% are abuse and 40% are non-abuse you cannot use that as diagnostic criteria of abuse as would be wrong in 40% of cases. He said diagnostically it is of very little value whichever way the needle swings and in any event the needle is not firmly to either side.

70. He also did not agree with the opinion of Dr Alu that absent underlying bone disease, metaphyseal fractures are highly specific for non-accidental injury as in his view specific means diagnostic specificity and from a radiological perspective there is absolutely no possibility of making a sensitive or specific (accurate) diagnosis of child abuse based on radiological imaging.

71. When asked by Mr Rees he maintained his view in respect of the videos M had provided. He added that he had never seen in his clinical practice or in a reputable part of the medical

literature a self-inflicted humeral fracture. He did accept that if the court accepts one of the mechanisms shown occurred at a force which was beyond what is commonly seen as acceptable then that may be a plausible explanation. The other possibility he posited was that the fractures occurred without excessive force as a freak event. He said that with symmetrical fractures to upper arms there would need to have been two identical freak events which statistically was a bit far out.

72. To Mr Day he said that the fractures were more or less precisely at the same point on each arm but added that this degree of symmetry from a radiological perspective did not assist in whether they occurred in the same event.

73. Mr Day also questioned Dr Olsen as to whether F throwing A in the air could have caused the fractures. Initially he replied that he had never seen fractures like this from a throw and catch activity nor had he seen descriptions of it in literature. He caveated this response by saying that this was based on the assumption that the child had been caught around the chest but it would be a different situation if the child was caught by the arms as F suggests he did to A. He said throwing a child in any direction would result in gravity doing its job. If the child is then caught by the arms, it would induce a very severe traction of the arm and traction of the arm is one possible mechanism for a fracture of the nature seen here. He added that it would not matter whether the child was caught by the inner or outer arm as if a child who had some speed due to gravitational acceleration was caught by the arm one would easily accept that it would lead to traction of the arm beyond what seem part of reasonable handling.

74. He clarified his position further by saying that the fracturing mechanism such as twist of the arm or sharp pull of the arm would require unreasonable force assuming normal bone strength. Any event that led to any such mechanism and force needs to be considered a plausible explanation.

75. Mr Day tried to draw Dr Olsen into the topic of fractures being caused or contributed to by EDS. Dr Olsen said that papers he had seen did not make a good case regarding bone fragility in children with EDS but appropriately pointed out that it was not his expertise and that he would defer to Dr Saggar. He acknowledged that he would need to revise his opinion in respect of A if it were to be found that she did have bone fragility.

76. Dr Saggar, Consultant in Clinical Genetics reported on 22nd November 2023. His report stated:

i. The gene panel test for the osteogenesis imperfecta (OI) and bone fragility genes and also the known genes associated with the different subtypes of Ehlers Danlos Syndrome (EDS) had found no clinically significant sequence or copy-number changes that would explain A's presentation.
ii. There is a residual risk that A has inherited hypermobile spectrum disorder (HSD) from M but this would not explain any fracture in the absence of a plausible and precipitant force to explain each fracture.
iii. Fractures do not occur spontaneously in hEDS or HSD and so if fractures occur, albeit after lesser force, there has to be a recognised precipitant force or memorable event for each fracture. Such a force would nonetheless be known to be excessive and inappropriate in the handling of such a small child.
iv. Examination of A found that she had epicanthic folds, low set ears (which are just like M) and not posteriorly rotated. Height and head circumference

on the 25th centile. There was no pectus excavatum. The hair texture was normal. The Beighton score was 4/9. The palate was high and narrow, the teeth were normal colour, the sclera normal. Dr Saggar noted red marks on the back and arms from handling, in keeping with F's observations.

v. The history in M suggests that she has hypermobile spectrum disorder (HSD), i.e. a milder form of hEDS, previously called EDS type 3.

vi. hEDS and HSD are part of a continuum and represent different degrees of severity (Aubry-Rozier, 2021). M describes other features in keeping with this diagnosis:
   - Family history suggestive of HSD
   - M has a diagnosis of ME
   - Fatigue
   - Daily joint pain
   - Whole body pain almost constantly
   - Possible POTS
   - Irritable bowel syndrome
   - Urgency of the bladder
   - Brain fog and 'confusion'

vii. M does not fulfil the criteria for the most severe end of the spectrum defined as hEDS in the 2017 criteria.

viii. A has a few features at present to suggest she has inherited HSD:
   - Red marks on skin from handling
   - Epicanthic folds
   - Palate high and narrow
   - Beighton score is 4/9.

ix. Given the family history of a mild connective tissue disorder on the hypermobile spectrum, A is at 50% risk of inheriting aspects of HSD from M. It is possible that A will inherit more aspects of HSD from M but at present, there is some limited evidence to suggest she has.

x. Ehlers Danlos syndrome hypermobile type, (hEDS) and also milder spectrum forms are inherited as an autosomal dominant trait. A dominant pattern of inheritance means that there is at least a 50% risk of passing down such a susceptibility to any child. This risk may, therefore, also predispose A to a greater degree of bruising and or bleeding (Malfait, 2009), for any given force.

xi. Bruising is very common in the general population. The association between bruising and hEDS (formerly called type 3) is well described. Easy bruising is quite common, frequently without obvious trauma or injury.

xii. It is also well described that the milder form, hypermobile spectrum disorder (HSD) is associated with easy bruising and bleeding.

xiii. Red marks on the skin after normal handling are also seen in some children with HSD. These are not bruises. The red marks may reflect skin hypersensitivity and a degree of mast cell activation/sensitivity. These red marks fade after minutes or longer. They do not discolour like a bruise.

xiv. A measure of whether A bruises more easily is to assess whether now, with increased play, she bruises more easily than would be expected.

xv. He was also not able to identify any clinical or genetic evidence of susceptibility to fracture with normal handling.

xvi. Fractures do not occur spontaneously in hEDS or HSD and so if fractures occur, albeit after lesser force, there has to be a recognised precipitant force or memorable event for each fracture.

xvii. The clinical features and examination findings suggest that the current degree to which A manifests any features of HSD would not explain the fractures unless there is a clear description of a plausible and precipitant force to explain each one. Such a force would be known to be excessive and inappropriate in the handling of such a small child. It is notable that no such obvious description is provided.

xviii. In the absence of OI or similar bone fragility disorder, it is a contentious issue as to whether hEDS or the milder form, HSD can be associated with fractures after a lesser force in babies under the age of one. This is theoretically possible, but there would still need to be a clear 'memorable' event. In other words, a force or impact that could explain each site of fracture.

xix. He was aware of the work by Holick, (2017) which purported to support the case for fractures in children with hypermobility. The testimony and impartiality of Professor Holick has been discredited following a recent case. Neutral Citation Number: [2018] EWHC 3283 (Fam). This doubt has also been reinforced by published opinion (Shur, 2019).

77. Dr Saggar responded to questions on 30th January 2024. His opinion remained unchanged that the current degree to which A manifests any features of HSD would not explain the fractures unless there is a clear description of a plausible and precipitant force. In respect of the mark to A's ear Dr Saggar said that information that A is continuing to bruise and get red marks after normal activity whilst in care supports the limited evidence that she has inherited HSD. He continued that the red marks may reflect skin hypersensitivity and a degree of mast cell activation/sensitivity. He said that the red marks from cleaning the ear with a cotton-bud therefore sounds plausible, if not a bruise.

78. Mr Rees enquired with Dr Saggar the extent to which his opinion that M has HSD was based on information provided by M that her sister had EDS. Dr Saggar replied that even without that information M has a lot of features that in his opinion fit within the spectrum or syndrome for EDS type 3 hypermobile the most severe being hEDS. He added that the only reason he had not said M has hEDS is because of the strict 2017 criteria under which a person has to have a Beighton score of 5 or greater. M is 2/9 so officially he is not allowed to say hEDS. However, he said that the 2017 criteria does not take into account all of the non-muscular skeletal issues such as POTS, chronic fatigue and bladder problems and brain fog/confusion. He said he was confident that M is on the spectrum without doubt.

68. Mr Rees also questioned Dr Saggar in respect of his 30th January response and the plausibility of the cotton bud explanation. Dr Saggar said based on his experience as a clinician lots of parents do use cotton buds to clean ears when they shouldn't. He said redness is very common as rubbing activates mast cells which release histamine and result in redness. When bruising against canal of the ear that becomes more concerning. He said someone would have to be rough to do that. He did not know the level of force but said that it was not something he has seen or heard and he would raise an eyebrow as to why pressing so hard that caused a bruise.

79. When asked by Mr Day, Dr Saggar maintained that he had no doubt that M has HSD. He agreed that as a result genetically A has a 50% chance of having HSD as well. He added that from the features he identifies in his report he would be quite willing to say that A had more than a 50% chance. He agreed with Mr Storey KC that there is no doubt an association between HSD and easy bruising and that it is the most well recognised and common characteristic. He accepted that as a connective tissue disorder there is a compromise in the

structure of the capillaries. He willingly accepted Mr Day's suggestion that this would make A more vulnerable or susceptible to bruising with lower degree of force.

80. Mr Day went on to say that the bruise to ear could be caused by lesser degree of force and that therefore the cotton bud explanation is plausible and the fall onto the plug is more plausible. Dr Saggar replied that he totally agreed.

81. Dr Saggar was more hesitant when considering fractures and EDS. He accepted that there is no controversy in respect of adults. He agreed that his hesitation in respect of children stemmed from a lack of accepted research.

82. When asked by Mr Day why there should be a difference between an adult and a child if the risk is genetic, he replied that Mr Day was making an assumption that bone density is the same. He went on that it is a dynamic process and that bone changes when someone gets more ambulant. The bones will get stronger and mineralise. He added that diet; vitamins; mobility and medication all make a difference to density. He said that he always reverts to his clinical experience and he does not see children presenting at that young age without a history attached to the injury.

