Neutral Citation: **[2021] EWFC 112**

IN THE FAMILY COURT AT COVENTRY

IN THE MATTER OF THE CHILDREN ACT 1989

AND IN THE MATTER OF CD (D.O.B. 1.6.20)

Date: 14th December 2021

Before :

Her Honour Judge Walker
Sitting as a Judge of the High Court

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Between :

X COUNTY COUNCIL

Applicant

- and –

BE (1)
AD (2)
CD
(BY HER CHILDREN'S GUARDIAN) (3)

Respondents

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Mr Sampson QC for the **Local Authority**
Mr Tillyard QC and Mr Cooper for the **First Respondent**
Miss Meachin QC and Miss Bull for the **Second Respondent**
Mr Day and Miss Tierney for the **Third Respondent**

Hearing dates: 29th, 30th, 6th, 7th, 8th, 9th, 10th, 13th and 14th December 2021

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JUDGMENT

1. C is the only daughter of BE and AD. I will refer to them both in this judgment by their first names. She was born on the 1st June last year. These are care proceedings brought by X County Council as a result of injuries sustained by C in the autumn of last year. Cis represented in these proceedings through her Children's Guardian, Amy Withers.

2. C and her family had never been known to the local authority before the 12th October. C was born at 37+2 weeks gestation by a normal vaginal delivery. The pregnancy had gone well, save that B had sought support on two occasions with respect to reduced foetal movements. Once born, C did suffer from a cows' milk intolerance (such that she was prescribed an alternative milk). She was taken to A&E on the 18th September as a result of having a poor appetite and vomiting more than usual. She was diagnosed with gastroesophageal reflux disease (GORD). The medication prescribed for that reflux has been a significant issue in this case, and I will return to the detail later in the judgment.

3. On the 30th September 2020, B, A, C and both grandmothers went on holiday to Cyprus. The central purpose of the holiday was to view possible wedding venues for the couple to marry. The whole family returned to the UK on the 7th October.

4. On the 12th October, C was taken to Accident and Emergency by ambulance as a result of her having a moment where she appeared to freeze, with eyes wide and staring. B said that she went a grey colour and afterwards, felt very cold. The doctor who examined C thought that she may have experienced a reflux anoxic seizure (a term used for a particular fit which is neither epileptic nor due to breath-holding but rather due to excessive activity of the vagus nerve resulting in a brief stopping of the heart).

5. On the 19th October, C was presented to A&E at 10.24am, after her parents had sought advice from their GP. The presenting complaint was that she was not using her right arm properly. An x-ray of her right shoulder showed a fracture to her right clavicle. A child protection medical was undertaken by Dr Olumuyiwa Oso whilst at the George Elliott hospital and she was transferred to University Hospital Coventry and Warwickshire. Dr Rajesh Srikantaiah, Consultant Paediatrician undertook an assessment on the morning of the 20th October.

6. B gave the history to Dr Srikantaiah. She said that C had made an unusual cry when her dad had picked her up under her shoulders the afternoon before. At about 4am, C had woken up crying and A had found a lump around her right shoulder. Dr Srikantaiah observed mild redness over the collar bone, with normal tone and power in both upper and lower limbs, with mild restriction of movement in the right shoulder. All the blood tests that had been done whilst at the George Eliot were noted to be within normal range.

7. B and C had been seen by a social worker, Rachel Dawes, in the company of two police officers as part of the section 47 enquiry on the evening of the 19th October. Although I do note that B responded to this first statement and assessment by telling the court that she has never met anyone called Rachel Dawes and does not understand why this person has drafted a statement in these proceedings. B was reported to be attentive and soothing towards C and was obviously concerned about her. B had given the same account that C had woken

at about 4am on the morning of the 19th, which was very unusual, as she was a baby who generally slept through the night. B had tried to feed her, but C was very distressed, with tears observable on her cheeks. After being given some Calpol, C settled back down, but B said that she had noted that C had less movement in her right arm and was not lifting it above shoulder height. When C woke at 7.30am, she still appeared uncomfortable when using her arm, so B rang her GP who advised that they should attend A&E.

8. B was asked about anything unusual that had happened. She described an incident the evening before, in which A had lifted C from her playmat, under her arms, and she had let out a squeal. The couple had been entertaining their friends, S and G, who had come over for the early evening.

9. A was seen the same evening by the social worker and the officers, but at home as a result of Covid restrictions preventing him from being in the hospital with C and his partner. He gave a similar account of the events in the night before admission, including giving a description of how he had picked C up from the play mat. On the morning of the 19th, A said that he noticed that C's shoulder had a 'crunchy' feeling, and whilst this was not unusual, it was the first time that C had presented as being in pain.

10. The full skeletal survey was undertaken on the 20th October by Dr Emma Helm, Consultant Radiologist. She confirmed the presence of the fracture to the right clavicle, but also indicated she had observed an indeterminate abnormality of the medial aspect of the left distal femoral metaphysis. She recommended follow up imaging. Her conclusions were reviewed by Dr Hiten Patel, Consultant Radiologist.

11. As a result, on the 4th November, the CT scan and skeletal survey were repeated. Dr Helm noted,
"1. Healing right clavicle fracture.
2. Previously demonstrated area of irregularity involving the distal left femur is no longer seen and there is no periosteal reaction on the left, suggesting that the appearance on the previous survey was artefactual.
3. Evidence of a bucket-handle fracture of the right proximal tibial metaphysis. With the benefit of hindsight, I think there was probably a subtle irregularity at the same site on the original survey and therefore it is likely that this injury was present at the time of the original survey."

12. Dr Srikantaiah requested a second opinion from Dr Adam Oates, Consultant Paediatric Radiologist based at Birmingham Children's Hospital. He responded by letter dated the 11th November. He confirmed the presence of a fracture to the clavicle at the junction of the lateral third and medical two thirds. There was no evidence of healing, and therefore had occurred within 7-10 days of the x-ray on the 19th October.

13. It was his view that the skeletal survey from the next day demonstrated a slight irregularity to the proximal right tibial metaphysis, which was confirmed to be a "*classic metaphyseal lesion fracture (bucket handle)"* on the follow up scan. Further, he identified a displaced fragment of bone adjacent to the medial aspect of the left distal femoral metaphysis (which had resolved by the 4th November) but this was likely to be a further metaphyseal lesion fracture (CML).

14. Having participated in the section 47 enquiry, the police continued their investigation. They attended the hospital on the 22nd October with a view to conducting voluntary interviews with both parents, but it became apparent very quickly that neither parent was in a fit state due to exhaustion and distress. However, they both willingly handed over their telephones. B and A both gave a voluntary interview on the 1st November and then underwent questioning under caution on the 12th November. Both denied hurting C but gave the same account of the incident on the 18th October. A accepted that he may have caused the fractured clavicle when he lifted C from the mat.

15. C was discharged from hospital into the care of her paternal grandparents on the 23rd October, where she has remained to date.

The history of this litigation

16. To say that this litigation has been beset with hurdles is an under-statement. As I will come on to set out in a moment, a number of medical experts have been instructed in order for the court and the parties to ascertain whether C suffered from any underlying condition that may have made her susceptible to fracture. The instruction of those experts has been sequential in part. But as part of the original case management directions, the court approved the instruction of a paediatrician, Dr Russell Austin.

17. He was originally directed to file his report on the 1st February 2021. To take account of the instruction of Dr Saggar and Dr Keenan, this was put back to the 14th May. He complied with that direction and provided a report. But, in short, he has failed to communicate with any party or the court since that time in any way whatsoever.

