Case No: BW15C000

Neutral Citation Number: [2015] EWFC 59

IN THE FAMILY COURT

8 July 2015

Before :

THE HONOURABLE MR JUSTICE PETER JACKSON

Sitting at Barrow-in Furness County Court

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Between :

CUMBRIA COUNTY COUNCIL **Applicant**

-and-

Q (mother)
H (stepfather)
C (father)

-and-

H & O (by their Children's Guardian) **Respondents**

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Peter Rothery and Patrick Gilmore (instructed by CCC) for the Local Authority
Gillian Irving QC and Zimran Samuel (instructed by GT Stewart Solicitors) for the Mother
Julia Cheetham QC and Arron Thomas (instructed by Clarkson Hirst) for the Stepfather
Jenny Scully (instructed by Gaynham King & Mellor Solicitors) for the Father
Michael Kennedy (instructed by Denby & Co) for the Children

Hearing dates: 23-25, 30 June & 1-2 July 2015. Judgment date: 8 July 2015

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JUDGMENT

JUDGMENT:

Cumbria County Council v Q (Injuries to Infant with Bone Disorder)

Mr Justice Peter Jackson:

Introduction

1. These proceedings concern two boys: H (aged 5) and O (aged 1). Until the end of last year they were living with their mother and her partner, Mr H. Since proceedings began they have lived with their maternal grandparents.

2. There are three applications before the court:

   (1) The local authority's application for care orders.

   (2) The father's application for parental responsibility.

   (3) The paternal grandparents' application for a special guardianship order.

3. During the hearing the parties reached agreement about how each of these applications should be decided and I made orders conferring special guardianship on the paternal grandparents, parental responsibility on the father and a one-year supervision order on the local authority. I will also make a declaration of parentage so that the father's name can be added to the children's birth certificates.

4. The outstanding issue is a factual one. O was brought to hospital at the age of 5 months with a fractured skull, three older fractures, and an account of having fallen off a sofa. Medical opinion is that this would be a highly unlikely explanation for the skull fracture but for the fact that O may have been suffering from Vitamin D deficiency rickets at the time, leading to his bones being more susceptible to fracture. This issue needs to be resolved so that it is clear why the threshold has been crossed and why the children cannot live with their mother.

5. The local authority, quite properly pleading its case at its highest, contends that the evidence overall permits or supports the conclusion that the injuries to O were inflicted by the mother, by Mr H, or by both of them. The mother and Mr H deny that they knowingly caused any injury to O, but say that if injury was inflicted, the other must be responsible. The father takes a neutral position, as does the Children's Guardian.

The hearing

6. Evidence was given over the course of five days from these principal witnesses (*evidence read)

Family members

The mother
Mr H
*The father
*The paternal grandparents
* Mr H's parents

Medical professionals

Dr O, consultant paediatrician
Dr S, consultant ophthalmologist
Dr A, consultant paediatrician
Dr C, paediatric neurosurgeon, RMCH
*Dr U, specialty doctor, A&E
Ms S, health visitor
Nurse A
Nurse C
*Nurse P

Expert medical witnesses

Mr Peter Richards, consultant paediatric neurosurgeon, John Radcliffe Hospital, Oxford
Professor Stephen Nussey, Professor of Endocrinology, consultant endocrinologist, St George's Hospital Medical School
Dr Kathryn Ward, consultant paediatrician, Airedale General Hospital
Dr Andrew Watt, consultant paediatric radiologist, Royal Hospital for Sick Children, Glasgow
*Dr Stavros Stivaros, consultant paediatric neuroradiologist. Royal Manchester Children's Hospital (RMCH)
*Dr Sarah Dixon, consultant paediatrician, RMCH
*Professor Zulf Mughal, consultant in paediatric bone disorders, RMCH
*Professor Sally Kinsey, consultant paediatric haematologist, The Leeds Teaching Hospitals

Social work professionals

Liz Allen, social worker
Claire Patel, Children's Guardian

Background

7. I will record the general background and consider the broader welfare issues before turning to the evidence about O's injuries.

8. The mother and the father, who are both in their mid-20s, met in a hostel. They never lived together and their relationship did not go much beyond the conception of the children at different points in time.

9. The father now lives with a partner. He served an eight month sentence of imprisonment for possession of an offensive weapon, being released in May 2014. After the children were born the mother resisted his efforts to see them and he has only had more regular involvement since they have been living with their maternal grandparents.