83. Mr Day asked whether he was comfortable with the proposition that A could fracture with lesser force but not suffer spontaneous fracture. His response was that he was absolutely not willing to accept spontaneous fracture and he would still want to hear of some sort of precipitant event. He said that he would not be drawn on the amount of force and would defer to the paediatrician regarding force.

84. He was pressed further on this by Mr Storey KC. He did not accept that HDS is a collagen deficiency. He said that it is a connective tissue disorder and that it not known whether it is collagen specifically or even that it is a deficiency. He said it is an abnormality of connective tissue definitely. He said he would accept the proposition of Mr Storey KC that whether connective tissue or collagen, if it is deficient in some way then mechanically may be capable of compromise or fracture with lesser force. He said that he could not rule out a susceptibility in A. He added that there would still have to be a plausible force that could be seen as precipitant and that it would not be from normal handling of A.

85. When informed of the evidence of Dr Olsen regarding the throw and catch by the arms Dr Saggar said that he would accept that as a plausible and precipitant force.

86. Dr Shade Alu, Consultant Paediatrician, reported on 21st August 2023 (prior to receipt of the report of Dr Saggar). Her report stated:

i. Given the lack of plausible explanations for the injuries that A presented with, that non accidental injury is more likely than not.
ii. Medical literature suggests that the majority of children that present with abusive fractures present to health providers without a specific history of trauma.
iii. Medical research evidence that supports non accidental causes include:
    - Any part of the body is vulnerable to bruising from abuse, however the head is the most common site of bruising in child abuse;
    - Abused children had significantly numbers of bruises to the cheeks, head, trunk and genitalia;

- In contrast to non-abused children, bruises in child abuse are commonly seen on soft parts of the body, away from bony prominences;
- Injuries to the ear are highly suggestive of abuse;
- Metaphyseal fractures are more commonly described in physical child abuse than in non-abuse;
- In an infant without underlying bone disease metaphyseal fractures are highly specific for non-accidental injury.

iv. It is therefore highly likely that the injuries A presented with are non-accidental.

v. Likely mechanism for the fracture includes grabbing, twisting or shaking a child's limb. Normal day to day handling of a child will not result in the injuries that A presented with. Excessive force would have been used.

vi. It is not possible to give a time frame for the bruise.

vii. The explanations by M and F of A toppling onto a plug; her ear being cleaned with a cotton bud or F throwing A into the air do not account for the bruise or the fractures.

viii. There is no medical condition which in whole or part explains the injuries sustained by A.

87. Dr Alu filed an addendum report on 5th February 2024 having received the statement of the foster carer. Her report said that her opinion remained unchanged.

88. Dr Olsen and Dr Saggar gave evidence on 2nd February 2024 due to their unavailability during the hearing window. When Dr Alu gave evidence, she had been provided with an agreed note of their oral evidence.

89. In evidence she said that she struggled to find the explanation of the topple onto the extension tower or the cotton bud as being plausible. She said she had tried to imagine the topple onto the plug and could not see it injuring just the concha whilst sparing other parts of the ear. She expanded on this when questioned by Mr Day saying that the extension tower is a tube and if A had fallen on to it there would be a bruise around the outer ear and that she did not see how it could have gone into the inner ear. She accepted that whether the bruise was inflicted or accidental something had to have entered the inner part of the ear (the concha) with some sort of force to cause the injury. She said that the use of a cotton bud from her knowledge and experience does not explain the bruise. She added that the concha is very much in the protected part of the ear and is an unusual area to bruise accidentally. In fact, with 30 years' experience Dr Alu could not recall seeing an isolated bruise in this location previously.

90. She also said that she did not consider F throwing A into the air and catching her by her arms was a plausible mechanism as a metaphyseal fracture requires forceful twisting and a catch by the arms does not seem the required mechanism. Her view remained the same even in relation to a child with fragile bones. This remained her position until towards the end of Mr Day's cross examination when she said that her reading of the literature was that such fractures require forceful twisting but if Dr Olsen says it is possible then 'maybe'.

91. Dr Alu said that she deferred to Dr Saggar as to whether A had inherited HSD from M. However, when questioned by Miss Edmondson it was clear that she had either not read or not appreciated the oral evidence of Dr Saggar that A in his opinion had more than a 50% chance of having inherited HSD due to other features he had identified during his

assessment. Her evidence was that Dr Saggar said A had a 50% chance which does not make it more likely. She went on to say that if (and she said if is the key word) A had HSD she would be susceptible to more easy bruising but A did not have a diagnosis of HSD and that even if she did it would not mean that all bruises are due to HSD. To Mr Rees she said that she had considered the statement of the foster carer and there was nothing remarkable in that statement to suggest that A had a propensity to bruise easily.

92. Mr Rees questioned Dr Alu on the issue of susceptibility to fracture and HSD. Dr Alu said that joint hypermobility is subject to significant uncertainty and confusion. She added that not being an expert on HSD her limited understanding was the literature as it is would still say fractures under the age of 1 are not seen. She again pointed out that even if A were diagnosed with HSD, then that is not mutually exclusive with NAI as children with HSD can still have NAI. In respect of A, she maintained that the explanations are not plausible and given the lack of plausibility NAI is high on the list.

93. In relation to the bruise Dr Alu said that it was difficult to say that the ear would have gone red immediately after the causative event as the development of bruises varies in each individual. She said that given a bruise is caused by excessive force she would expect a child to cry in response and to then settle on being comforted.

94. In relation to presentation following the metaphyseal fractures Dr Alu said that A may have presented as irritable as a result of pain. She may have gone off her feeds. She pointed out that all children are different and from her experience a carer may not pick up on the fact that A had been injured. She accepted that A is likely to have cried at the time of fracture but in the context that children of that age cry for a variety of reasons. She again said that a parent may not pick it up as a sign of something untoward. She said that from her experience parents do not necessarily realise that they have caused a fracture or injury so would not necessarily attribute the cry to what they had or had not done.

95. She said that she would not necessarily expect there to have been reddening or swelling at the fracture and that A may not have had any difficulty in moving her arms or upper. She said that metaphyseal fractures tend not to present that way. She described them as being occult. and do not present the same as other fractures clinically. She added when questioned by Mr Rees that, given the occult nature of metaphyseal fractures and the fact they are often not picked up until the child is presented for other reasons, it would suggest that such fractures do not always present with pain.

96. When questioned by Mr Day, Dr Alu again said that she deferred to Dr Saggar on the issue of genetics and agreed that he is the expert in relation to EDS. She also confirmed that she deferred to Dr Olsen. She would not accept that A has a diagnosis of HSD and repeatedly drew a distinction between a formal clinical diagnosis and the evidence of Dr Saggar. She said that she was entitled to her opinion; that A does not have a diagnosis of HSD and even if she did it did not exclude NAI. She maintained that no plausible mechanism had been proffered by M or F for the injuries.

Other experts

97. Dr Damian Gamble, Consultant Forensic Psychiatrist, was instructed to assess M. His report dated 25th August 2023 concluded:

   i. M has been diagnosed with myalgic encephalomyelitis / chronic fatigue syndrome (ME/CFS).

ii. This is an appropriate diagnosis. The condition causes a wide range of symptoms, including tiredness and pain throughout the body.
iii. M has symptoms of anxiety and a diagnosis of generalised anxiety disorder is also appropriate.
iv. There is no history of alcohol misuse and no significant history of substance misuse.

98. Concerns were raised at an early stage of proceedings that F may have autism. MIND were instructed to assess F as a result. The reported dated 19th June 2023 says:

> *"Autism is considered a neurodevelopmental life-long condition with different levels of symptom severity with two core domains: deficits in social communication and reciprocal social interaction; and restricted repetitive behaviours, interests, or activities (RRBs) including sensory differences."*

99. The outcome of the assessment was that F meets the criteria for diagnosis of Autism Spectrum Disorder at the level one severity. The report made numerous observations as to how F's autistic presentation impacts upon him. It recommended that F needed an intermediary during court hearings and the giving of his evidence to ensure that he had interpreted questions as advocates intended, was not misunderstood in terms of the lack of integration between his verbal and non-verbal communication and was able to manage his stress and tendency to become fixated on certain details. Communicourt subsequently reported and F was assisted by an intermediary throughout the hearing. I am grateful to the intermediary for his assistance throughout.

Evidence

100. The health visitor attended on 18th April 2023. Her evidence was entirely consistent with her statement and written note. Other than the bruise to A's ear she had no concerns. She did not see M on 18th April but had met her twice previously. She confirmed that both M and F were co-operative and engaging and that A was thriving in their care. She had no concerns about the interaction between F and A and readily agreed that A enjoyed being with F. She noticed the bruise to A's ear and said that F immediately told her that A had fallen from a sitting position onto a plug three days before. She said that no mention was made during her visit of a cotton bud. She said that in 26 years as a health visitor she had never seen a bruise in the concha before. She made a referral to social services following the appointment as per Health Board policy for bruising to non-mobile infants.

101. The initial allocated social worker and author of the initial social work statement attended at M and F's home on 18th April 2023 as part of the section 47 investigation. She spoke to M and F together and apart but could not remember in which order. She recalled examining A and noting that the bruise was inside the concha which she described as an unusual place for a bruise. She was told that A had fallen onto a plug a few days earlier by M and F. She had no recollection of either M or F mentioning a cotton bud as possibly causing the bruise. She said that both M and F were both co-operative with her. She later transported F and A to the hospital for the child protection medical.

102. The foster carer has been A's foster carer since 21st April 2023. She has produced one witness statement and foster carer logs. Her statement sets out occasions that A has been observed to have marks or bruises whilst in her care. She has been a foster carer for just over five years. She did not agree with the suggestion that A bruises more easily than other

children. She said that from what she had witnesses A the same as any other child. She said that she did not see a difference but acknowledged that she is not an expert.