18. Ms Noel, solicitor for the child, has provided the court with a chronology of the almost daily efforts that she went to between the 5th May and February 2021 to contact Dr Austin, and I attach a copy of that document to this judgment. All communication between Ms Noel and Dr Austin was sent to both his professional and personal email addresses and were also posted to him. After the hearing on the 20th August when the situation was brought to my attention, I took steps to email Dr Austin personally. Such was the bizarre nature of his blanket failure to respond in any way to communication, I was concerned that there may be personal or sensitive reasons for Dr Austin's default, and I wanted to afford him an opportunity to communicate those to the court. I received no response at all.

19. In desperation, I authorised a witness summons be issued to require Dr Austin to attend (remotely) at a hearing on the 15th October 2021. He was served with that summons and he did not comply with it. On the 9th November, Dr Austin was personally served with a further witness summons to attend this court in person on the first day of the hearing (the 30th November), and he was also served with a letter making it clear to him that a copy of the witness summons was going to be served on his professional body. He did not attend and offered no explanation for his failure to do so.

20. Dr Austin's failure to comply with his professional obligations is unexplained and inexcusable. The duties of a jointly appointed expert are set out within Practice Direction 25B of the Family Procedure Rules 2010. An expert is bound by their overriding duty to the court. They must comply with the Standards for

Expert Witnesses in Children Proceedings in the Family Court. He has not afforded this court with the courtesy of any explanation for his failure to communicate with Ms Noel or myself. He has failed to comply with two witness summons, which I remind myself is a criminal offence for which I could (and I indeed as I have been urged by those who represent the father in the course of these proceedings) to have him arrested.

21. As a result of his failure to engage with the proceedings since the filing of his report, I have been faced with and have refused two applications by the Guardian for the instruction of an alternative paediatrician. If allowed, those applications would have delayed any decision being made about C's future for many more months, and perhaps that is the most significant and harmful effect of Dr Austin's conduct. Public law litigation concerns the welfare of vulnerable children and all those engaged in the process have a duty to keep that at the front of their mind. But the specific legal consequence of Dr Austin's default within this hearing is clear; the parties have been denied the opportunity to put questions to him, either written or oral.

22. Despite having received the parents' mobile 'phones within days of the investigation commencing in October last year, the material from those phones still had not been provided by the time I heard the case on the 20th August. As a result, I repeated the request from the family court for the material to be provided, or in the alternative, for the physical 'phones to be handed back to the parents, and approved the instruction of Evidence Matters in order for the analysis to be conducted in the event that the police had not been able to do so. Warwickshire Police then made an application to vary the terms of that order. I was informed that the officer in charge of the investigation only had access to one antiquated computer, and each time that she wished to view the material that had, by that stage, been downloaded from the 'phones by an external agency, it was necessary for the whole content of the CD to be uploaded, a task that took many hours.

23. I refused an application by the police to assert public interest immunity over the material that they had, by that point, extracted from the parents' phones. I ordered them to disclose it, after giving them a period of weeks to interview the parents. It was still necessary for me to approve the instruction of Evidence Matters in order to analyse the material, as we were uncertain as to the format in which the mobile 'phone material would be provided. But it was agreed by all parties that Evidence Matters enquiry would be asked to concentrate on the window in which it was asserted that the injuries may have been caused. However, it is right to reflect that, in a closed statement which supported the police's application, the officer drew the court's attention to some text messages that she was already aware of, which might have suggested that there had been discussions between the parents about previous incidents of poor handling of the baby, and some relationship difficulties.

24. The police appealed my order. That appeal was later compromised, but the effect of the delay caused by the listing of the appeal was that the 'phone material was late going to Evidence Matters and late being received by the parties. It is vast. And over the course of weekend before this hearing began, the parties were provided with copies of the parents' most recent police interviews, which took place on the 11th November. Both parents were asked about text messages, photos and videos that began only three weeks after Cwas

born, outside of the Evidence Matters report. At the start of the hearing, it was impossible for any party to extrapolate those messages and videos of potential significance from the material we had, and so I was asked to make a further police disclosure order to seek the officer's notes for her interview, and the specific videos to be made available to the court. Mr Sampson made it clear that he wished to review that material before he made any application to amend the findings sought.

25. Mr Sampson did make that application on the morning of the second day. He indicated his intention to plead the following additional matters against the parents;

A. C was repeatedly inappropriately and recklessly handled by A in a manner which he knew or should have known posed a risk of harm to her. This included:

- Being picked up roughly, without supporting her head;
- Being picked up by her head;
- Having her bottle ripped out of her mouth and pushed into her mouth;
- Blowing hard into her face to keep her awake by feeding in a way that was clearly inappropriate;
- Winding her roughly and inappropriately.

B. B was aware of and complicit with the above handling in that she a) videoed it and b) found it (at least in part) funny and / or unconcerning.

C. B was, at other times, concerned about A's responses to C, including his anger with her, refusal to feed her, and, in her words 'rough' handling of her when feeding her, but failed to protect C by failing to act on her concerns beyond occasional texting of her mother and friend.

26. It was Mr Sampson's case that he wished to
"explore the environment in which C was parented, the father's state of mind, his view of C, the mother's awareness, with specific focus on the father's response to C, his levels of stress / anger and his careless or reckless handling of her in relation to all of the fractures. The LA will say that, in the event F's concessions as to causation of the fractures are accepted as both mechanically and factually plausible (it being accepted that several of the experts acknowledge these as a possible albeit unusual mechanism for the metaphyseal fractures), the enquiry does not stop there. The court will need also to look at the father's state of mind during the relevant period to inform its view as to how and why this happened – having regard to the definition of a 'non-accidental injury' by Ryder LJ in Re S (A Child) [2014] EWCA Civ 25. *There is, it will be said, a distinction of some importance when considering the manner in which the fractures were sustained, between a parent who knowingly, deliberately and repeatedly handles a child without any regard for their safety and the likely distress caused by their actions on the one hand, and a parent whose conceded but entirely unwitting failings 'as a first-time father' led to those fractures on the other. The Local Authority will say that the videos (particularly when coupled with the texts) paint a very different picture, both as to the father's handling and the mother's knowledge of it, than that set out in the parents' evidence."*

27. After hearing the submissions of all parties and reading their position statements, I determined that I would allow the amendment sought. However, I

refused the renewed application by the Guardian to instruct an alternative paediatrician. Such a course, in my view, was wholly disproportionate. As I indicted within the extempore judgment that I gave, the issues in this case could be summarised as follows;
(1) did C suffer from any underlying medical issue that is relevant the causation of the sustained fractures, and in particular, the level of force required to cause them?
(2) if the injuries are inflicted, are they the result of an observed incident and unintentional rough handling, or was either of the parent motivated by a darker motive?

28. The local authority did not assert that any additional injuries had been caused as a result of this handling. The videos did not directly relate to the mechanism of the fractures, and as asserted by the local authority went more (if probative of anything) to the father's state of mind and the mother's awareness of any issue, both of which were issues for me and not any expert.

The schedule of findings

29. The local authority seeks findings that C suffered four fractures (based on the expert opinion of Dr Jeanes which I will set out below), and that those fractures were caused by either her mother or her father. It is asserted that the metaphyseal fractures were caused by excessive and significant torsional/twisting forces, and that the clavicle fracture was caused by either direct forceful manipulation of the shoulder following a yank or a direct blow. The local authority asserts that there is no evidence that any underlying medical condition has any relevance to either causation or mechanism, including the level of force required.

30. A and B have always been clear that they believe that C's clavicle was fractured when A picked her up from the floor on the 18th October. As far as the metaphyseal fractures are concerned, A has accepted that he may have caused these injuries when he was vigorously 'jiggling' C's legs, which he did frequently and often. He has produced a number of videos of him doing exactly that. He is clear that he never intended to hurt his daughter by his actions.

The Law

31. In respect of the task of determining whether the 'facts' have been proven the following points must be borne in mind as referred to in the guidance given by Baker J in *Re L and M (Children)* *[2013] EWHC 1569 (Fam)*.