10. The mother has a difficult family history, being known to children's services during her childhood and having long been estranged from her own mother. She has a number of criminal convictions, including an offence of violence, which is also a feature of a past personal relationship and of her present relationship with Mr H.

11. In fairness to the mother professionals involved with the family in the past were satisfied with the care the children were receiving. H was noted to be a fit, happy and healthy child, with good presentation and attendance at school. O's health visitor, Ms S was generally positive about the care being given to him, his development and the attachment between mother and baby.

12. The mother is a person of at least normal intelligence who is now a troubled and vulnerable young woman. She has made a number of more or less serious attempts at self-harm over the years, including two earlier this year and one during the hearing. These may be an attempt, perhaps a subconscious one, to exert some sort of control over her situation. She has begun to receive the support she clearly needs from mental health services. She has not been in attendance for significant parts of the hearing though she was fully able to give evidence. She has not attended to hear this judgment but has sent a letter expressing her love for the children, her sadness at losing them, and her determination to get well for their sake.

13. The mother and Mr H met on the internet in March 2014. In July, when O was a week old, they moved in together and became engaged in August. However, they then separated for about six weeks before Mr H returned to the home in around October.

14. Mr H, who is a few years older than the mother, has an older child he does not see. He has experience of looking after small children and when he was living in the home, he played a full part in the children's care. In this brief period he was an active father-figure to H and would feed and change O regularly, including at night and when the mother was out. The mother is generally complimentary about Mr H's treatment of the children.

15. Mr H has a criminal record for violence, having served three significant periods of imprisonment between 2009 and 2012. As with the mother, his previous

significant relationship was characterised by violence. Mr H has also suffered from poor mental health and takes regular medication.

16. There have been a number of occasions when the mother and Mr H have assaulted each other in the course of their frequent arguments. For example, he has kicked and injured her in the ribs, and on 23 October he pulled her down by her ankle when she was standing on the stairs. She has hit him on the head with the stiletto heel of a shoe that she was holding, gashing his head (having heard them both, I reject her account that she merely threw the shoe at him). The mother accepts Mr H's account that she has a tendency to be violent when she has been drinking.

17. On 5 November, the mother called the police, saying that Mr H had come back and was trying to break into the house, breaking the glass in the back door. This episode was not much explored at this hearing, beyond the ventilation of conflicting accounts, but it illustrates the difficulties that existed.

18. The relationship between the mother and Mr H has continued during the course of this year, though somewhat hampered by bail conditions. It is volatile, unhealthy and dysfunctional. They both say they recognise this, but they have still continued to be together and the mother is now expecting Mr H's baby. On 3 June, they moved out of the county to live together in a rented flat. During the course of the hearing, the mother took steps to remove her belongings from there, but did not carry through with this and was instead admitted to hospital after taking a number of tablets.

The children's future

19. For the past seven months, the children have been staying with their maternal grandparents, who live a long way from Cumbria. However, after assessment, the local authority found itself unable to recommend them as long-term carers, proposing instead that the children should move to their paternal grandparents. This proposal, which was supported by the Children's Guardian, was a blow to the maternal grandparents but they have unselfishly accepted it. They have fully cooperated in planning the children's transition. The plan is for the maternal grandparents to visit the children in Cumbria and for the children to stay with them for holidays.

20. The Children's Guardian describes the paternal grandparents as *"a steady ship and a safe pair of hands".* She expects that the children will flourish. They are making a permanent move. The grandparents have made a commitment to look after them throughout their childhoods, as reflected in the special guardianship order. One advantage of the children being in this branch of the family is that the paternal grandfather has achieved the mother's respect, which is a hopeful sign for future contact and for the maintenance of boundaries.

21. The way that the maternal grandparents stepped in for these children in a crisis and the way that both sets of grandparents are now working together shows high quality grandparenting all round and I am sure that in time the children will thank them for it.

22. I also wish to acknowledge the dedicated work of the social worker, Ms Allen, and the Guardian, Mrs Patel on behalf of these children. Their input has been intense, particularly recently, showing the mother's capacity to draw in professionals to meet her immediate needs.

23. A detailed support plan has been prepared, covering the children's move and the longer term support that the local authority will provide.

Why the children cannot live with the mother

24. Regardless of any finding about O's injuries, the local authority has established that a household occupied by the mother and Mr H is not a safe environment for a small child because of the risk of the child being caught up in adult violence, and because of the pernicious effect of witnessing behaviour of this kind, as H has done on at least some occasions.