103. General Practitioner, saw A and F at 14:15 on 18th April 2023. She qualified as a GP on 9th January 2023. She said that she conducted a thorough examination of A and at the time was satisfied on the basis of the history provided and A's presentation that it was not a NAI. She said that on examination she could see A was able to sit up and considered the fall as being a plausible explanation. However, she has since review safeguarding guidelines and accepts that they are certain areas of the body including the ear which require more in-depth investigation regarding possible mechanism.

Events and accounts since 18th April 2024

104. Much is made by the local authority of the lack of credibility of M and F. Mr Rees says they have been wholly unreliable both prior to and during proceedings which was amplified by their oral evidence.

105. It is necessary in my judgment to consider in detail events since 18th April 2024 and the timing and detail of accounts given by M and F. There were many messages between M and F and M and various friends over 18th April to 20th April. I have identified only a few in the following paragraphs but will consider the totality of the messages later in this judgment.

106. 18th April 2023

i. 9:15 health visitor visited. F stated that A fell onto her ear from a sitting position on the floor and knocked her ear on a plug. F stated he had not sought medical advice as he was observing the area for any deterioration (he said he felt this appropriate due to his medical past).
ii. 12:45 during a message exchange with a friend, S, M sent messages saying:
   - *"It's ridiculous to take her to the doctor over this. I didn't think it was bad enough to get a bruise, I was mortified when I saw it and F said it would be okay with the HV"*.
   - *"All I did was put her on the floor for less than a minute and she lunges forward on an extension plug. It's like the first time I've not been OTT about something I even ask F first if I could and this happens"*.
iii. 14:15 GP attendance. F said about three days ago, A was trying to sit up, and wobbled about, went sideways and hit herself on an extension lead. When asked if A cried, F replied 'a little wince' before agreeing she had cried a bit until picked up.
iv. The social worker attended that afternoon and spoke to M and F separately on the home visit and both said that A had been placed on the floor a few days prior and toppled sideways onto cylindrical multi-plug socket lying sideways at the time. F said he was trained as a paramedic so monitoring the bruise.
v. Police Niche Record from joint visit in line with social worker's account.
vi. 18:34 Child Protection Medical. F said M sat on sofa three days ago. They put a on the floor sat up. He said they turned their backs for 2 seconds; heard a bump and found she had hit the side of her head on an extension cord cylindrical tower. The social worker had picture of tower with phone charger plugged in. A had a "little cry". F said he had an ambulance

background so he conducted a quick check and A was fine. A couple of days later he noticed a bruise there. F said that M later told him that she was cleaning A's ear with cotton buds and that may have caused the bruise, this was the same day that A toppled over. F said he noticed the bruise 1 day later and pointed it out to M. F thought A had toppled onto either the phone charger or the base of the extension cord stack.

vii. 19:08 further messages between M and S:
   - *"there's been no other cuts or bruises so surely they can find anything… but to take her for this…"*
   - *"They have said they just need a medical professional that isn't [F] to tell them that the item showed them could cause that bruise as they do not see it… but we are just telling them the truth! I'm starting to wish that we would of made something up that sounded more plausible*".

viii. Untimed case recordings from hospital supervision. F sat A up to show she could - she was unstable and could not do it unaided. F said two possible versions:
   - A sat up and had fallen onto a charger plug that was in the extension lead.
   - M may have applied too much pressure whilst cleaning out A's ear. Note said F had also given this version to hospital staff.

ix. 21.43 M messaged F *"It sounds odd and weird but if they can pull this all up over a small bruise anything can be used against us*".

x. 21.45 F replied, "*True. All deleted*"

xi. 22:27 messages start between M and RL. M had been put in contact with this person by S as she previously had social services involvement.

xii. 23:03 M messaged RL *"…I put her on her mat sitting up something behind her and she went to grab something and fell sideways onto an extension plug nearby its ridiculously stupid but I just didn't think*".

xiii. 23:26 RL told M told to be careful what she said as phones could be taken and things like messages or internet searches could be use against her.

xiv. 23:32 F messaged M that he had seen the message from the lady about checking their phones. He said "*just as well we did that. WhatsApp is encrypted so cannot be recovered either*".

xv. 23:33 M responded "*and texts, I'm just deleting everything so nothing can be taken out of context*". In a further message at 23:38 M said *"messenger, text, WhatsApp, photos*".

107. 19th April 2023

i. 12.21 M in a message to a friend, E, M said "*we think A got it (the bruise) when I put her down near an extension plug tower and she fell over sideways, they saw she falls to the left when sitting up…my leg is covered in them all the time*" M said that A has sensitive skin so can get a little red in places when picked up.

ii. 13:00-17:00 case recording from hospital supervision. F handled A appropriately. A was observed as not being able to sit up on own for long periods. She was able to sit unaided but was unsteady and for 1 min at the longest before falling to the side or the front. F put forward both have plug and cleaning ears as possible explanation

iii. 17.13 F called his parents. He told them that the bruise in A's ear is a "little bruise", either from when she was sat up and went headfirst onto a plug or from when M was cleaning her ear with a cotton bud and may have pushed a bit too hard.
iv. 18:38 M said in message to a friend (Pr) that A had been pulling on her ear when M puts the fan on too high. They knew A fell forwards when sitting so assumed it might have been that but thinking about it may not be but cannot change the story or it will "look dodgy" but A didn't cry for more than 2 seconds, or she bruises easily.
v. 19:37 M messaged Pr *"that's the thing we were just truthful and not withholding anything or keeping her from seeing her."*

108. 20th April 2023

i. 11:24 M messaged F *"It's unhealthy, she didn't even cry. How on earth was I meant to know she was hurt…it just feels like it's a thin bit of tissue and that might be why it bruises…I forgot she was pulling her ears too"*
ii. 11:30 F was informed of the results of the skeletal survey. F described by Social Work Assistant as looking worried. F had said he did not know how this could have happened but went on to say it may have been when he lifts A up in the air by her underarms playing around.
iii. 11.51 F messaged M *"CT came back fine, x-ray shows a fracture on the top of each arm???? How the hell that happened I'll never know, but I looked it up and it can be common with c- section births"*
iv. 11.53 M messaged F asking why this would show up after 6 months.
v. 11.53 F messaged M said A is in no pain at all so he will ask about this and past fractures will show as the bones knit together.
vi. 12.04 M messaged F asking if it could happen when he 'does this'. The message attached a video of F holding A under arms.
vii. 12:05 F replied saying I don't think so.
viii. 12.24 F messaged M and said A had always been using her arms and never stopped.
ix. 12.25 phone call between M and F lasting 5 minutes 15 seconds. M said she did not understand how this happened, and F said he did not either. F said there had been no bruising or swelling and A had always been using her arms and had never stopped. M said it did not make any sense and she could not understand how it is possible. F said, "*they've found something we've got no explanation to whatsoever*".
x. 12:35 M message to Pr saying fractures found.
xi. 12:35 M message to S *"… literally I have no clue what the fuck is going on [by] they've found that A had two fractures on top of both arms and I have no idea how or why or what"*
xii. 12:38 M message to Pr *"no she's never fallen anyway or had anything bad happen to her … F is asking if it could have been from birth and the c section but no one is saying anything"*
xiii. 12:59 M message to Pr "*I wish we could explain it but I'm not going to say she had a big fall because she didn't…now because of that it looks worse*".
xiv. 13:42 M message to Pr *"she was sitting down hun I put her sitting on her may playing and she just fell sitting on the plug… it barely touched her to be honest .. it has to be from the c section pulling her out"*

xv. 13:52 M message to RL "*they've found that A has had two fractures on top of both arms and I have no idea who or why or what…its not looking good*".

xvi. 13.35 M message to F "*I don't get this at all I wish something would explain it because it looks worse we can't explain it*".

xvii. 13.37pm M message to F "*didn't you once do the air thing and she cried? In the bedroom…didn't you catch her wrongly on her arms? It's saying most like a fall but she's never fell only when you play with her in the air but she loves it but I'm sure that one time she got upset*"

xviii. 14.15 M messaged F asking if had shown them the video of him catching A.

xix. 14.29 phone call between M and F lasting 7 minutes and 26 seconds. M & F discussed section 76 consent. M asked F if he had shown them the video. F confirmed that he had. M asked how else A could have got the injuries and F said he had no idea. M queried whether it could have been a seatbelt too tight. F said he had no idea and he was unsure where on her arm the fractures were. He knew it was the humerus but not where on the humerus it was or how bad they were. F said the injuries were unexplained and that is why they wanted to investigate. M said *"I'm pretty sure you caught her wrong and she cried once"*, F replied *"possibly yeah"*. M then said *"she cried once in the bedroom and that's all I can remember you doing and I told you. You told me she was fine and I took your word for it but she did cry once when you grabbed her. it's a fall isn't it"*. F replied "*yeah essentially*".

xx. 14:40 M messaged E "*she has fractures on her arms and we can't explain them…I dunno what to do*".

xxi. 15.03pm F messaged M asking if she could remember roughly when she winced a bit when he played with her.

xxii. 15.04 M replied "*I have no idea it was in the bedroom and I think you caught her wrongly*"

xxiii. 15:06 F replied "*yea, it could help out cause, that could explain arms and rib*"

xxiv. 15.06 M replied "*I thought it was ok! You said it was ok but they you caught her wrongly that one time*"

xxv. 15.08 F asks M for a rough idea when.