32. The burden of proof is on the local authority. It is for the local authority to satisfy the court, on the balance of probabilities, that it has made out its case in relation to disputed facts. The parents have to prove nothing and the court must be careful to ensure that it does not reverse the burden of proof. The standard to which the local authority must satisfy the court is the simple balance of probabilities. There is no room for a finding by the court that something might have happened.

33. Findings of fact must be based on evidence, and the inferences that can properly be drawn from the evidence, and not on speculation or suspicion. The decision about whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and the court should have regard to all of the evidence.

34. The definition of non-accidental injury sufficient to satisfy s.31 threshold criteria is particularly relevant in the circumstances of this case and is summarised by Ryder LJ in *Re S [2014] EWCA Civ 25* at paragrpah19-21:

"The term 'non-accidental injury' may be a term of art used by clinicians as a shorthand and 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).
The court's function is to make the findings of fact that it is able on the evidence and then analyse those findings against the statutory formulation. The gloss imported by the use of unexplained legal, clinical or colloquial terms is not helpful to that exercise nor is it necessary for the purposes of section 31(2) to characterise the fact of what happened as negligence, recklessness or in any other way. Just as non-accidental injury is a tautology, 'accidental injury' is an oxymoron that is unhelpful as a description. If the term was used during the discussion after the judgment had been given as a description of one of the possibilities of how the harm had been caused, then it should not have been; it being a contradiction in terms. If, as is often the case when a clinical expert describes harm as being a 'non-accidental injury', there is a range of factual possibilities, those possibilities should be explored with the expert and the witnesses so that the court can understand which, if any, described mechanism is compatible with the presentation of harm.
The threshold is not concerned with intent or blame; it is concerned with whether the objective standard of care which it would be reasonable to expect for the child in question has not been provided so that the harm suffered is attributable to the care actually provided. The judge is not limited to the way the case is put by the local authority but if options are not adequately explored a judge may find a vital piece of the jigsaw missing when s/he comes to look at all the evidence in the round."

35. The opinions of medical experts need to be considered in the context of all of the other evidence. 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.

36. The evidence of the parents is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them *(Re W and Another (Non-Accidental Injury) [2003] FCR 346).*

37. It is common 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 at all times that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear, and distress. The fact that a witness has lied about some matters does not mean that he or she has lied about everything *(R v Lucas [1981] QB*

720). This guidance has recently been considered by the Court of Appeal in *Re A, B and C (Children)[2021] EWCA Civ 451.* Such a direction should not be included as a 'tick box' exercise but the court should consider;
(1) the lie upon which reliance is placed by any party,
(2) the significant issue to which it relates, and
(3) on what basis it can be determined that the only explanation for the lie is guilt.

38. The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or the scientific research would throw a light into corners that are at present dark. Particularly, recent case law has emphasised the importance of taking into account the possibility of an unknown cause. The possibility was articulated by Moses J in *R v Henderson-Butler and Oyediran [2010] EWCA Crim 126* when he said,

> "*Where the prosecution is able, by advancing an array of experts, to identify a non-accidental injury and the defence can identify no alternative cause, it is tempting to conclude that the prosecution has proved its case. Such a temptation must be resisted. In this, as in so many fields of medicine, the evidence may be insufficient to exclude, beyond reasonable doubt, an unknown cause. As Cannings teaches, even where, on examination of all the evidence, every possible known cause has been excluded, the cause may still remain unknown*."

39. When seeking to identify the perpetrators of non-accidental injuries, the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator. In order to make a finding that a particular person was the perpetrator of non-accidental injury the court must be satisfied on a balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interest of the child, although where it is impossible for a judge to find on the balance of probabilities, for example that Parent A rather than Parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to do so.

40. In relation to the allegation of failure to protect, I have well in mind the decision of the Court of Appeal in Re L-W (Children) [2019] EWCA Civ 159 in which King LJ stated the following:
"62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.
63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries.
64. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of

perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm."

The written medical evidence

41. I have permitted the instruction of a number of medical experts within these proceedings. It is my intention to address the contents of their written reports chronologically as they were prepared before then going on to address their oral evidence and then considering the totality of that evidence within the broad canvass.

42. Dr Annmarie Jeanes is a Consultant Paediatric Radiologist based in the hospitals in and around Leeds. Her report to the court is dated the 29th January 2021. Dr Jeanes was asked to review the skeletal surveys undertaken on the 20th October and the 4th November. She did so, and it is her view that *"they demonstrate three further fractures, a metaphyseal fracture of her right proximal tibia, and healing metaphyseal fractures of the distal left femur and proximal left tibia."*

43. After reviewing the parents' account of the incident on the 18th October, it was Dr Jeanes' view that this was a *"plausible, although highly unusual explanation for C's clavicle fracture."* She goes on,
"In my opinion, C's bones are normal in structure, with no radiological features to indicate that she has an underlying inherited disorder of bone that could result in her bones being more liable to fracture. However, given that radiographic assessment of bone density is a poor indicator of bone strength, I cannot completely exclude the possibility that C has an underlying bone disorder, resulting in increased bone fragility."

44. It is Dr Jeanes's view that, in the event that there is no underlying bone weakness, the forces and manoeuvres involved in causing the clavicle fracture are likely to have been excessive and inappropriate. She could not find any plausible explanation for the metaphyseal fractures, and so she concludes that all three are likely to have been caused by inappropriate and forceful handling.

45. Dr Jeanes describes in some detail what she observed on the images sent to her. I summarise those findings as follows;
    (a) There is a fracture through the junction of the mid and lateral third of the right clavicle, with cranial displacement of the medial fragment. There is some associated soft tissue swelling, but no subperiosteal new bone or callus formation, which is consistent with this being an acute injury.
    (b) There is fragmentation of the medial metaphysis and irregularity of the posterior metaphysis of the distal left femur, consistent with a metaphyseal fracture.
    (c) There is irregularity with patchy sclerosis and lucency of the proximal tibial metaphysis, with bucket handle morphology on the lateral view, indicative of a healing metaphyseal fracture.

(d) In relation to her right lower leg, there is irregularity, fragmentation and lucency of the proximal tibial metaphysis suspicious of a metaphyseal fracture.
(e) By the 4th November, the fracture of the clavicle is now associated with subperiosteal new bone and callus formation, consistent with healing.
(f) The appearance of the distal right femoral metaphysis is unchanged, and therefore is considered to be physiological. However, the metaphyseal fracture of the proximal right tibia is much more apparent and has evidence of healing new bone formation.
(g) The fragmentation and irregularity of the distal medial and posterior femoral metaphysis is no longer apparent, consistent with healing. The left proximal tibia is completely healed and now appears normal.

46. Dr Jeanes lists the fractures she was able to identify as follows
(1) A displaced fracture through the mid/lateral third of the right clavicle
(2) A metaphyseal fracture of the right proximal tibia
(3) A healing metaphyseal fracture of the distal left femur
(4) A healing metaphyseal fracture of the left proximal tibia
These are the fractures as pleaded by the local authority.

47. Clavicle fractures are common in mobile children and usually result from a fall onto the shoulder or an outstretched arm. But they are uncommon in children under the age of three and when they are seen, are often occur following sudden traction of the arm, such as if the arm was yanked. They can also result from a direct blow or impact to the clavicle. Dr Jeanes considered the way in which A described the way that he picked up C from the floor on the evening of the 18th October, and she says,
"Although the description provided would be an unusual explanation for the clavicular fracture, the described action, could in my opinion result in significant tractional forces to the shoulder and clavicle, particularly if C's weight was taken solely by her shoulder girdle. In order for this manoeuvre to have resulted in the fracture however, in my opinion the forces and or mechanisms involved are likely to have been excessive and inappropriate for an infant of C's age."

48. Metaphyseal fractures typically result from shearing, torsional and/or pulling/tractional forces applied either directly or indirectly to the joint. They are highly associated with inflicted in children under 18 months of age, where they are believed to have been caused when an extremity is held and forcefully twisted, pulled or yanked.