25. I therefore find, as the mother to her credit accepts, that both children were at risk of suffering significant emotional and physical harm as a consequence of the domestic violence within the mother's relationship, her poor mental health, her attempts at self-harm and occasions when she struggles emotionally, all of which severely affect her ability as a parent.

26. I further find that the mother can mislead those who do not know her. She is articulate enough to have misled a very experienced social worker and Children's Guardian by assuring them that she had separated from Mr H, to the point that until two months ago the care plan was for the children to return to her alone. This would have been a disaster, particularly for H who would like to live with his mother and will need sensitive support and explanations in the forthcoming move.

27. For his part, Mr H helped to mislead professionals by failing appointments and keeping his head down until the middle of May. He then attended a meeting at which the picture of what was going on in the relationship became somewhat clearer, though by no means dependably so. Even now the social worker and Guardian do not feel that they have heard the full truth.

28. I accept the united professional view that despite the mother's strong feelings for the children and some adequate past parenting of H, her deep-seated problems prevent her from meeting the children's needs as their main carer. It is also the unanimous view of professionals and family members, which I share, that if the mother can be dependable and not destabilise their placement, it

would be in H and O's interests if she could see them on a regular basis during their childhoods.

29. Given the degree of uncertainty about the mother's circumstances, I do not consider that a 'contact' order is appropriate or necessary. The grandparents, particularly while they are being advised by social services, can be trusted to support the mother's contact provided it is benefiting the children. Likewise, no order is required in the father's case. He will have regular contact, it having been made clear that the children's placement with his parents is not a step towards a placement with him.

30. There is no suggestion that Mr H should have ongoing contact with the children, whether or not he remains in a relationship with the mother.

The injuries to O

31. These were:

    (1) A right linear parietal skull fracture

    (2) Associated overlying bruising and soft tissue swelling

    (3) A subdural collection in the same area.

    (4) A transverse fracture of the left distal radius (above the wrist)

    (5) Fractures to the 7th and 8th left lateral ribs.

    (6) A 4mm by 5mm bruise on the low extremity of the anterior surface of the right thigh just above the knee

32. The verifiable sequence of events is as follows.

33. In contrast to H, O was not an easy baby. He had feeding difficulties and episodes of choking which led to admissions to hospital on 25 August and 19 September. He had keratitis (inflammation of the cornea) which required five ophthalmology appointments at hospital. He lost weight, falling from the 50th centile to the 9th to 25th centile, though he was not significantly failing to thrive. By the age of four months, he was beginning to roll. The mother was given standard safety advice by Ms S, the health visitor.

34. Because of the extent of O's problems, there were a high number of visits by the health visiting service: nine in his first five months. None of these gave Ms S cause for concern. Mr H created a good impression when he was present on the periphery of one visit and was seen playing with H.

35. The mother said that she had always been anxious about O. There always seemed to be something wrong with him. H had been different.

36. On 25 August, O was admitted to hospital for three days with a history of poor feeding, irritability and lethargy. Unsuccessful attempts were made to insert a line. The notes refer to a 'difficult' cannulation. Evidence was given by Dr O about the degree of force that would be involved in holding a baby's arm while inserting the needle. He described it as a gentle pressure on the arm to promote a vein, not involving an angulating force but perhaps some flexion of the wrist.

37. On the evening of 19 September, O choked while his mother was feeding him in his chair. He went red in the face and started going blue. He was having difficulty in breathing. Mr H picked him up and took him to the front door for air, held him in one hand while patting him firmly on the back and trying to get mucus out of his mouth with the other. It was an alarming incident. Mr H could not say how much force he was using as he was anxious to get the baby breathing again. An ambulance was called and O was taken to hospital, where he stayed overnight and was discharged the next day.

38. When O attended eye appointments at hospital it was sometimes necessary to insert a speculum or clamp to keep his eyes open for examination. On one occasion in October, O was screaming while being held still by Mr H and a nurse.

39. On 17 October, an incident took place, witnessed by Mr H and his parents, the mother being elsewhere in the house. O was sitting in his seat which had its back to a wall in the living room opposite the door. H ran in, tripped on the rug, and fell on top of O, who began to scream and was hard to settle.

40. On Thursday 27 November the mother attended a hospital for an appointment at 12.10. She left Oakley at home in the care of Mr H. H was at school.

41. At 12.51, the mother called an ambulance from the home. The recording of the 999 call is unfortunately incomplete. The ambulance arrived at the family home at 12.56. The paramedics were told that O had fallen off the settee onto laminate flooring overlaying concrete. On examination there was swelling to the back of the head, but no blood.