xxvi. 15.08 M replied F "*don't you remember it? I guess it could have been you've always done it*"

xxvii. 15.12 F says "*yea I don't remember, but that's ok, there's an explanation possibly*"

xxviii. SWA supervising F in hospital presence of social worker. Social worker arrived at 14.20. F asked how anyone could hurt this little thing. At 15:00, F said he had done his own research and found that the injuries could be caused due to the c section but rare. He said he had played with A by throwing her into the air lightly, not past his fingers and catching her again and believed this could have caused the injuries. F was observed on his phone and a couple of minutes later said that M remembered a time he threw A into the air in the bedroom (cannot remember when) and she did wince but there was nothing more to this.

xxix. 15:56 M message to Pr ".. *we think it might of happened when he throws her up in the air and catches her… I told him I didn't like it and he said babies are more versatile than you think…apparently not*".

xxx. 16:06 F was arrested

xxxi. 16:13 M message to Pr. M said that A loved it (referencing the video she sent of F throwing A in the air) and always laughed apart from once when F didn't catch her right. M said she hated it most of the time due to her

anxiety and thought F knew more than he did as ex-ambulance. She said "*he was trying to make her happy, it's not abuse, just misjudgement*".

xxxii. 16.23 M messaged S "*all we can think of is that F throws her in the air only a little and catches her, once he caught her on her arm but(?) I don't get that it would hurt her, she did cry and I had to take her*"

xxxiii. Unknown time M arrested

109. 21st April 2021

110. F was interviewed under caution at 11:10. The interview lasted 1 hour 32 minutes.

111. With regard to the bruise F said he turned his back for 2 seconds, and when he turned back A had flopped over onto an extension lead which had his phone charger plugged in. He said a big white plug was plugged in together with a few other plugs. He said he could only assume that caused the bruise on the ear. He did not mention that it may have been caused by a cotton bud.

112. With regard to the fracture he said that he not noticed anything unusual about A's arms at any period. He never any concerns. He said A never guarded the area to top of arms or not moved arms. He said she was hitting out and moving about. There was never any swelling, redness, bruising, or crying if she was picked her up or held by her arms. F did not mention during the interview his concern that he may have caused the fractures by throwing A in the air and catching her by the arms.

113. M was interviewed under caution at 13:23. The interview lasted 1 hour 59 minutes.

114. With regard to the bruise M said her stomach was hurting and A was kicking so she wanted to put her down. She put her on the floor with an elephant behind her. Within a minute M said she heard A crying and when she looked she was sideways on the plug. M said that F was in front of her and he said A reached for toy and fallen on to the plug and screamed. M said she picked A up and she stopped immediately. M said she didn't think anything of it as F checked her over and said she was fine. Later in the interview M said it was just a normal cry not a scream and A stopped as soon as she picked her up.

115. M said that on Sunday F then said that A had a bruise. She said she panicked but they knew the health visitor was due to attend and F said to mention it to her.

116. With regard to the fractures said that F regularly played with A and lifted her in the air and grabbed her. She said one time she was in the bedroom, sitting on the bed and F was playing with A. She said A was laughing. She then said F 'chucked' her and she thought he grabbed her wrongly and she screamed. She said A screamed a scream she had not had before. She said she was watching tv and only saw it out of the corner of her eye. She said F started saying 'sorry, sorry, it's ok, it's ok and comforting her'. M said they then comforted her and said if she did not settle in 30 minutes they would call the hospital. She said she asked F what had happened and he *"I just grabbed her wrongly, I just grabbed her and I grabbed her by her arms*".

117. M said it was not like you see in videos and 'they're chucking them in the air and catching them'. She said she never felt comfortable with F doing it and had said to F not to do it but he continued saying there was nothing wrong with it and that babies don't break as easily as you think they do. M said she just assumed he knew better.

Parents written evidence

118. During these proceedings M has filed an initial response to threshold, final response to threshold and four witness statements. In these documents M has put forward various explanations as to what may have caused the injuries such as attempting to stick A's ears back; A pulling at her own ears; A getting her arm stuck whilst trying to roll; F swaddling A and getting arm stuck. She has also maintained the accounts of A falling onto a plug and cleaning her ears with a cotton bud in the days leading up to 18th April 2023.

119. In her initial statement she said she propped A up with a pillow behind her and toys in front of her and carried on what she was doing. Within 10-20 seconds, she heard a cry looked down and saw A had toppled sideways and her head was on the plug into the extension tower. She immediately picked her up to comfort her and A stopped crying almost instantly. M said she thought A had cried as she toppled and was in an uncomfortable position.

120. After the incident with the plug, M said she noticed dry skin while cleaning A's ear. She said asked F to get her a cotton bud and removed it this and water. Her statement said she used a little force but not excessive. She put moisturiser on A's ear afterwards. She said that the bruise was brought to her attention by F on the Sunday.

121. In her initial statement M also provided detail as to F throwing A in the air. She said that F played a game with A where he would throw her into the air with outstretched arms. She said A would leave F's hands momentarily and F would then catch her underneath her arms with his thumbs on chest. She said that within the last two months an incident had occurred where A didn't like the game and she cried. M said she saw this out of the corner of her eye. She was in bedroom watching TV and F was standing next to her holding A. She said when F caught A she screamed all of a sudden. M took A from F and went out of the room. She asked F what happened and he said he did not know but he might have caught her wrong. M said that A was difficult to console, as she usually stopped immediately but on that occasion cried loudly for 5 minutes then calmed but took 30 mins to be fully consoled. The statement said that M and F both assumed A was upset as near her bedtime, she was teething and tired. In a later statement M said this definitely happened after 5th March 2023 when they had been on holiday.

122. F has also filed an initial response to threshold, final response to threshold and four witness statements. In these documents F also puts forward other possible explanations such as trying to stick A's ears back, rocking A and A trying to crawl and roll.

123. In his initial statement he said that he first saw the mark to A's ear on Friday 14th April. He said that initially he wondered if it was related to an incident that took place a few days earlier when A had toppled over from a sitting position and seemed to hit her head on a tower extension cable that had several plugs in it. He said that before that A was with M but she was wriggling and causing M some discomfort, so M asked if he thought A would be okay on the play mat on the floor. He said yes and M put her down. He said at that point in her development A was starting to sit up unsupported for longer and longer periods. Within a short space of time he saw A topple to the side out of the corner of his eye. He said A cried but not a high pitched or shrill cry. It was more a cry as if she was unhappy about finding herself in the position she was in and stopped immediately when M picked her up. He said he checked her ear and head but there was no redness or pain.

124. His statement also describes how M noticed white stuff on A's ear and cleaned it with a cotton bud and water.

125. With regard to the fractures, F's initial statement said he could not recall any accidents that could explain fractures to A's arms or rib but he wanted to set out his general handling of A and some incidents when he may have been more boisterous than was appropriate. He went on that he would throw A up in the air and catch her, catching her under her arms. He said she would usually laugh and really enjoyed it. However, there was one occasion when he caught her wrong and she cried. He said he would usually catch her under her arms but on this occasion he caught her by the top of both arms. He said he caught her about an inch or so down from her armpits, on the underside of her arms. He did not recall the date but said it was within the last two months of her being in their care. He described A as being difficult to console for 5-10 minutes. He checked A over after this incident and she seemed fine and not to be in any pain. He said she was easily comforted and did not show any signs of discomfort or pain after she stopped crying.

126. In a later statement of 11th August 2023, F said that A would leave his hands for a few seconds when he threw her. He accepted that this was not shown in the video M sent on 20th April 2023 but said that sometimes she would be airborne for longer. The statement went on that he caught A by the arms rather than the armpits and that A went from happy and laughing to very unhappy and crying. F said A stopped crying after a short time after but continued to be unsettled. She settled fully within 30 minutes.

Parent's Oral Evidence

Mental Health

127. When questioned by Mr Rees, M said that she felt she had post-natal depression but this was not diagnosed. She repeatedly said that she just wanted to go back on Amitriptyline which she was on before her pregnancy but the doctors refused. She said that her mental health was affected by social services involvement following A's birth; her health issues; falling out with her family; obsessive worry regarding A and hair loss. She said that she was struggling with pain and said that the only way to get the NHS to take you seriously is to say impacting on MH. She said that she had difficulties both physically and mentally.

128. She accepted that F told his father on 19th April 2023 that she was bordering on psychosis. She did believe this was correct saying that F had read up on it and read that post-natal anxiety could lead to psychosis. She denied seeing a dead chinchilla in the kitchen. She explained that one of her chinchillas had died and F left it in the kitchen. A couple of weeks she walked into the kitchen and saw a white mop out of the corner of her eye and later joked to F that she thought she had seen a dead chinchilla. She said that she did not mean this but F took it literally. This interpretation of F's comment by F is entirely in keeping with the MIND report which highlights that one of the impacts of F's autistic presentation is a tendency to interpret others literally.

129. She accepted that F had struggled with some mental health issues and that social services involvement post birth had affected both of their mental health.

130. F accepted that M was losing her hair in February. He said that this made her feel self-conscious and impacted on her mental health. He said that M was in a lot of pain from the c-section and should not have been so this also impacted on her MH. He accepted that M said she could not cope but added that M often used that phrase. He accepted telling the GP in March that M could not cope. He justified this as he said he wanted to try and get M back on to Amitriptyline which she was on before the pregnancy as this would allow her to be able to

deal better with the pain from the c-section and her ME. He said as a result of the pain M was struggling to hold A which was making her upset and anxious.

131. With regard to himself he said that he felt on top of the world when A was born but then became stressed by the local authority involvement. He could not recall telling the GP in December 2023 that he was snappy at times. He accepted that he may have been snappy and anxious. He accepted he was prescribed Sertraline around that time as he had struggled before with his mental health and wanted to pre-empt any problems given local authority involvement.