49. It was Dr Jeanes' view that C's clavicle fracture was likely to be less than 10 days old on the 19th October. The metaphyseal fracture to the proximal right tibia is less than 10 days old on the 20th October. The fractures to the left distal femur and left proximal tibia are approximately 2-4 weeks old on the 20th October (caused between the 13th September and the 6th October). She felt it was unlikely, although not impossible that C suffered from any kind of underlying bone disorder, and she did not consider that the fact that B has a diagnosis of Ehlers Danlos Syndrome (EDS) was relevant to the causation of C's injuries. Dr Jeanes was not able to assist with the potential relevance of the reflux medication, Lansoprazole.

50. Dr Russell Keenan is a Consultant Paediatric Haematologist. His first report is dated the 1st March 2021. He had not received any medical results in respect of B, and he required the laboratory source documents for C's haematological tests. He was not able to answer the questions put to him in the absence of this information. Dr Keenan produced an addendum report dated the 1st April. By this time, he had received C's results, but not B's. A second addendum dated the 30th April was finally able to review all the information that he needed (save for B's full medical records). B was not anaemic and there was no evidence that she suffered from any white blood cell or platelet numerical disorder. She had normal iron stores and blood folate. Neither C nor B suffers from any haematological disorder.

51. Dr Anand Saggar is a Consultant in Clinical Genetics. His report is dated the 3rd May. His summary of his conclusions is as follows,

    C presents as a non-mobile baby with a fracture collar (clavicle) bone and metaphyseal fractures of the femur and tibia. A possible explanation has been provided for the clavicle fracture.
    Clinically C does not have the appearance of a child with Osteogenesis Imperfecta (OI) or a similar bone fragility syndrome. The bluish tinge to the sclerae may be normal for her age. This, in combination with the fractures would not support a clinical diagnosis of OI.
    C's mother has hypermobile spectrum disorder (HSD). There is no specific genetic evidence to suggest that C is predisposed to a greater risk of fracture for any given force or lesser force except that Chas a 50% susceptibility of inheriting HSD from her mother.
    However, HSD would not result in spontaneous fractures. It is my opinion that the fractures did not occur spontaneously and so occurred following a precipitant force or memorable event, given that the mutation in the OI or related genes has been excluded by genetic testing.
    Skin marking may occur after a lesser force but such handling in hypermobile Ehlers Danlos Syndrome/HSD or even rough handling would not explain the metaphyseal fractures. Any history of continued fracture whilst in foster care should be explored."

52. He goes on,
    "The most probable explanation for the fractures is a force or injury as a precipitant. The role of reduced foetal movements and proton pump inhibitor medication as a cause of fracture after lesser force should be explored further."

53. He did recommend that the opinion of a metabolic bone expert should be sought, and that the parents should be tested for Variant of Unknown Significance (VUS) in the AN05 gene, with regard to whether this could be relevant to the risk of fracture. Mutations of the AN05 gene are associated with some thickening of the long bones in patients. He was also asked about the effect, if any, of the Lansoprazole medication upon C's propensity fracture, which he considered to be out with his expertise, but that they should be asked of a metabolic bone specialist.

54. Having subsequently tested the parents, Dr Saggar was able to conclude that *"I am confident that the AN05 variant is now of no significance in this child as a cause of her presentation."*

55. Dr Austin was instructed to prepare a paediatric overview. His first and only report is dated the 17th May 2021. He is a Consultant Paediatrician based in the Wirral. It is his view, that on the balance of probability, C's clavicle fracture occurred as a consequence of the lift from the floor, although he agrees with Dr Jeanes that there are four possible mechanisms for such an injury:
    (1) A fall onto an outstretched limb
    (2) The limb being pulled, twisted forcibly
    (3) A fall onto the shoulder from a height
    (4) A direct blow to the clavicle
    He is able to exclude (1), (3), and (4) from this list on the basis that Cwas non-mobile, did not fall, and a direct blow would have been likely to result in major bruising and swelling at the site and this was not seen.

56. Dr Austin considered that the description given by A of how C presented on the evening of the 18th October would be consistent with her having sustained a fracture to the clavicle. A child of age 20 weeks would experience discomfort when being undressed, but the pain would be non-specific as a result of the fact that the fracture would be relatively stable. Metaphyseal fractures cause little or no discomfort at the time of injury.

57. As a result of the court and the parties receiving the reports of Dr Austin and Dr Saggar, Dr Jeanes was asked some additional questions. In particular, she was asked to consider the research papers in relation to the association between PPI medication and bone fragility. She also felt that this question was outside her field of expertise and she too advised that the court consider the instruction of a paediatric metabolic bone expert.

58. She goes on to say that metaphyseal fractures are not fragility fractures but result from specific mechanisms applied directly or indirectly to the joint. They are not seen to a greater degree in children with bone fragility disorders (OI and prematurity). But it was her view that, even if the PPI medication had affected C's bone strength, these fractures are most likely to have been caused by inappropriate and forceful manipulation of the limbs, in excess of normal handling.

59. Dr Jeanes prepared a second addendum dated the 9th July 2021. Dr Jeanes was unable to assist in whether B's antenatal history or reported reduced foetal movements whilst pregnant were significant to the causation of C's injuries, as both issues were outside of her field of expertise. The same was true of the dosage and period of time that C had taken Lansoprazole.

60. Therefore, the court approved the instruction of Professor Peter Sullivan, Emeritus Professor in Paediatric Gastroenterology, based at the John Radcliffe Hospital in Oxford. Professor Sullivan's report is comprehensive. He begins by telling the court what Lansoprazole is.
    "Lansoprazole is a powerful antacid that it works by inhibiting the 'pump' in the parietal cells of the stomach lining that produce the hydrogen ions (protons) that go on to make hydrochloric acid i.e. gastric acid. It is amongst the group of drugs known as gastric protein pump inhibitors (PPI). The inhibition of this 'pump' is dose-dependent and reversible. Lansoprazole is used in clinical situations where it is necessary to reduce the secretion of gastric acid and the commonest of conditions are gastro-oesophageal reflux and peptic ulcer."

61. Lansoprazole is not licensed for use in children, and current guidance is that it should only be considered when omeprazole is unsuitable. But no PPI has ever been approved for use in infants under 12 months old. Despite this, PPI use for children who are experiencing GORD has increased steadily since 2000.

62. Having considered the issue, he did not consider that there was any evidence that any calcium or vitamin D deficiency in C indicated any problems with her bone metabolism. He considered all of the available research on the issue being;
Freedberg DE et al Use of Protein Pump Inhibitors is associated with fractures in young adults: a population based study Osteoporosis International 2015, 26(10); 2501-7
Malchodi et al Early Acid Suppression Therapy Exposure and Fracture in Young Children Paediatrics 2019; 144(1): e20182625
Feishman N et al The Clinical Characteristics of Fractures in Pediatric Patients Exposed to Protein Pump Inhibitors J Pediatr Gastroenterol Nutr 2020: 70(6): 815-9
Wang YH et al Short term omeprazole treatment does not influence biomechanical parameters of bone turnover in children Calcif Tissue Int 2002; 71(2): 129-132
He considered that due to the relatively short duration that C had been taking Lansoprazole, it had not predisposed her to sustaining any fracture, duration being the key factor that had been identified in all of those studies.

63. Dr Jeanes provided one more (and her third) addendum report dated the 27th July. She had been sent a twenty video clips of A 'jiggling' C's legs, and the report of Professor Sullivan for her comment. She reminds the court that, histologically, metaphyseal fractures are a series of microfractures through the metaphysis, running parallel to the growth plate. They are now believed to be caused by shearing, torsional and/or pulling forces, although the precise degree of force is not known. It was her view that the videos did demonstrate the application of shearing forces to the knees and could be a potential mechanism. But she felt it was important to note that the fracture to the right knee was associated with SPNBF (sub-periosteal new bone formation) which indicated that either the injury was more complex or the degree of force to cause it was greater.