42. O was taken with his mother by ambulance to hospital and arrived at the A & E department at 13.16. He was examined by Dr U, who noted a 1.5cm bruise to the upper right side of the head, in the occipital region. There was no cervical spine tenderness and no other bruising to the body was noted. It was concluded that this was a minor head injury, the mother was given advice, and O was discharged home.

43. At 17.25 on the same day, the mother returned to hospital with O because the swelling had become bigger. He had vomited once but this was not unusual as he had reflux. On examination, O appeared conscious, alert and cheerful. Reassurance was given. The mother was given the option of O being admitted for observation but she was happy to observe him at home. She was advised to bring him back if he vomited again or showed any other concerning signs.

44. Although further investigations would undoubtedly have produced valuable information for the purpose of these proceedings, the external experts have no criticism of the hospital for not keeping O in on 27 November. The protocols for assessing what seemed to be a minor head injury were followed and it would be wrong to be critical of the hospital staff with the wisdom of hindsight.

45. On Friday 28 November, the mother spoke to O's GP by telephone. She was given reassurance.

46. On Monday 1 December, the mother had an operation at hospital, returning home the same day in the evening. O was in the care of Mr H that day.

47. On Wednesday 3 December, the mother contacted the children's ward reporting that O had not been himself for the past couple of days. He was drowsy, quiet and squinting. She was advised to take him to the Emergency Department and did so, arriving at around 09.30.

48. O was seen by the consultant paediatrician, Dr A, who examined him and ordered a CT scan. The bruise on O's knee was then seen.

49. The report identified a fracture on the right side of the skull but no intra-cranial bleeding. O was admitted at 10.30. An opinion was sought on the scans from Manchester, and a possible chronic subdural haemorrhage above the right hemisphere was identified.

50. O was transferred by ambulance to the Royal Manchester Children's Hospital in the early hours of 4 December in the company of Dr O and Nurse C. He had an MRI scan at 09.00. This showed a subdural collection. At 02.25 on 5 December he underwent a right frontal mini-craniotomy performed by Dr C to drain the subdural collection which was impacting upon on his brain. Dr C found xanthochromic (yellow) fluid under high pressure, with no acute component. O's brain re-expanded after the operation. A sample of the fluid was tested. According to the cytology report, the results do not assist in determining the age of the blood in the sample.

51. On 8 December, O underwent a skeletal survey. This identified the fractures to the ribs and wrist.

52. O was discharged from hospital on 11 December into the care of the maternal grandparents. Contact has continued, despite the distances involved

53. The mother and Mr H have been interviewed by the police twice. They denied injuring O. The interviews, and particularly the second interview with Mr H, illustrated the level of discourse and violence in their relationship. There is no indication of any visit to the home by the police to attempt a reconstruction. Likewise, the police unfortunately did not seize the couple's telephones until several months later and as a result no useful information has come from that quarter. The file has not yet been sent to the Crown Prosecution Service for a charging decision. The mother and Mr H remain on police bail.

54. Professor Mughal saw O on 2 April 2015 and reported that the abnormality in his bones appears to have improved since his admission in December. He opines that O did not now have any clinical signs of osteogenesis imperfecta or any other medical disorder associated with diminished bone strength.

The medical evidence

55. The evidence about O's overall medical status and injuries is complex, but a broad consensus has emerged. This has been possible as a result of the methodical way in which opinions have been gathered and discussion facilitated. For this, credit must go to Mr Scott, the children's solicitor, and to his counsel Mr Kennedy, who chaired the experts meeting on 2 June.

56. Reference can be made to the full and exemplary Schedule of Agreement and Disagreement, updated to the end of the hearing. The very detailed evidence can be distilled into this series of propositions:

<u>Metabolic abnormality</u>

(1) It is likely that O was suffering from a metabolic bone disorder at the time he sustained the fractures to his skull, ribs and radius. It is not possible to be sure of a diagnosis, but on the balance of probabilities it is likely that he was suffering from partially treated vitamin D deficiency rickets.

(2) The main reason for this conclusion is the abnormal findings from the skeletal survey in December. His skeleton was affected generally, characterised by osteopenia, splaying and cupping of the ends of the bones and sclerotic metaphyseal lines. These are some of the features that suggest partially treated rickets.

(3) The radiographs from December 2014 and those from April 2015 (which show an improvement in the abnormal appearances) are more consistent with a diagnosis of healing rickets than a genetic condition such as a bone dysplasia.