Routine

132. M said that for the first six weeks she was required to supervise all of F's time with A. She accepted that in the two months leading up to A's removal she had spending less time with A. She said that during March and April F was doing night feeds. She accepted that she would get anxious if she was alone with A and would on occasion call F back if she was in pain. She said that the longest that she was probably left alone with A was when F went to hospital due to the drill incident. She said that F did a lot during that time looking after everyone but if he was struggling or tired he would wake her up to take over.

133. To Mr Rees, she said that she was struggling due to the pain from the c-section. She felt that she was not getting any real help from medical professionals. She accepted that this did impact on her ability to handle A as she would need naps and was reluctant to carry A up the stairs. She added that at the same time F was her carer as well.

134. She said that the usual routine would be for F to sleep downstairs on the sofa with A in a bassinet as she was not well and was also anxious so would check on A every hour

135. F also accepted that in the two months prior to removal he was doing more of the care. He said he would generally do things such as meals, feeding, nappies, helping with bathtime, dressing and carrying A from one floor to another. He said that at that time he and A were sleeping in the middle floor front room with him on the sofa and A in her bassinet. He said that this was not every night but the majority of them and that he was probably doing 80% of the care but if he became tired he would ask M and she would take over.

136. He said that he would go out alone at times and leave A with M - such as when he went to the shop or to do other things. This would mean A was alone with M for sometimes 30 minutes and on other occasions an hour or so. He accepted that he had a good bond with A and in the hospital A got upset if her left her. He said that A did not get upset if left with M. Sometimes if he was out she would call him back if A would not settle but that was mainly during a time that A had cholic and like being rocked stood up which M could do that.

137. He did not accept that 23rd March when he was in hospital was the only time that M had spent more than an hour or two with A. He said that M would do nights at times. He did however, accept it was the longest time M had been alone with A without him being in the house.

Relationship

138. In evidence in chief M said that a few days before the drill incident she found out that F had been lying to her about money he was spending at Starbucks. She accepted that she was concerned that he was being unfaithful. She accepted that for a period things were bad and there was talk about divorce. She said this arguing came to a head with the drill incident.

She said that prior to this period having a baby was stressful but otherwise good. She said at one point they were taking it in turns to care for A so she did not see much of F.

139. She accepted that there were financial problems and that she was in the process of entering into an IVA.

140. To Mr Rees she accepted that things had been unsettled due to social services involvement post birth; F's past; different medication; ongoing pain; having a new born baby and F's lies. She accepted that things were particularly difficult in March. There was an issue with F going to Starbucks without telling her. There was an issue with the amount of money F would spend there and M's jealousy. She accepted they rowed about it on 20th March and 21st March 2003. F recorded these arguments and transcripts have been produced. M accepted getting angry during these arguments and saying hurtful things to F.

141. She accepted that this argument continued into 23rd March 2023 and culminated in the drill incident. She said this was the only incident of violence between them of note. She said there had been other arguments and they may have barged past each other but could not recall any examples.

142. When questioned by Miss Edmondson she accepted that things were toxic in the days leading up to the drill incident. She maintained throughout her evidence that they would not argue in front of A. She said if A was awake they would stop and message each other rather than argue in front of her. She did not accept that A would have heard the violent altercation on 23rd March 2023.

143. Having accepted the volatility of the relationship in March, when M was asked by Mr Storey KC to describe F she described him in glowing terms. She said he was a wonderful human being; head and shoulders above most men; never been treated so well; 'my family love him'; 'I do not deserve him'; 'he is not perfect but understand it more now with his autism'; we laugh most of the time even in this the worse time

144. She said that A is an extension of that. That F always wanted a good family as his family have been terrible to him. She said F has with A what she had with her F. That he loves her and she loves him and that F had never been happier.

145. In evidence in chief F described M as the most caring person he knew. He said she was sensitive - over sensitive at times which was one of the qualities he loved about her. He said she was supportive and loving. He accepted that they argued as all do but time apart and then come back together and the argument is over. He said M was the best thing to ever happen to him.

146. With regard to A, he said she was the perfect little bundle. He said he had two other children but had not seen them for years. He now feels like he has lost that again with A. Before he thought he could not put himself through having children again. He told M this but as he got to know her and the type of person she is he knew he wanted a family. He said A is so precious and clever.

147. In cross examination he said that before A born the relationship was very good. He said that apart from the March 2023 incident it was a very good relationship. Later he said after A was born it was still good but there was more stress and pressure from a new baby and

disagreements over parenting styles. Like M, he said sometimes he felt like he and M were passing ships.

148. He accepted that things were tense in March due to arguments about him spending money at Starbucks and M's jealousy. He said that this came to a head a couple of days before the drill incident. He said that the drill incident was the only physical incident between them but added (using exactly the same words that M had in her evidence) that after verbal arguments they may have barged past each other.

149. Like M, he accepted to Miss Edmondson that the atmosphere was toxic around the time of the drill incident.

Drill

150. M accepted lying in her interview under caution about there being no violence in the relationship. When asked why she said reason she was there was not there for that.

151. She did not accept that F had punched her in the face. She said it was a physical tussle and her face was hit during this. She said she thought at the time that F had punched her but now accepts it was her hand that hit her in the face.

152. She accepted pushing F's keyboard down stairs adding that she had told him for months to move it. She said that they had been arguing downstairs. F grabbed her. They grappled and she was hit to the face. She ran upstairs panicked and threw things down stairs like a can of coke and the drill. She did not accept aiming for F but accepted that they were thrown in his general direction. She said that A would not have heard any of this as she was upstairs asleep

153. She would not accept that this evidenced a loss of control of her part or that she was angry. She said she was scared.

154. As a result of the drill F sustained a cut to the head. She said that whilst he was at the hospital there were a number of phone calls but she also spoke to F over Alexa and during these calls they had made up.

155. In evidence in chief she said that when social services rang she did not want to say there had been an argument as she was worried that A would be taken off them. She accepted that she should have been honest. When questioned by Mr Rees she said that she was caught off guard when social services rang as F had already lied to them. She said the long pause in the recording is when F is telling her what he had said and that she had to go along so she did.

156. To Mr Rees she accepted she lied about the incident until filing her June statement. She said she wanted to come clean at that point and could not cope with lying any longer. She said that she knew the phone records were coming out so it was likely to come out then anyway. She said she knew from the very start that it was likely that their phones would be analysed at some point.

157. Mr Rees put to M that it was during the time that F was at hospital that she caused the fractures to A. He posited that she lost control with F and then lost it again with A when F at hospital. M denied this saying her anxiety does not show as violence but as worry. She said she would never harm A. She said that A was no bother that day - she had received her jabs that morning and was lethargic as a result. M said she stayed up waiting for F to come home

from the hospital and said that A was asleep when he did. She could not remember anything significant or memorable happening whilst F was at hospital.

158. In re-examination she said she was not angry after F left. She was worried - worried about his head and worried about what he was going to say. She said that she just played with A on the bed (which has rails) as that is easier for her to manage. She said it was just a normal day with A and nothing remarkable happened.

159. F said this argument spanned a few days and related to the Starbucks issue. He accepted that at that time things seemed pretty bad in the relationship and that M had mentioned divorce and had threatened to smash his car. He said the argument started to escalate when M pushed his keyboard down the stairs. He said the keyboard was one he had since aged 13 or 14 and had been bought by his parents as part of his music GCSE. He said this resulted in the keyboard being damaged and he said he felt 'gutted' initially, upset and angry. He denied attacking M. He said he thought M was going to damage the keyboard further so he grabbed hold of her and in the ensuing struggle M hit herself to the face. He said following this M threw a can of coke at him and then threw the drill which hit his head. He said that he believed M when she says it was not intended to hit him.

160. He said that there were no discussions between him and M during his time at the hospital where she was saying she could not cope with A. She was just making sure he was ok and he was asking how A was. He said when he returned from hospital A was asleep in bed.

161. He accepted he lied to the social worker on 27th March 2023 about what happened with the drill and that on same day he lied to the health visitor about matters. He said he lied as he wanted to protect A from further local authority involvement. He accepted he also lied to his father on 19th April 2023 in a phone call. He said he did not want to worry his father as his M was very ill.

Fall onto plug

162. M maintained throughout her evidence that A had fallen onto the plug tower in the days leading up to 18th April 2023. She said there was lots of plugs in there at the time which are not shown on the picture. She said she did not see A fall. She heard her cry so picked her up. She said her head was on the plug but accepted in cross examination that she could not say exactly where her head was. She said A cried but settled quickly when comforted. She said she did not see any redness at the time.

163. F also maintained that this incident happened. He said that he did not see it happen. He said A was sat down when he heard her cry out. He turned around and saw A laying to one side on the floor. Her head was on or by the plug. He said he did check her ear for redness but did not see anything.

164. In hospital and in his interview under caution F said that L flopped into the extension lead with the phone charger in. In evidence he stood by this and said that the white plug (phone charger with USB) was pointing upwards when A fell onto it.

Cotton Bud

165. M said that was the only time she used a cotton bud. She said that there was no reaction by A. She said saw white in A's ear and thought it was food. She tried to remove it but A was kicky and unsettled so she stopped.

166. In evidence M said she strongly believed the bruise was from the cotton bud which A then made worse by pulling or the plug made it worse

167. She said that F brought the bruise to her attention by saying do not panic A has mark in her ear. He said she did it on the plug. M said she started crying and said she did not think A had hurt herself. F said if she was concerned he would ask the health visitor when she visited.

168. M in her evidence said that she did tell the social worker about the bud but the social worker and the police officer dismissed this as she said she did not use excessive force. Later in her evidence she said that F shook his head when she tried to mention it again to stop her.

169. F could not remember the exact date that M used the cotton bud. He said he knew M had used one as he gave her the bud and some water. He said this was the first time M had used a cotton bud on A. He did not think M had been rigorous or that A had cried when M was doing it.

170. He accepted that he did not mention the cotton bud to the social worker or Police. He said he truly believed the bruise was from the fall onto the plug.