64. Dr Jeremy Allgrove prepared a dated the 5th August 2021. He is a Consultant Paediatric Endocrinologist, with a particular interest in calcium and bone disorders in children. There was no evidence, in his view, of any significant abnormalities in B's blood tests which might have indicated any impact upon C's bones. Whilst B was low in Vitamin D at a point when C was five months old, C's level when tested was satisfactory. When adjusted, C's calcium level was normal. He concludes, *"There is no evidence, either radiological or biomechanical, to suggest that Chas an underlying predisposition to fracture."*

The oral medical evidence

65. I was not asked to hear oral evidence from Dr Saggar or Dr Keenan, although Dr Saggar was asked one further written question which did not change his conclusions in any way. Dr Allgrove was asked questions in respect of two key areas of his report; the impact, if any, of protein pump inhibitor medication on an increased propensity to fracture/bone fragility, and the relevance of C's mother being hypermobile, and therefore, C possibly suffering from the same

condition. Dr Allgrove appropriately deferred to the opinions of others when appropriate to do so.

66. In broad terms, Dr Allgrove was clear in his opinion that there was no evidence that C suffers from Osteogenesis Imperfecta, nor that the variant in her AN05 gene has any relevance to the issues that I must determine. Variants of uncertain significance are not unusual when gene sequencing is undertaken, and the particular variant seen in C is associated with three very rare conditions. Two of those conditions are recessive, and therefore require both genes to carry the same abnormality. Only one condition might be relevant in this case, which is a condition associated with an increased tendency to fracture from adolescence onwards, and abscesses in the jaw that are difficult to heal.

67. Whilst there is a 50/50 chance that C will have inherited her mother's hypermobility, Dr Allgrove was clear that there is no known association between EDS and fractures in very young children. The particular fractures suffered by C did not fit the possible mechanism that might make such a condition relevant, which would be the muscles around the bone not being tight enough to resist forces. Insufficiency of Vitamin D may enhance a child's propensity to fracture, but Dr Allgrove reminded me that one half of the population in this country is deficient in Vitamin D. C was, not, in fact, within that category and her level was within the normal range.

68. Protein pump inhibitor medication reduces the acidity of the stomach. This can reduce the ability of the body to absorb calcium and magnesium, but this is most likely to be a factor after long term use. C's results did not suggest that she was low in calcium. Dr Allgrove was taken to the same research papers referred to by Professor Sullivan for his comment, although I think it is fair to say that he was less familiar with that research than Professor Sullivan proved to be. He was willing to accept that there was some evidence that might indicate that usage of a PPI for less than 30 days can increase bone fragility and that the age at which a child is prescribed a PPI medication is a factor that might increase propensity to fracture

69. Professor Sullivan was an engaging witness who professed to having a particular and personal interest in the association between PPI medication and propensity to fracture, as he has taken such a medicine for twenty years himself and has suffered a considerable number of fractures. He was clearly engaged in the topic, knowledgeable, careful and considered in his oral evidence.

70. He did not move from the opinions expressed in his written report and told me that, *"I would rule out Lansoprazole as a potential explanation. I really do not think that this drug is responsible in any shape or form for the fractures in C.* "Later in his evidence, he said that it was, "*vanishingly unlikely that Lansoprazole had any effect whatsoever on her bones."*

71. He confirmed that Lansoprazole is not approved for use in children under the age of 12 months, but also confirmed that it is routinely prescribed. Further, he expressed a degree of scepticism that there is little evidence that any of the PPI medications are actually effective in treating the symptoms of GORD. But that being said, it was clear that PPI medication is routinely used for reflux in babies, including neo-nates, and Professor Sullivan was not remotely surprised at the treatment C received.

72. We watched the video that had been filmed by the parents of precisely how they were told to administer Lansoprazole to C. Professor Sullivan provided a useful commentary from the witness box. It was his view that the way that the mother described having aspirated the tablet in water, syringed it twice and the given it to C would not have led to her having received a toxic, or even high dose. In fact, she was prescribed a level at the lower range of the acceptable level. Despite the admission of UHCW that they now conceded that a 15mg tablet may have been a preferable dose, he did not attach any significance to the fact that C was prescribed a 30 mg tablet, as the instructions were to aspirate it in an appropriate amount of water and then C was given a dose of the amount of the suspension.

73. His knowledge of the research papers was comprehensive. He agreed with Dr Allgrove about the two current 'theories' that might account for PPI medication causing bone fragility. The first relates to the ability of the body to absorb calcium, but the second concerns the fact that bones are in a constant state of remodelling, and that PPIs may affect the rate at which the osteoclasts are forming new bone. However, Professor Sullivan was quick to tell me that the Wang research study in respect of the effect of Omeprazole had identified that there were no significant changes in either osteoblast or osteoclast activity.

74. As far as the Wang study was concerned, the identified hazard ratio for children who were prescribed a PPI for less than 30 days was only 1.03, which he did not feel spoke of any association with propensity to fracture. Whilst the Malchodi study did identify a higher rate of 21% greater propensity, this was an enormous retrospective study of the records of nearly a million children. Professor Sullivan was of the view that the cohort was, therefore, likely to include a large number of very poorly new-born babies, who are frequently prescribed a PPI as part of their treatment. The Fleishman study also identified a potential association, but it was Professor Sullivan's view that the key factor in all of these studies was the duration of time that the medication was taken for, and C had taken Lansoprazole for only thirty days. In truth, he could not have been more clear that he did not consider that C having taken a PPI for the amount of time that she did was not a factor that I should take into account when considering either underlying causation or mechanism of injury.

75. Dr Jeanes was equally clear about the fractures that she had diagnosed and the probable timeframe for them having been sustained. The metaphyseal fractures of the left knee were completely resolved by the time of the follow up survey. It remained her view that the right knee injury involved bleeding into the periosteum and therefore, either indicated that more force had been used, or that it was a more complex mechanism. She was willing to accept that the 'jiggling' might be a possible mechanism, there was some question in her mind about whether, if that was how the injuries to the left knee had been caused, why the presentation of the right knee was not the same.

76. One of the difficulties in expressing any clear opinion about the causation of metaphyseal fractures is that they are generally only diagnosed in children who are already under investigation for having had an inflicted injury and undergo a skeletal survey. Therefore, it is impossible to have any understanding of how frequently these fractures might occur in the general paediatric population. However, Dr Jeanes did say that it was her experience that they are not routinely

seen and remained of the view that handling with a degree of force outside of the normal was required.

77. Dr Jeanes remained of the view that the parents' account of the incident on the 18th October could be a possible, if unusual, cause of the clavicle fracture, although she had never seen such a fracture in her clinical practice. Whilst a common mechanism is a yank to the arm, Dr Jeanes told the court that a sudden lift involving a forceful twist might be enough to put too much pressure on the shoulder, particularly if the baby was held under the arms.

The Wider Canvass

78. S and G have been friends of the parents for a number of years. On the morning of the 18th October, A asked S to come over in order to witness a mortgage deed, as B and A were buying a new home. S and G arrived at about 4pm and walked directly into the living room, where A and C were. S describes A picking C up and turning her to face outward in a twisting motion, at which point C let out a loud and high-pitched noise for a couple of seconds. S says that this noise was not like any he had heard before. It is S's evidence that when B asked what had happened, A immediately said that *"he must have held her funny."* C was crying by this stage, and B took her and offered her some comfort.

79. G describes A holding C underneath her armpits, with her back towards him and extending her to his left-hand side to an outstretched position in order to *"say hello to Uncle S."* She also heard a high-pitched scream and G says that she thought that C was clearly in some discomfort and pain. G recalls B directly challenging A by saying *"what have you done?"* Neither S or G could be precise about the exact way in which A got from the floor, or how he picked up C, which did not surprise me, as they would not necessarily have been playing close attention, having just arrived at the family home.