(4) Vitamin D is responsible and necessary for stimulating the placental transfer of calcium and phosphorous to the foetus in order to increase

healthy bone formation and stimulate growth. About 80 per cent of the transfer occurs in the third trimester. Following birth, the child becomes entirely dependent on other sources of vitamin D primarily through exposure to sunlight and diet. O was a child who had difficulty feeding from birth. Further support for his having had rickets arises from the fact that the mother has recently been diagnosed with vitamin D deficiency during her current pregnancy and, on this occasion, in line with national guidelines, has been prescribed a vitamin D supplement. Despite the 2010 Guidelines from the Royal College of Obstetricians and Gynaecologists, the mother was not provided with a Vitamin D supplement by when pregnant with O.

(5) A diagnosis of osteogenesis imperfecta has been discounted.

(6) The biochemical findings are non-specific in formulating a specific diagnosis. The normal vitamin D test results might be explained if there was a period of adequate vitamin D intake prior to admission on 3 December.

(7) The clinical findings are also non-specific but would support a diagnosis of rickets potentially associated with a past history of intrauterine or subsequent vitamin D deficiency.

(8) There is no inherent or underlying haematological disorder present that would dispose O to spontaneous bleeding or bruising or to excessive bleeding or bruising following trauma.

(9) None of the presenting injuries are likely to be birth related

<u>Bone strength</u>

(10) It is likely that the metabolic bone disorder would have reduced the tensile strength of O's bones generally and predisposed him to fracture more easily following trauma.

(11) The exact forces required to break a bone in a child with normal bones are not known. Opinions based on experience of the population as a whole conclude that significant force outside that found in normal handling and childhood mishaps is required. These broad assumptions cannot be applied in the case of a child with a bone disorder.

(12) It is not possible to quantify the degree by which the tensile strength of O's bones would have been reduced. The radiographs from December 2014 provide a snapshot of the appearances of the bones at that point. It is not possible to say whether at an earlier date the appearances would have been even more marked and the tensile strength of the bones even

further reduced, though the trajectory of improvement seen in the May radiographs allows for this possibility.

(13) Notwithstanding the presence of a metabolic bone disorder, some external force would have been required in order to cause the fractures. They would not have occurred spontaneously.

(14) On a spectrum ranging from a child of normal skeletal strength to a child with a severe skeletal fragility, O is likely to have fallen somewhere in the middle. An event which caused him to sustain a fracture would have been a memorable incident of some sort.

Mechanism

Ribs and wrist

(15) The likely mechanism for the rib fractures was a compressive force to the rib cage from front to back or back to front.

(16) The likely mechanism for the radial fracture was indirect bending or compression (as when a mobile child uses a hand to break a fall). In a pre-mobile child of O's age the former is the more likely mechanism

(17) Depending upon the level of force applied and the response of the child at the time, the following events might account for the fractures to the ribs and/or the radius in terms of timing and mechanism:

- The forces applied during a 'difficult' cannulation on 25 August.
- The choking incident on 19 September.
- The ophthalmological examination in October.
- The fall by H onto O on 17 October.

Skull

(18) The mechanism for the skull fracture was blunt trauma at the site of the fracture.

(19) In a child of normal skeletal strength it is highly unlikely that a skull fracture would have been sustained as a result of a low level fall, such as from a sofa. However, if there was a degree of underlying skeletal fragility, the likelihood of such a fall accounting for the skull fracture increases.

Subdural haemorrhage

(20) The pattern and distribution of the subdural haemorrhage, the absence of retinal haemorrhage, the absence of hypoxic-ischaemic change and the absence of haemorrhage in the cervical/spinal area all suggest that the subdural haemorrhage is more likely to have been caused by blunt force trauma resulting from the head impacting against a surface or object than a shaking injury.

(21) Although it would be unusual for subdural haemorrhage to be caused in the course of a low level fall it remains entirely possible that it was caused as a result of an event such as a fall from a sofa.

(22) The bruise on the knee is small but significant for its unexplained presence in a pre-mobile child. It was not present, or at least not seen, on 27 November. Its position does not suggest any specific mechanism, but it is unlikely to have occurred during the described fall from the sofa as it is not in the same plane as the head injury. It might have been caused by gripping but that is entirely a matter of speculation. It might equally have been caused accidentally by the leg banging against something or being struck by something.

Timing

(23) The dating of fractures radiologically is an inexact science. In this case it is complicated by the likely presence of rickets which may delay the normal healing process.