171. F did mention it during the child protection medical. He said this was because as medical professionals they would want to know all of the circumstances around what happened for examination and treatment. He was unable to explain why the same logic did not hold true for the GP as he did not mention the bud to her.

172. He agreed with M's evidence that he had shaken his head when she tried to tell the social worker and Police. He said he did this as M had already told them about the cotton bud and they said obviously not that as M said she had not used excessive force. He said when M mentioned it again he was concerned that they would think they were trying to fabricate or change the story so shook his head to tell M to stop.

Throw

173. M said she saw F do this many times. She did not like him doing it as she is very cautious. She said she could remember an occasion where A did not like it. She could not recall the exact date but said it was after the holiday in March. She said she did not see what happened as whilst she was in the same room she was watching television. She said out of corner of her eye she saw A in the air laughing but then heard a loud cry. She said she had not heard it before as A went from laughing to crying. She said A cried for about 5 minutes and was not herself for around 30 minutes. To Miss Edmondson she said that straight afterwards F said that he caught her by arms wrong. She seemed to accept that A was not thrown really high but also said that she did not see it as she was watching television. She accepted that she should have asked F more about what had happened but said she was more focused on settling A. She said she discussed with F that if A did not settle after 30 minutes then they would take her to hospital

174. In cross examination she said that she had seen A leave F's fingertips before but usually it was not far from his tips. She accepted that F's messages to her from hospital said that A had winced and that she had not corrected him. She said that F downplayed it massively.

175. She accepted that F did not mention this to the police. She said she asked him after the interview if he had mentioned it and he said he had. It was not until the transcript came

through that she saw he hadn't. She said had she known at the time she would had dragged him back there to tell them.

176. In cross examination F accepted that he did not mention this in his police interview. He said that he was scared as he knew he had thrown A so the injuries were caused by him. He said it was an accident but he was still scared. He said that he had been in hospital for 2 days; overnight in a police cell and was scared of what would happen to him and to M and A.

177. He maintained that the accounts in his statements were correct and that on one occasion he threw A and caught her by the tops of her arms. He said he was in the bedroom. He said A went from laughing to crying quickly. He said he would not have called it a scream - it may have been a shriek but not a big scream. He said he checked A over and she seemed fine but was difficult to console for about 5-10 minutes. He said that he regularly threw A in the air to catch her but on this occasion she was in the air for longer than usual. She would not usually leave his fingertips and he would usually catch her under her armpits but on this occasion he caught her by the arms.

178. He was questioned by Mr Rees regarding the messages whilst in hospital. He said that he and M were wracking brains to see what could have happened. He did some research and thought initially it may have been from the C-section. He said that M raised the incident of him throwing A in the air. He said that he did remember the incident and what he meant in his message was he could not remember when it happened. He said it stood out as it was the only time A had cried when playing like that.

179. He did not accept that his account had developed regarding the throw after receipt of Dr Olsen's report.

Amanda Reed

180. Amanda Reed was initially commissioned as an ISW to prepare the parenting assessment. She did not complete the report as for unrelated reasons she made a decision to stop independent assessments immediately. She has filed a statement in this proceedings setting out what she viewed as inconsistencies in accounts given by M and F in her sessions with them. She has also produced her hand written notes of the assessment sessions. She was warned to attend as a witness but ultimately was not required by M or F.

181. There were issues in the working relationship of Miss Reed and M and F. M was not happy with Miss Reed. She said that she did not keep to what the court had asked her to do. She said that Miss Reed shouted at her; called her lazy and did not recognise her disability. Later in evidence she questioned the qualifications of Miss Reed and suitability to carry out the assessment as she is not a registered or qualified social worker.

182. She said that F was wrong when he gave a date to Miss Reed about when the bruise was first noticed. She said that he did not know and was just guessing. She said she was the better historian as she will only say if 100% sure whereas F will say even if not sure.

183. F says he found Miss Reed's style of questioning bullying and attacking. He said he was confused by her approach at times particularly in relation to NAI and accidental. Injuries.

184. He did not agree with the entirety of AR handwritten notes. He accepted that he had given different accounts as to when he first noticed the bruise. He said that he had given different

dates at different times as trying to do the best he could. He said he could not remember the date he saw the bruise but felt when asked that he needed to give a date.

Deleted Messages

185. We do not have access to any messages prior to 18th April 2023 as both M and F deleted them from their phones whilst F was in hospital.

186. M accepted doing this. She said this was done before the fractures were identified as she did not want social services to take things out of context.

187. F also accepted deleting messages whilst at hospital as M was speaking to someone through a group and they said SS would want to look through their phones and would try and twist messages. He said he deleted his entire WhatsApp history up to that point.

Health Visitor

188. For the first time in cross examination M said that she was not up when the health visitor came as she was in bed after cleaning all night and that her ME had been fine that night. This was completely different to what F told the health visitor.

189. F accepted telling the health visitor on 18th April 2023 that he was concerned about M's mental health. He clarified that he was concerned about her anxiety and the amount of pain she was still in. He wanted M to be seen by someone to alleviate the pain.

190. Like M, F for the first time in evidence F said that both he and M had been up all night cleaning the house which is why M was in bed. He accepted not telling the health visitor that as he did not see it as relevant. He said he was focused on getting M mental health looked at due to the pain she was in.

191. He accepted that he did not show the health visitor the bruise as he said he was not concerned about it. He said that he had told M that if she was worried he would show it but he made a judgment call himself not to as he did not think it was anything to be concerned about.

Consideration of the medical evidence

192. Following the oral evidence of the experts it was apparent that they were not entirely in agreement with each.

193. There is no dispute:
    a. That A sustained metaphyseal fractures of the right and left humerus.
    b. That the fractures were almost exactly symmetrical in location.
    c. That it is not possible to accurately date but the fractures were roughly between ½ and a month old as at 18th April 2023.
    d. That there is no radiological sign of an underlying abnormality.
    e. The likely mechanism for a metaphyseal fracture at the shoulder is abrupt pulling of the arm and/or forceful twisting of the arm, if the rotation is beyond what the shoulder joint will accommodate naturally.
    f. That A sustained a bruise to the concha of her left ear measuring 0.5x0.5cm.
    g. That there is no evidence of a bleeding disorder.

194. There are issues of disagreement as to:
    a. Whether the explanations put forward by M and F are plausible.

b. The extent to which A may have a genetic condition and what impact that may have on her susceptibility to suffer bruises or fractures

195. Dr Olsen is a vastly experienced expert and I found him to be an impressive witness. He was in his evidence open to an unknown cause. For the first time in his evidence it became apparent that it was his opinion that the mechanism of throwing A in the air and catching her by her arms could account for the symmetric fracture presentation and this was with or without the presence of a genetic condition. He set out clearly his reasoning for this by reference to the gravitational forces at play as A descended which would create tractional force if A were caught by the arms. Mr Rees submitted that Dr Olsen only said arm singular and that there would need to be two separate incidents of a similar nature to explain the fractures. I do not accept that submission. Dr Olsen may have said arm but it was in the context of F throwing A in the air and catching her by her arms. Dr Olsen said:

> *"Assumption is then that the child had been caught around the front of the chest but as we know from this case it has been suggested that the child was caught by the arm and that would of course be a different situation. Throwing a child in any direction letting gravity do it's job and then catching child by the arm would of course induce a very severe traction of the arm and traction of the arm is one of the possible mechanisms for a fracture of the nature seen here."*

196. He went on:

> *"Child who has some speed due to gravitational acceleration if caught by the arm one would easily accept that would lead to traction of the arm beyond what seem part of reasonable handling."*

197. I have no hesitation in accepting that the evidence of Dr Olsen related to the mechanism of throwing A in the air and catching her by her arms. It was a mechanism which Dr Olsen accepted as being plausible.

198. Dr Saggar is also vastly experienced and well known to the courts. He gave evidence in a calm, measured manner. He was more than willing to discuss alternative theories and explain why he disagreed. He explained clearly the issues that he had with the research of Professor Hollick whilst at the same time accepting that very much is still unknown about HSD. He readily accepted that there is an association between HSD and easy bruising. He was less ready to accept an association with fractures given the lack of accepted research. He said even if there was a susceptibility he would still want to hear of some sort of precipitant event.

199. Dr Saggar assessed M and A. His evidence, which I accept, was clear that he had no doubt M had HSD. The only reason he did not say she had the more severe hEDS was because M did not meet the strict 2017 criteria. His evidence was equally clear that genetically A has a 50% chance of inheriting HSD and that from features he identified in his assessment he was willing to say A had more than a 50% chance. He was equally clear that if A did have HSD she would be more vulnerable or susceptible to bruising with a lower degree of force.

200. Mr Day submits that based on his diagnosis in clinic; the tests on M and his wealth of experience Dr Saggar was more than happy to accept that the injuries were caused by the cotton bud/fall on the plug and throwing in the air by F. I do not accept that his evidence went as far as that. His evidence was that the cotton bud was plausible and the fall onto the

plug more plausible and that given the view of Dr Olsen he would accept the throw as a plausible and precipitant force.

201. Dr Alu is also very experienced. She has 34 years' experience. 23 of which are at consultant level. Generally, I found her to be a less impressive witness.

202. In evidence Dr Alu confirmed that she had read the agreed note of the evidence of Dr Olsen and Dr Saggar but did not seem to appreciate that Dr Saggar's evidence was that A had more than a 50% chance of having HSD. Dr Alu would not consider, or did not appear to consider, or reflect on the opinion of Dr Saggar that A most likely has HSD. She kept repeating that it was not a clinical diagnosis and, if A were her patient, she would be treating her as not having HSD. The difficulty with this approach was that Dr Alu came across as having a restricted and rigid viewpoint. The only extent to which any consideration was given as to HSD was Dr Alu repeatedly saying that even if A did have HSD that was not mutually exclusive to NAI. She did not seem willing to consider that if A did have HSD the potential impact that could have on her susceptibilities.