80. After C settled, the four adults and C then went to view B and A's new house and A and S collected a pizza. C was placed in her car seat and expressed no discomfort when being positioned. No-one drank any alcohol. C remained in good spirits. After the pizza however, she became more restless, although she enjoyed her bath. S and G left between 7-8pm.

81. S and G both gave statements to the police about these events. Both gave oral evidence to me. S and G both impressed me in their genuine efforts to assist me and they both struck me as being entirely honest about that night, although it is clear that these events have been the subject of much discussion between the four adults who were present since C's injuries were discovered. That would be the natural and predictable response of people trying to understand the importance, if any, of the incident that had taken place once C had come to the attention of professionals.

82. Both B and A told me that the day had been unexceptional leading up to S and G arriving. Nothing had occurred that was significant in anyway. They were preparing for their imminent house move. Both B and C were suffering from a cold. B believed that she answered the door to S and G.

83. A's account of the moments after S and G arrived is as follows,
"I then picked her up under her arms and turned her around to face outwards by leaning her (in a pivotal motion) about my chest area. This was to allow her

to face the arriving guests. I scooped her up under her arms, stood up from my kneeling position, then extended C outwards at arms length towards S, at a slight angle to my left. C then let out a very loud screech for approx 3 seconds whilst I was holding her."
He has also said that he heard a crunch noise from C before he heard the scream, although there is no mention of this in the text messages between the couple at the time.

84. He tried to explain to me the way that he got up from the floor but it was clear that he was far from certain about how either he had moved or how he had held C in those brief moments. He and B agreed that the scream, which was unusual and not like a normal cry, and lasted for a few seconds, came about immediately that A got up and held C out in front of him.

85. C woke up at about 4am. Whilst winding her, A noticed that there was something unusual about the feel of her shoulder. He pointed this out to B, and she agreed. They discussed seeking the advice of the GP in the morning. But it must have been obvious to B that something significant was wrong, as the analysis of her mobile telephone indicated that just before 5am that morning, she began to google *"how to tell if a baby has a fractured shoulder"* and *"baby crunchy shoulder."* Once at hospital and aware of the initial diagnosis, perhaps unsurprisingly, her google searches on the issue of fractured clavicles are extensive and wide-ranging.

86. As I have already noted, A was not allowed into the hospital with B and C, and so they were limited to communicating through text and telephone call. When B tells him that the professionals have been asking questions about how the injury may have been caused, he responds and says, *"the only thing that I can think is when I pick her up with her arms. But wouldn't class that as significant trauma." "She's always been a bit crunchy in that shoulder and maybe it's been like that for a while but got worse."*

87. There is then a series of texts between them in which the mother asks about how A had picked her up, particularly whether C's arms were under or over his hands. B tells him, *"I just said that she was on her playmat and you picked her up as you normally would."* B says that she was not with them when they were playing on the mat, but then she reassures him by saying that he had done nothing wrong.

88. B was also texting her mum at about 2pm on the afternoon of the 19th October, telling her about what was going on. She tells her mum, *"So A picked her up last night and she screamed. She was okay after that but woke screaming at 4am. Her shoulder felt odd, clicky as if something was moving underneath the skin…she's got a fractured collar bone."* B also said to her mum that she *"told A to be gentle with her all the time."*

89. C was a planned baby who was very much wanted and anticipated. By the time that she was born, the country was in lockdown, and so A was on furlough, only working once or twice per fortnight. A was not able to attend any of the later antenatal appointments, and there was no opportunity for this young family to be able to attend the normal NCT or parenting groups. They have a number of friends, including S and G and also B's mum, who lives reasonably locally. B

told me that she is an only child and neither of them had much experience of being around babies before C was born.

90. During the second formal interviews conducted with the parents, the police put to both of them a number of texts between them, which begin when C was only 25 days old. B texted N and said, *"A's pissed me right off….I had a bit of a moan at him today because I feel like he could do a little more in terms of dealing with C when she's crying and he's turned round and said,' Well, you get paid maternity. It's your job."* She went on to say that she was worried that A had said that he did not like C and that he did not feel as though he had bonded with her and that her crying made him angry. B tells officers that they did disagree about caring for C at times, but they always talked about it afterwards.

91. Around the same time, B was also texting her mum talking of A having *"meltdowns"* and complaining that he cannot *"deal with the crying in the evening, says it makes him angry and he thinks she doesn't like him."* A told me that he could not remember using the word 'angry' himself, or that he ever felt angry towards C. He told the court that he had expected to 'bond' with C immediately and when that had not happened, he had felt guilty.

92. On the 8th August 2020, B sent a text message to another one of her friends, *"he'd kill me for even telling anyone but he doesn't feel like he's bonded with her so he says. He literally cannot stand the sound of her crying, it makes him angry to the point he'll have to put her down and leave the room. I get it can be hard for men, he hasn't had her in his belly for 9 months but he doesn't even sleep in the same room as us anymore. It's like he'd rather not be around her which breaks my heart she's so innocent and hasn't done anything wrong what's going to happen when she's that little bit older and starts to understand and pick up on things. I don't want her to grow up thinking her dad doesn't like her.*
He's had some pretty major angry meltdowns at me too because I've told him to do something differently, or to be more gentle with her…he reckons I put him down which I honestly don't feel like I do. I just don't feel like I can rely on him very much for support at the mo, half of me feels like I can't leave him alone because he wont cope but then I think I deserve time out for myself as much as he does."

93. As part of this text discussion, B says that she has talked to her mum about how A was feeling and that she had encouraged him to talk to his own mum but that he felt *"embarrassed"* to.

94. She has told me, and she told the police, that she has a tendency to exaggerate her feelings in arguments, and that she was never actually concerned that A behaved in an angry way towards C. B told me that she had spoken to him about the need to be more gentle, but that she thought, with the benefit of hindsight, that A may have perceived this as her being *"naggy."* There are also texts from B calling a *"fucking prick"* and *"being a dick about her (C) crying."* A told the court that he felt that he was being criticised, and this is certainly borne out by some of his responses at the time.

95. There was undoubtedly an issue between B and A in terms of their approach to feeding C. Not only was B frustrated that it was her perception that A did not

do his 'fair share', as early as 30th June, B accuses A of *"forcing it down her for ..selfish reasons."*

96. B accepted to the police and to me that she did a google search of the term *"force feeding",* which she described as persisting with a feed when C had had enough. She even texted her mum on the 17th October saying that she was starting to think that A's forceable feeding had caused C to develop an aversion. She also texted A on the same day saying, *"If you are forcing her to feed, I will not be happy."*

97. There are also texts that refer to various marks which the parents observe on C. The local authority does not seek any specific findings about those matters, so it is not my intention to make specific reference to them, save to say that A acknowledges that he could be *"heavy handed."* It is also right to note that Dr Saggar suggested that C's skin may mark more readily as a result of her hypermobility.

98. During the course of this hearing, I have watched numerous video clips of C, and specifically, A's handling of C. Some of those videos were put to the mother and the father by the police in their second interviews. Whilst these are just a few taken from the many thousands that are contained on the parents' phones, I will set out what any objective observer can see from those I consider to be directly relevant. I pause to note that these descriptions need to be understood in the light of C's age at the time. She was born on the 1st June.