(24) Based upon the radiology alone the rib and radial fractures were between 1 to 3 months old on 8 December 2014.

(25) Based upon the radiology alone the skull fracture was less than about 2 weeks old on 3 December 2014.

(26) The bruising to the head is extensive and is likely to be associated with the same episode of blunt force trauma that caused the skull fracture and the overlying soft tissue swelling.

(27) The presence of swelling on 27 November is consistent with an injury occurring that day, and the enlargement of the swelling from 27 to 28 November and the emergence of the bruising is also in keeping with an event on 27 November.

(28) The subdural haemorrhage is likely to have been caused as a result of the same episode of trauma which caused the skull fracture and overlying soft tissue swelling. It arose in one of two ways: (i) the depression of the bone which caused the fracture directly caused a meningeal tear; or (ii) the fracture of the skull allowed forces into the intracranial space that

would not otherwise have passed through, and those forces caused the tear. Whichever mechanism is preferred, the implication is that less force than normal could account for the subdural collection.

(29) The subdural collection is more likely to be an acute traumatic effusion than a longstanding chronic subdural haematoma in the light of these features:

- The absence of a rapid increase in head circumference prior to the admission on 3 December.

- The clear increase in the separation of the skull joints between 3 and 8 December, suggesting an active process whereby the intracranial volume was increasing in the acute phase of the admission.

- The appearance on the MRI scan of 4 December of increased compression of the lateral ventricle and the development of midline shift suggesting a rapid increase in intracranial volume.

- The mother's reports, recorded in the medical notes, of O becoming increasingly unwell after 27 November.

- The acute onset of a squint and the development of bilateral sixth nerve palsy between 27 November and 3 December

- The xanthochromic appearance of the cerebrospinal fluid evacuated from the subdural space during the craniotomy performed on 5 December.

(30) The bruise was probably recent (in that it was not obvious on 27 November) but cannot be timed with any precision.

<u>Pain response</u>

(31) With each of the fractures, O would have been expected to show a degree of pain and distress during the acute phase of injury. It would have been apparent to a carer present at the time that he was in pain.

(32) The skull fracture was associated with overlying soft tissue swelling that would have been apparent to a carer who was not present at the time although he/she might not have been aware of the skull fracture alone.

(33) In the cases of the rib and radial fractures a carer who was not present at the time would not have been expected to be aware of the actual source of the child's discomfort and to attribute the same to a fracture

57. The effect of the medical evidence is that the cause of the injuries could have been accidental, careless or inflicted. The medical evidence alone does not mandate any particular conclusion. In a child with normal bone strength, injuries of this kind would be highly unlikely to arise accidentally but, as Mr Rothery for the local authority puts it, the presence of the bone abnormality limits the conclusions that the court can draw from the nature of the injuries. The local authority therefore invites the court to consider the other evidence, and in particular what it describes as lies and inconsistencies in the evidence of the mother and Mr H.

Accounts given by the mother and Mr H

58. The local authority accepts that the mother and Mr H have given a consistent account to the court and to the police that O sustained his head injury when he fell off a sofa onto a laminate floor laid over concrete. However it points to lies told by the mother and variations in the details given which mean that the story cannot be accepted at face value.

59. The mother and Mr H say that 27 November was a normal morning. The mother (it was probably her as Mr H often did the night-time feed) got up early and fed the children before taking H to school. O stayed at home with Mr H. The mother returned and spent about two hours at home, part of it spent cleaning. At about 11.30, she went for a hospital appointment, again leaving O with Mr H.

60. The mother's attendance at her hospital appointment between 12.10 and 12.30 has been verified.

61. Mr H says that after the mother left to take H to school, he sat on the sofa with O, watching television. When the mother came back, she asked him to carry on with the hoovering while she went to hospital. O fell asleep in his arms and he placed him against the armrest of the sofa and went into the kitchen to get the Hoover. He carried it upstairs and was sitting on the top step unblocking it when he heard a thud and O beginning to cry. He ran downstairs, found him lying on the floor in front of the sofa and picked him up and nursed him. O cried for a couple of minutes. Mr H tried to telephone the mother with the baby in his arms. He could not get through, so he texted her that O have fallen off the sofa and had a lump on his head. She texted back – *"ring me"* – so he did and told her what was happening. She said she would come home. He gave O a bit of a bottle that had already been made. He was sitting on the sofa with O when the mother returned.