203. She said that she deferred to Dr Olsen, but then proceeded to not accept his evidence that a throw in the air and catch by the arms was a plausible explanation. She kept saying that this would not result in a twist and therefore was not a plausible explanation. Dr Olson's evidence was clear in this respect that a throw and catch by the arms could create the tractional force required to result in a metaphyseal fracture and therefore was plausible. It was only very late in her evidence that Dr Alu reluctantly conceded that if Olsen said it was plausible then in her words it may be.

204. In respect of the bruise Dr Alu's evidence was that she had only considered the photograph of the extension tower that day. She said she could not imagine how a fall onto that tower, would result in an injury to the concha, and yet not injure the outer aspect of the ear. F's explanation from an early point (in hospital, police interview and initial statement) has been that the phone charger was plugged into the tower. He said in his police interview and in his oral evidence indicating that the charger and USB lead may well have been pointing upwards. This was not considered by Dr Alu. It was not considered whether that would account for an injury inside the ear whilst sparing the outer aspects of the ear.

205. The bruise has been described by a number of professionals as being in an unusual location. The health visitor said that she could not recall seeing an isolated bruise in the concha of the ear in her 26 years as a health visitor. The social worker commented that it was an unusual place for a bruise. Dr Alu seemed very reluctant to accept this. She did say that she could not recall seeing another bruise of this nature in her 30 years' experience but added in my judgment somewhat sarcastically "I do not file away in my brain where to the ear it has been".

206. Numerous comments have been made about A's skin. Dr Saggar commented on her skin and marks left by his exam. The GP during the consultation on 18th April 2023 said that A appeared to have sensitive skin. I fully accept that the foster carer did not share this view. She felt that A presented as no different to any other child in terms of marks or bruises. I of course have regard to her experience as a foster carer, parent and grandparent but she, on her own admission is not an expert. Mr Day in his closing submissions has compiled a list of entries from the foster carer logs which he submits supports the view that A marks easily.

207. The foster carer was at the consultation with Dr Saggar but could not recall the marks that Dr Saggar references in his report.

208. I accept the evidence of Dr Olsen and the evidence of Dr Saggar. There is clear evidence from Dr Saggar that there is more than a 50% chance that A has HSD. There is very much that is unknown about HSD. It is uncontroversial that HSD is associated with easy bruising. What we do not know is the extent to which A will be affected by it.

209. The issue as to susceptibility to fracture is much less clear. There is an absence of credible research on the matter and there remains uncertainty. However, it may not be of significance in this matter as the opinion expressed by Dr Olsen was put on the basis that it was irrespective of any bone fragility.

210. Mr Day says that the court can confidently find that Dr Alu was both a dogmatic and self-opinionated witness. I have reservations about her evidence but would not extend to this conclusion. She had a rigidity about her approach and thinking that was unhelpful. She had her own opinion as to what was right and would not consider or reflect upon the opinion of others to any great extent.

Consideration of Parent's Evidence

211. The medical evidence does not provide a definitive answer in respect of this matter. It is of course necessary to consider the expert evidence in the context of all other available evidence. As Mr Rees said in his oral submissions the parent's evidence is of the utmost importance when considering plausibility. His written submissions state that the evidence of M and F is not reliable and has developed over time to fit the expert evidence.

212. I had the immeasurable benefit of observing M and F over the course of the hearing and listening to their oral evidence. Both M and F gave evidence in an entirely appropriate and calm manner. Mr Rees expresses some cynicism about F's evidence and the extent to which he required assistance from the intermediary. I fully accept that F had a wide and impressive vocabulary. That was of no surprise to the court. The MIND assessment said:

> *"F was verbally fluent, speaking in a combination of complex and simple sentences. No overt grammatical, syntactical, or semantic errors were present in his spoken language. His speech and vocal patterns were typical, with no obvious atypicality evident in his intonation patterns, speaking volume, rhythm, or pitch. No examples of immediate echolalia were present and his phrasing was not overtly stereotyped, idiosyncratic, or repetitive."*

213. The MIND assessment was not challenged nor to any great extent were the assessments of three intermediaries who assessed F and gave recommendations as to participation directions that were required to enable F to effectively participate in the proceedings.

214. Both M and F have at times told lies. They accept that. They lied to multiple professionals about the true extent of the drill incident. People lie for many reasons. M and F had previously had local authority involvement. They knew that an argument which led to F sustaining a significant laceration to his head would most likely result in further involvement. F initially told the truth whilst at hospital but then tried to change the narrative when social services rang him on 27th March 2023. There is a clear gap in the recording of that discussion and I accept M's evidence that F was telling her what he had told the social worker and

asking her to go along with it. The reason for the lie was to mislead social services and to prevent any further involvement. It is however a significant leap from that to an inference that they are lying about causation of injuries to A.

215. It is clear from the evidence that there were struggles in relationship. M has longstanding anxiety and physical difficulties. I have no doubt these were exacerbated by the birth of A and the ongoing pain from the c-section. M found herself limited in terms of the care she could provide A and in the months leading up to A being removed F was carrying out 80% of the care. That does not mean that M was incapable of caring for A. In the first six weeks post-birth M had to supervise all of F's time with A. She continued to play an active role with A an would take over when F was tired or required a break.

216. The difficulties were further compounded in March by F lying to M about his expenditure at Starbucks. This led to a number of arguments. There are transcripts of the arguments on 20th March and 21st March. They accept that the atmosphere was toxic between them and matters escalated further on 23rd March when there was a violent physical altercation between them which left F needing hospital treatment.

217. I have considered carefully the evidence and find myself unable to ascertain exactly what happened that day. It was clearly a volatile situation. There was clearly a physical struggle between M and F during which time M was struck to the face. I do not make the finding sought that F punched her to the face. That may have happened but I am not satisfied on the balance of probabilities that it did. It is perhaps of little relevance as it is clear that M and F physically tussled with each other and during this tussle M was struck to the face. There was shouting and both M and F were angry. F's keyboard became damaged and M threw a drill down the stairs knowing that F was at the bottom of the stairs. That drill struck F and caused a significant wound. I do not accept M's evidence that she was not angry when throwing the drill. She had been arguing with F for a number of days. This culminated in the physical altercation and in anger M threw the drill in the direction of F. Even on their own account this was an unsavoury incident all of which took place when A was in the house.

218. I do not minimise or condone such incidents but it must in my judgment be viewed in the context of other evidence or absence thereof. The local authority have received no other PPNs or third party referrals raising concerns about the relationship or domestic abuse. No concerns have been raised by other professionals (save for Maria O'Neil who questions whether there is power imbalance in the relationship). There are no other hospital attendances or evidence of injuries being sustained on other occasions. M and F accept that they argue and accept that in the past they may have pushed or barged past each other following a verbal argument but there is no evidence that the 23rd March 2023 was anything other than an isolated incident.

219. The parents credibility is not assisted by the deletion of all material from their phones on 18th April 2023. During the course of her many messages it was raised with M that the local authority may well view their phones and use the contents against M and F. This message was received at 23:26 on 18th April 2023. By that time it would appear that M and F had already deleted much of the content as suggested by F's message at 21:45 in which he said 'true all deleted'. M and F said they did this out of a fear that the local authority would twist things. This was without doubt a poor and inadvisable decision by the parents. Mr Rees raises the inevitable point that messages were deleted because M and F had something to hide. He asks me to draw that inference.

220. I consider the deletion of messages in the context of F being in hospital with A and M being at home. They had a whirlwind of a day. M had been messaging various friends about matters throughout that day. M and F's own evidence is that if A was awake they would stop arguing and continue their argument via messages rather than do it in front of A. I have no doubt that the messages deleted would have provided an insight into the relationship and would have most likely contained messages evidencing their arguments and issues within their relationship. I draw that inference but I do not draw the inference sought by Mr Rees that they deleted messages to hide incriminating evidence about the injuries to A. At that stage the only injury that was known about was the bruise to A's ear in any event.

221. Parents have lied at times to professionals. That does not mean that they are lying about everything or that their credibility is fatally undermined. When considering the explanations put forward by M and F it is clear that the fall onto the extension tower was put forward at the earliest opportunity by M & F. It was put forward to the health visitor, the GP, the social worker and police officer and during the child protection medical. Throughout F has said there were other plugs in the tower (police interview and initial statement). The cotton bud was not mentioned until the child protection medical but that took place the same day as the health visitor appointment. So within 9 hours of concerns being raised both explanations have been put forward

222. M and F have maintained both explanations since. In my judgment there has been limited if any development or evolution of the events. There have been some inconsistencies in respect of the date when the bruise was first noticed; about whether they intended on telling the health visitor; about whether M was in bed unwell or from cleaning all night but any inconsistencies do not, in my judgment, detract from the consistency of the actual explanation. A fell sideways onto plug and landed on the extension tower which had various plugs in it. The length of time A was sat was given at various times as 10-20 seconds or a minute. I take nothing from this difference but note that it is consistent with the social work assistant observations at hospital that A was able to sit for up to about a minute but would then topple sideways

223. I have set out individual text messages sent whilst F was in the hospital earlier in this judgment but have also considered the entirety of the exchange between M and F including the transcripts of the phone conversations on 20th April together with the entire message threads between M and various friends and acquaintances

224. Mr Rees submits that M did not attend at the hospital as she was trying to avoid professionals. The inference being that M had something to hide. M said she thought that only one of them was allowed to attend at the hospital. Mr Rees submits this is a further lie by M. In the body of the messages there are messages to Rl at 23:01 on 18th April and to P at 18:35 on 19th April. In both of these messages M says that both of them were not allowed to go to the hospital as they were both in the room when it happened. This may not be factually correct but is, in my judgment, a clear indication of what M thought the position to be at the time. It is inherently unlikely that M has not only stayed away from the hospital to avoid professionals but has then also concocted a reason for that decision in a message to her friends. M did not attend at the hospital as she was under the misapprehension that only one of them could be there. She said, and I accept, that she would have struggled at the hospital due to her physical health and therefore decided F should be the one who attended.