    19 June (age 3 weeks) – there is a short video of C being held in an uncomfortable position
    19 June (age 3 weeks) – C is positioned behind A's head on his shoulders and her head is flopping to the side, as it is unsupported
    30 June (age 4 weeks) – A is seen very vigorously slapping C's back in order to wind her
    12 July (age 6 weeks) – there are two video clips in which A is seen to be feeding C when she has fallen asleep. He blows in her face forcefully. He lifts her from his lap without supporting the back of her head. He is seen to wind her by revolving her forcefully in a circular fashion and elevates her by her neck.
    5 August (age 9 weeks) – C is in the bath and she is being moved back and forth by A pulling on her right leg
    7 August (age 9 weeks) – C is in the paddling pool and A pulls her towards the rim by her neck
    There are numerous videos of A vigorously jiggling C's legs up and down towards her tummy
    Nanit video (undated) – my perception is C is a tiny baby. A goes into the room and removes her from her cot by holding her under her arms. He does not support her neck.

    The police also put to A, a number of other videos in which he is seen not to support C's neck whilst moving her

99. A accepted to me, and to the police, that his handling of C was inappropriate in those videos. He told me that he feels embarrassed and ashamed of his conduct. He says, *"I feel looking back that I was an inexperienced father and I lacked parenting skills."* He denies that he ever had any intention to hurt her, and that

he was not aware that any of his actions had caused C pain or distress. He said to me in evidence,
"I never had a dad growing up, I had a step dad. I wanted to be a great dad and I just got ahead of myself." What I took that to mean is that he was so motivated to be a fun loving dad, he failed to see that she was a tiny baby and that, whist those times would come, C was too young to be treated in the way that he did.

100. Both the police and the local authority have sought to explore with B why she did not step in and protect her baby when she saw A handle her in the way he does within the videos. B is the camera woman in a number of the videos, and in very many of the ones that are taken in her presence, she can be heard to be laughing. On the 12th July, she does encourage A to stop feeding C, and she told me that she took it in order to be able to play it back to A to try and show him that the way he held C was not acceptable. In the Nanit video (which is a video baby monitor), it is clear that there is a discussion between the parents after A had picked C up, which B told me was her telling him that his actions were not ok.

101. Since C's removal from their care, a parenting assessment has noted that the parents enjoy a relationship in which they are kind and supportive towards each other and share similar values. They are still planning their wedding for next year. They were assessed as being loving parents, who had the ability to meet all of their daughter's needs.

My findings

102. I accept that the parties have not been able to cross-examine Dr Austin. All parties have been in the same position. But when I return to the central questions which I identified that I needed to determine and which I set out at paragraph 27 above, I do not believe that I have been hampered unduly in my investigation. The court has benefitted from a wealth of medical evidence as to the possibility of there being an underlying condition relevant to the fractures. Dr Jeanes has been able to assist me in relation to the identification of the injuries. And as to motive, that is and always has been a question for me.

103. I am entitled to place some weight on Dr Austin's written report, particularly where there is a measure of agreement with the other instructed experts. It was suggested to me in submissions that the significant area upon which this court has been denied specific assistance is that of C's likely pain response, specifically in relation to the metaphyseal fractures. I remind myself that, whilst Dr Austin tells me that these fractures would be unlikely to cause any discomfort at the time of injury, pain response is generally accepted to be a variable and unpredictable indicator, particularly in a child who is not able to speak or express themselves. As I indicated to the local authority, babies cry for a variety of reasons, and there is no evidence that C's discomfort would have been obvious to an untrained eye. Indeed, she was noted in hospital after admission to be a smiley, happy baby, kicking her legs with no signs of discomfort. This was the baby that both A and B knew.

104. I accept the evidence of Dr Jeanes that C sustained the fractures listed at paragraph 43 above and that they were sustained in the timeframes identified by her.

105. The parents have, quite understandably, wanted to explore every possible medical cause for C's injuries. I have set out that evidence in some detail in this judgment, but the stark reality is that the evidence from Professor Sullivan, Dr Allgrove, Dr Saggar and Dr Keenan is overwhelming that C suffered from no underlying medical condition that might be relevant to either causation or probable mechanism/level of force.

106. Any objective observer would find that the way in which A handled C during those early weeks that can been seen in the video footage was careless. In my use of that word, I have reminded myself of the definition of it within the Oxford English Dictionary as *"not giving sufficient attention or thought to avoiding harm or errors."* The listed synonyms are "*inattentive, incautious, negligent, reckless, slapdash, hurried, perfunctory, thoughtless, unthinking, insensitive."* All those words accurately describe what is observable within those video recordings. When he lifts C from her cot, he is slapdash. When he has her on his shoulders, he is reckless. When he blows in her face, he is thoughtless. In much of his handling which I have been able to observe in these videos, he is perfunctory and incautious.

107. But what is singularly absent from any of those videos is any evidence of malice, or a desire to hurt his daughter. Frequently, there is evident joy and love. C is often smiling and laughing. A makes silly noises alongside his actions. It is apparent to me that there is a lack of any awareness from A that his behaviour might even pose the slightest risk to her or that he might hurt her. He treats her like an older child, playful and boisterous. But he is too rough on those occasions, even if I accept, as I do, that there were hundreds of other videos in which his handling was not of concern. I consider that the footage evidences exactly that which A has reflected back to this court, which is that he was a first-time father, in lockdown (so without the benefit of any family member or professional coming into the home and being able to demonstrate how to care for a baby) who is trying to be a father to C in a manner that was months ahead of her developmental stage. He wanted to be the 'fun dad' too soon. The 'piggy-back' video is a stark example of this. To watch it back now raises the hairs on the back of one's neck as a result of how inappropriate it was, but the clear impression is that he simply thinks that he is 'playing' with his daughter.

108. I do not believe that there was any intention at the time to be reckless or careless. It is frequently said that hindsight is a wonderful thing. Had he his time again, knowing what he does now, I am in no doubt at all that A would act differently. But that very fact, in itself, indicates that his parenting of C, on occasion, fell below that which he would expect of himself and that which is expected by this court.

109. A would not be the first father who has struggled to feel an immediate bond with his new-born baby. B would not be the first mother who felt a sense of resentment towards their partner, perceiving that they are left to do the majority of the childcare. It is not unusual for any parent to have periods of feeling overwhelmed and under stress. This couple is not alone in arguing about the division of childcare, or to find themselves bickering about who has benefitted from a night's sleep whilst the other has been kept awake. In the average family, who does not come before the court, these issues arise, they are experienced, but they pass and people move on. But the inevitable consequence of investigations of this nature demand that every part of a family's life is

subject to unusual and detailed scrutiny, where every feeling (justified or not) is put under the microscope.

110. I accept B's evidence that some of her messages were over-dramatic, partly as a result of being a first-time mum and partly because that is who she is. I did note that she gave much of her evidence to me in a state of some distress. Her text messages have to be read within that context. But even saying that, B was also telling others at the time that A would never hurt their child. I am clear that there is no evidence that has been put before this court that would suggest that A's poor handling ever went beyond the careless into something that was deliberately harmful, or that his emotional struggles led him to hurt his baby.

111. I am not persuaded that A ever used 'force' to feed his daughter. The language that B uses is emotive. That which concerned her was that A persevered with a feed longer than she did, and given C's reflux issues, this worried her. This issue does not give me reason to believe that A's handling of his daughter went beyond the careless handling that I have already acknowledged and identified.

112. It is my assessment of the evidential picture, taken in the round as I must do, provides a very clear basis to conclude the probable causation of C's injuries. I accept the evidence of B, A, S and G that something happened as A lifted C from the floor on the afternoon of the 18th October that caused her to scream out in a way that she had never done before. Having viewed the numerous videos of how A held and picked up C prior to this occasion, it is all too easy to see how he may well have done so in a way that was unintentionally reckless to her safety, and in doing so, caused the fracture to her clavicle, however accidental it was.

113. In fact, he cannot precisely recall how he moved either himself or his daughter in that brief moment. But the pick-up must have involved rising himself from the floor, picking C up from the mat and twisting her round to turn away from him. On any analysis this was a clumsy operation, in which it is entirely predictable that forces could have been applied to C's upper chest quite unwittingly. With the benefit of hindsight, A should have got himself steady and upright before he attempted to lift his baby up.