62. The mother confirms that she received a text or a phone message from Mr H to say that O had fallen off the settee and had a bump. She came straight home in a taxi, cutting short her hospital visit. When she saw O, she rang for the ambulance (timed at 12.51). He was quiet and she could tell he had been

crying because his eyes were red. He had swelling on the side of his head but was not distressed and seemed all right.

63. The mother says that Mr H told her that he had left the baby on the sofa while he went to get the Hoover. She could not remember whether he said he had been in the kitchen or upstairs when the baby had rolled off the sofa.

64. The mother saw the Hoover at the top of the stairs with its hose hanging down.

65. The mother says that she lied about this incident to a number of people. She told the paramedic on 27 November that she had been there when O fell. She repeated this to Nurse P and Nurse C on 3 December, also telling Nurse C that she had been hoovering and that Mr H was O's father.

66. There are also inconsistencies in the mother's account of whether Mr H had been in the kitchen or on the stairs when O fell – his account was of taking the Hoover from the kitchen to the stairs. These, and a couple of other inconsistencies, are in my view of less potential significance than the big lie about her having been present.

67. I note that the mother's account varied, seemingly randomly. For example, on 4 December at 11.00 she told the health visitor Ms S that she was at the hospital when O fell and gave a similar account to the paediatric neurosurgeon at RMCH (Dr R) the same day.

68. For completeness, I would add that I reject the mother's denial that on 3 December she had told Nurse P and one of the paediatricians (Dr R) that O had been lying on the retractable footrest of the settee. How else could they know that the settee does in fact does have a retractable footrest, particularly when the evidence is that it was not extended on 27 November?

69. The mother says that she lied to protect Mr H, who had been distressed and said *"I'm going to get fucked, say you were with me"*, meaning that with his record he was bound to be suspected. She also says that Mr H told her later on *"Don't blame me and I won't blame you."* This was much later in the context of angry arguments about how O came to be injured. The mother agrees that she sent a message to the father saying that this response by Mr H was *"dodgy".* The mother said that she had not hurt O or had any reason to believe that Mr H had done so. It was anger and worrying that made her accuse him.

70. The mother said that she had lied to the social workers about her relationship with Mr H because she wanted the children to come home.

71. Mr H denied asking the mother to say that she had been with him. It would have been pointless to do that (i.e. it could easily be disproved as she had been at the hospital) and anyway he did not need an alibi. When he later heard her saying that she had been there, he asked her why she was lying. He agreed

that he had said to her that he would not blame her if she did not blame him. It was just unpleasantness in the course of an argument.

72. Mr H spoke fondly of the two boys, describing H as a lovely little boy to live around and O as a cute little baby. He admitted to losses of temper with adults but never with children. He denied that the story about him hoovering had been made up to explain him leaving O alone.

Approach to fact-finding

73. The proper approach to fact-finding has been set out in the judgment of Mr Justice Baker in *Devon County Council v EB and WD and ED, JD and TD* [2013] EWHC 968 (Fam) at paragraphs 53 to 64. I need not repeat what appears there. Suffice it to say that the burden of proof remains upon the local authority and the standard of proof is the balance of probability.

74. In this case, where the mother admits to telling a number of lies, I remind myself of the guidance in *R v Lucas*. People tell lies for many reasons. The fact that they lie about one thing does not mean that they must be lying about everything. The court must take care when drawing inferences and must consider why the particular lie was told in the particular case.

Conclusions

75. Having considered all the evidence, medical and non-medical, I reach these conclusions about O's injuries:

    (1) This is an exceptional case. In a child with a normal metabolism the almost inevitable conclusion would be that these fractures, and in particular the broken ribs and wrist, would be likely to be the result of violence or at least of rough handling. Likewise, it would normally be extremely unlikely that such serious injuries as a skull fracture and a subdural haemorrhage would result from such a low fall. Taken together, the medical picture would point strongly to inflicted injury.

    (2) However, the fact that O was probably suffering from rickets means that conclusions that might have been drawn in a normal case would be unreliable and unsafe in this case.

    (3) None of the injuries is of the kind that is particularly suggestive of inflicted injury.

    (4) Looking at the broader background, the mother and Mr H both have dismal records for violence to each other and other adults. However, there is no evidence of a propensity for serious violence to children. On the contrary, the mother's physical treatment of both children has never caused any concern. H has never come to harm. O was taken to all his

many health appointments. For his part, Mr H has never been criticised for his behaviour towards these or any other children.