225. The message exchanges in my judgment shows M and F struggling to understand what is going on after the devastating news that A has 2 fractured arms. F's immediate response was to Google it and find that injuries from the c-section were a possibility. M replied asking why they would show up after six months to which F said he would get them to age them.

226. Less than 15 minutes after finding out about the fractures M was putting forward possible explanations of whatever she could think of. She sent an image of F holding A underneath her arms asking if that could cause it.

227. F showed his bewilderment by stating within half an hour (at 12:24) of the discussion beginning that A had never stopped using her arms.

228. There was a phone call at 12:25. This call is around 30 minutes after F had told M about the fractures. I have considered the transcript of that call repeatedly. In my judgment it is a conversation between two people who are confused at the injuries A has sustained. I do not get the impression from that conversation that M and F are concocting an account that would explain the fractures.

229. At 13:37, within 2 hours of F finding out that A had fractures and after various messages where M and F were racking their brains to think of an incident that could account for the fractures, M raises the issue of father throwing A in the air. Mr Rees says that M knew the location of the fractures by this time as F said upper arm in the messages. I do not accept that submission. It is clear from the phone conversation at 14:29 that F himself did not know at that point where on the humerus it was. F knew it was the upper arm i.e the humerus rather than the forearm. He did not know where on the humerus and nor did M.

230. There was a further phone call at 14:29 when again M and F discussed possible causes. M queried whether a seat belt could have caused it before again raising the throw in the air.

231. In my judgment there was limited opportunity for M and F to liaise or concoct a story in that time. We have a clear record of the communication that took place between them via the messages and call transcripts.

232. I also consider the messages M was sending to friends at the time. She sent messages to S, Pr and E saying that fractures had been found and she had no idea what caused them. She messaged Pr at 12:59 saying she wished she could explain it but she was not going to say that A had a big fall because she did not.

233. I have considered all of the messages that we have over 18th to 20th April 2023. The entire tone of the messages and the wider conversations are in my judgment indicative of genuine worry and concern. M and F are brain storming for an explanation that could account for how A has fractures to both of her arms. They are not contrived nor in my judgment do they support the theory that the throw is a concocted explanation. At the point the throw is put forward even M and F did not think it was an explanation. The 13:37 message from M says saying it is a fall but didn't you catch her wrong once. As an explanation it did not fit with arm and rib fractures at all.

234. I have considered the evidence carefully together with the likelihood of parents concocting an explanation within an hour of F discovering the fractures that has ultimately been accepted as plausible by the radiologist. There has been some development in terms of the detail of this explanation, but the fundamentals of it have not changed in that within a short

space of time it was said that F threw A in the air often, and on one occasion at least caught her wrongly. Mr Rees submits that F's account has developed in line with the expert evidence. Dr Olsen's report is dated 22nd July 2023. F in his initial statement dated 18th May 2023 said:

> *"I would throw A up in the air and catch her, catching her under the arms. She usually laughs and enjoys it. However, there was one occasion when I have caught her wrong and she cried. I would usually catch A under her arms but this occasion I caught her by the top of both arms…"*

F's account has not developed in that respect. The mechanism he put forward in his initial statement pre-dated Dr Olsen's report and is the mechanism that Dr Olsen now accepts as being plausible.

235. The local authority are right that F does not mention the throw in the air during the course of his interview under caution. However, that interview must in my judgement be viewed, not only in the context of F's autism, but also in the context of the events of the proceeding days. Father was interviewed at 11:10 on 21st April. He had not been home since 18th April having spent the night of 18th April and 19th April in hospital with A. He was then arrested at 16:06 on 20th of April and kept overnight in the police cell before being interviewed in the morning of 21st of April. I have no doubt he was tired, confused and concerned.

236. F explanation as why he did not mention it in the interview is entirely credible. He was scared. Scared that he would be blamed even though it was in his mind an accident.

237. I have considered carefully the submissions of Mr Rees and the wider context points he makes regarding social isolation; domestic abuse; parental stress and distress, including depression or other mental health conditions. Many of the matter raised by Mr Rees are factually correct but every household has stresses. The combination of physical and mental health issues; a new born baby and arguments in March would undoubtedly have meant there were pressures in the house. But standing back and looking at all of the evidence there is no doubt that A was cherished and loved. She was thriving in the care of M and F and they were obviously doing many things well. I have regard to the following protective and positive features that are abundantly apparent from the evidence:

   a. Observations of Family Time have been overwhelmingly positive. M and F have engaged well with L and there have been no issues with their care within the confines of contact;
   b. M and F clearly had nurturing parenting skills. A was thriving at her six week check and again at her six month check when she was said to be thriving and meeting her developmental milestones. The parents were clearly doing many things right in their parenting of A;
   c. All professionals throughout have had nothing but positive comments about the interaction, relationship and care, particularly of F;
   d. The video albums and photos F produced during the hearing. They are in no way determinative, but evidence in my judgement, the deep extent to which A was loved and cherished within this family unit.
   e. The parents heartfelt and endearing way in which both parents referred to and describe A;
   f. The fact that A was not being hidden away. The parents could easily have cancelled the health visitor appointment on 18th April 2023 but did not do so. The health

visitor herself said no issue would have been taken with a cancellation. She would have simply rearranged it.

g. F sought out and made an appointment with the GP. He did not try and hide away. I do not condone F's recording of discussions but as a result we have a transcript of that appointment. F was open with the GP and gave a consistent account with regard to the bruise to the ear.

h. There are no drug or alcohol issues

238. F was the main carer in the weeks leading up to 18th April, but it would be a disservice, in my judgment, to M to say that she had not cared for A. She was the primary carer for the first six weeks of A's life and thereafter whilst F did the majority of the care they would still take turns, including night shifts.

239. The fall onto the plug was put forward immediately and the cotton bud that same day. The accounts of this have remained consistent since. The GP noted that A able to sit up but was wobbly and could fall to either side. The foster carer when A went into her care said she was a bit wobbly sitting up properly. A was observed in the hospital to be able to sit up for up to a minute. All of this is consistent with the account of M and F that they put A sat up on the floor and within a minute she fell to one side.

240. The description of F throwing A was put forward within a short time of the fractures being identified. F has at times referred to A's reaction as being a wince. This seems to be a word that F uses. He used the same word to describe A's reaction to falling onto the plug during the consultation with the GP. I accept the evidence of the P that A cried after the throw in the air and continued to do so for 5-10 minutes and took up to 20 minutes to fully settle. I accept the evidence that A cried after falling onto the plug but settled when comforted by M.

241. There is no evidence from any of the medical professionals that there would have been any prolonged reaction from A after sustaining the fractures. Dr Alu said with metaphyseal fractures there is often no swelling, redness, bruising, deformity or reluctance to use the arms. There may be nothing to alert a carer whether present or not that A had sustained a significant injury such as a fracture. F said he checked A over following the throw but the signs that he was checking for, on the evidence, may well not be present following a metaphyseal fracture.

242. Dr Olsen accepted the throw as being plausible. He did not caveat this by reference to any particular height that A would have to been thrown. Miss Edmondson suggested to M that unless A was thrown really high gravity would have no effect. In my judgment that cannot be correct. If A left F fingers there would be period however brief of going up before coming back down. Gravitational acceleration would be caused coming back down and this is exactly what Dr Olsen was referring to. I accept F's evidence that on one occasion he did throw A when she was in the air for longer and then caught her wrongly. Dr Olsen's evidence was that if F then caught A by arm as she was coming down this would create tractional force and would be plausible as an explanation for fracture.

243. With regard to the ear. It is clear that a bruise to the concha is unusual. The health visitor had not seen it in 26 years and Dr Alu could not recall seeing in 30 years. The concha in a 6 month old child is very small. There was no bruise or injury to the outer ear. It is likely to have been caused by a small object coming into direct contact with the concha. M and F

have always said that A fell onto the extension tower which had other plugs in it including a charger plug with a USB. Dr Alu did not consider whether that could have caused the injury.

244. I am required to view the evidence in its entirety. From the medical evidence plausible explanations were accepted by Dr Olsen and Dr Saggar. Medicine has a great deal to learn about HSD as is clear from Dr Saggar's evidence. There are aspects of the unknown and uncertainty regarding HSD and its impact on A. Dr Saggar said it is well described that the milder form, hypermobile spectrum disorder (HSD) is associated with easy bruising and bleeding. He said that he could not rule out a susceptibility in A to fracture from lesser force but there would still have to be a plausible force that could be seen as a precipitant. In evidence he deferred to Dr Olsen re the throw mechanism and accepted it as being a plausible and precipitant force. I cannot discount the possibility that it has some relevance in this case.

245. I am satisfied that the evidence of M and F is accurate when they describe the throw in the air; the fall onto the plug and the use of the cotton bud.

246. Dr Saggar said the cotton bud was plausible and plug more plausible. Dr Olsen said that the throw in the air and catch by the arms was plausible.

247. It is for the local authority to prove on the balance of probabilities that the injuries are inflicted. I remind myself again of **Re FM**

> *"Where, as here, there is a degree of medical uncertainty and credible evidence of a possible alternative explanation to that contended for by the local authority, the question for the court is not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability' ."*

248. For the reasons set out I am satisfied that in this there is credible evidence of a possible alternative explanation for A's injuries. I am not satisfied that the local authority has proved its case on the simple balance of probabilities.