(5) As indicated above, the mother is not a witness whose evidence can be relied upon. She is prone to lie on the spur of the moment. She is inconsistent. I have carefully considered whether her lies at the time of O's admission cast light on how he came by his injuries. My conclusion is that they do not. The mother is capable of lying without a logical reason or a sinister motivation. She has been sadly damaged by her experiences. She is isolated and involved in a mutually destructive relationship. My assessment is that she probably lied about being present on 27 November with hardly any thought for the consequences. Faced with figures of authority, she told a naive and pointless lie that was designed to support Mr H because he was in difficulty. I do not know whether he actually asked her to do this: it is equally possible that she was reacting to his need for support. Whatever the truth of the matter, it does not alter my conclusion that the mother's lies do not illuminate anything beyond her own difficulties.

(6) I am satisfied that an incident leading to O's head injury took place on 27 November and that it had occurred in the mother's absence. I believed the evidence she and Mr H gave of the calls made to and from the hospital and the mother's description of how O was when she returned was credible.

(7) The mother made no attempt to conceal the head injury. She behaved entirely appropriately in getting medical treatment for O at the earliest opportunity and persisting to seek help on the following days. She has never tried to avoid discussion about the event.

(8) In contrast to the mother, Mr H's account of what happened on 27 November has been consistent. Like her, he is not someone whose word can be taken at face value. He has a streak of self-pity and consistently minimised his responsibility for his behaviour, both criminal and domestic. He has not shown any sign of shame at his own account of having recklessly left a small baby in a dangerous position that led to a grave injury. However, having listened to his evidence about the events of that day, I did not find any solid reason to disbelieve it. In so far as any weight can be placed on his demeanour as a witness, Mr H appeared to be a man with a bad record who was scared of being convicted of something that he did not do, rather than a guilty man attempting to cover his tracks. There were moments in his evidence that rang true. Asked why he agreed to do some hoovering, he indignantly said that he was not lazy. Asked whether the injury happened as a result of him dropping O, he immediately replied *"I'd have said if I dropped him."* Asked a question based on the premise that we do not know what happened to O, he shot back: *"I do know what happened – he rolled off*

the sofa." It is not the words themselves, but the manner in which they were said that made an impression.

(9) I am also confident that the mother and Mr H are not colluding to conceal occasions when they know injuries were inflicted. They are quite capable of forming a plan of that kind but they are not capable of sticking to it. Their relationship is so volatile and chaotic that one of them would be bound to try to spill the beans on the other at some low point, particularly as they have been facing not only these proceedings but also possible criminal charges. In short, it would be beyond them to maintain an effective lie.

(10) With regard to the specific injuries:

- I cannot identify with certainty when and how the fractures to the wrist and ribs were caused. I cannot exclude the possibility that they were caused by violent or rough handling, but I do not think it probable. Given O's particular vulnerability and very young age I consider it more likely, indeed probable, that these injuries were caused in another way. They may have been sustained on one of the occasions suggested by the mother and Mr H, or on a similar unrecorded occasion. To take an example, it is entirely possible that some or all of these fractures occurred when H fell on top of O. It is also entirely possible that the rib fractures were caused by Mr H in the stress at the moment when he was trying to prevent O from choking. All these were occasions when O was in real distress. Given his likely bone condition, injuries may have occurred without carers realising.

- It is less probable that the fracture to the arm occurred as a result of a medical procedure, but it cannot absolutely be discounted.

- The only candidates for the causation of the head injury are the described fall from the sofa, or an undisclosed accident, negligent or otherwise, or a concealed assault. I cannot exclude the second and third possibilities, but taking account of all the evidence I find that on the balance of probabilities the injury occurred in the manner described by Mr H.

- There is no basis upon which I can find that the small bruise to O's knee was an inflicted injury. Although Dr Ward was suspicious, she in the end had to concede that her suspicion was purely speculative.

(11) I therefore conclude that the local authority has not proved its case that O's injuries were inflicted injuries. At the same time, I approve its decision to put the matter fully before the court. The outcome could not be known until the evidence was heard and any other course would not have met the needs of the children.

(12) Making full allowance for the frailties of the mother and Mr H, and acknowledging the mother's assiduous efforts to get medical treatment for O, I consider that they deserve serious criticism for aspects of their conduct on and after 27 November. It was thoroughly foolhardy of Mr H to have left O in an unsafe position. The mother's wilful lies have complicated matters and made it more difficult for the doctors and the lawyers to get to the truth. However, in the end this is a case where the person who was present is probably telling the truth about what happened, while the one who has lied was not there at all.

76. I thank counsel and solicitors for their assistance.

77. That is my judgment.