114. The fact that B undertook a google search at 5am the next morning is clear evidence that she only became aware of the possibility of an injury that night. She struck me as the kind of mother who would never allow her daughter to be in pain under any circumstances. Had she been worried about C at any point before then, she would have done exactly the same google search. She and A decided to present her to medical professionals the very next morning. There is no evidence that they contemplated not doing so in an effort to conceal C's injuries. Their account of the events of the night before was given at the time and has been consistent throughout. I consider that C's clavicle fracture occurred during that lift from the floor, and that, whist 'an accident', it is likely that A was careless in the way that he did so.

115. I am also in no doubt that the metaphyseal fractures to C's legs were also caused by A's careless handling. His vigorous jiggling of her legs is a probable cause of the fractures to her left knee. Whilst there is no literature that assists Dr Jeanes in her assessment of whether this was the probable

explanation, I am entitled to look at all of the evidence. Anyone looking at those videos would consider that it was overly forceful and was likely to have induced the kind of torsional forces necessary to cause fractures of the kind seen in C. Further, I have considered the evidence of A manoeuvring C around the bath by her right leg, and I am of the view that this kind of careless handling is likely to have caused the injury to the right leg. The videos are snap shots of the way in which he parented C in those first few months of her life. There are likely to have been other incidents of this nature, in which specific force was applied to her right leg in a similar fashion. Those fractures would not have been apparent to either of the parents either at the time they were sustained or afterwards, and A had no reason to believe (apart from objectively being too rough) that his actions were injuring his daughter. Even if she had cried, there would have been no reason to associate that crying with an injury.

Failure to protect

116. I have already indicated that the manner in which A picked C up without supporting her head, picking her up by her head and winding her roughly were careless and placed her at risk of harm. The jiggling of the legs was too rough. I do not believe that he had any intention to risk the welfare of his baby. I entirely accept that these are two parents who love their daughter with all their hearts. A has found it hard to watch the videos because it is apparent to him now, with the benefit of hindsight, that his parenting at that time was not good enough. It fell below that of a reasonable parent. Whether he would have fallen into those errors had the country not been in lockdown, had he been able to attend parenting classes, had his mother or his mother-in-law been able to come into the family home and spend time with these new parents, I do not know and cannot speculate. But that is the important context of his failure.

117. It is also the context of B's responses to the way A held their baby. Whilst she was equally inexperienced, she did recognise that A was not being sufficiently gentle. In some of the videos, it is hard to understand why she filmed his conduct rather than stopping him in his tracks and stepping in. Whilst she may have used the video on the 12th July to show him where he was going wrong, there are other videos (such as the piggy-back) when she is not stopping A from behaving in a careless manner with their daughter, and she should have done. In not doing so, she has failed to protect C. But I believe her when she tells me that A never acted in anger towards their daughter, and that she did recognised that he was not sufficiently gentle and did what she could to reinforce that message. She, too, found herself without the sources of support that one would normally seek out for advice and assistance.

118. There is no evidence to suggest that her limited failure to 'step in' extends to having failed to prevent the specific injuries that brought this case before the court. Whilst she might have recognised that the jiggling was over-vigorous, she had no reason to know that it might harm her baby's bones in the way that it did. Nor were there any steps that she could or should have taken to prevent an accidental, albeit heavy handed, action which caused the clavicle fracture.

119. In summary, my determination is that the threshold criteria pursuant to s31 Children Act 1989 is satisfied on the following basis;

(1) C suffered significant harm (being a fractured clavicle and metaphyseal fractures to her left and right knee) as a result of careless but unintentional handling by A
(2) There were other incidents of careless handling (as evidenced by the videos) by A that placed Cat risk of significant harm.
(3) B recognised that A was not sufficiently gentle and did not take sufficient steps to protect C

120. A and B have learnt the hardest of lessons. To know that, despite not intending to, C suffered injuries in their care must be unbearable. And I do not doubt that the last year has been nothing short of a nightmare for them both. But the evidence obtained since October last year may well suggest that the lesson was learned a long time before I have been able to make the decisions that I have. No professional has raised a single concern about the way in which they parent their daughter since she has been out of their care. There is every reason to believe that B and Aare now the most careful of parents. The risk that A presented twelve months ago is now reduced both as a result of the steep learning curve he has been on, but also the development of his baby.

Sanctions against Dr Austin

121. As I indicated to the parties, this court and the parties have already spent too much time and energy trying to ensure that Dr Austin complies with his professional obligations, without any success. I am told that he has already been paid his costs for the preparation of his report. Such sanctions as I have, such as to make a wasted costs order against him, are likely to prove more problematic and to be even more time-consuming.

122. The focus of this court has been and will continue to be C. It is my determination not to make any further sanction against Dr Austin, save that I direct that a redacted copy of this judgment should be sent to his professional body. It is also my intention to place an anonymised version of this judgment on BAILLI. All of the court appointed experts will be identified.

123. This is my judgment.

CHRONOLOGY OF COMMUNICATIONS WITH DR AUSTIN SINCE MAY 2021

All email communications with Dr Austin were sent to both his home/personal email address and work email address. Hard copies of document sent by email were also sent to his home postal address as requested by Dr Austin.
17 May 3.17pm- Dr A emails his report.
17th May – report filed and served 3.38pm
25th May 2021- 11.16am medical bundle resent to Dr A
25th May 2021- 3.11pm- Notifying Dr A that an advocates meeting took place on evening on 24th May 2021 and there will be clarification questions for him.
25th May 2021- 5.01pm- Email from Dr A confirming he is away and it will be early next week
25th May 2021- 5.21pm- SN emailed to acknowledge safe receipt, would send questions hopefully by tomorrow and notified the parties of his absence, and await report.

26th May 2021- 12.45pm- SN emailed the agreed clarification questions, and further updated bundle to Dr A.
26th May 2021- 1.49pm- SN sends Dr A a copy of the clarification questions that have been sent to Dr Jeanes and Dr Saggar for them to consider.
2 June 2021- 12noon- SN emails Dr A a copy of Dr Jeanes Addendum/clarification questions report.
2 June- Hard copy of Dr Jeanes report sent to Dr A home address by first class post
3 June 2021- 9.58am- amended report of Dr Jeanes sent to Dr A
3 June 2021- amended report of Dr Jeanes sent to Dr A by first class post
9 June 2021 12.25pm- SN emails Dr A asking for report and reminding him of needed the clarification questions by PHR on 14/6/2021
14 June 2021- SN emailed requesting Dr A to confirm when he can file a response to clarification questions.
auto out of office received from Dr A- he will return 15/6/2021
15 June 2021- 3.55pm- SN emailed Dr A to notify the fact find had been vacated and requested availability October- December 2021 and availability for experts meeting August- September.
15th June 2021- 6.13pm- SN's paralegal telephoned Dr A hospital to note concern of no response to recent communications, is he unwell/on annual leave? Dr A's secretary had already left for the day and unable to assist.
16th June 2021- 9.30am- SN's paralegal telephoned Dr A to ascertain availability– no response so voicemail left.
16th June 2021- 9.30am- SN's paralegal telephoned Dr A's secretary to ascertain availability– he is not on leave or unwell and she cannot pass on any messages to him regarding this as it is his private work.
16th June 2021- 2.35pm- SN's paralegal telephoned Dr A to ascertain availability– no response so voicemail left.
18th June 2021- 8.12am- Dr A emails SN (replying to email of 14th June) confirming he will look at the questions today
18th June 2021- 12.04pm- SN emails Dr A confirming the new finding of fact dates, asks if he can attend remotely, asks for availability for experts meeting in August and September.
24th June 2021- 12.38pm- SN emails Dr A asking for date he can provide the clarification questions given his email of 18th June 2021.
2nd July 2021- 12.30pm- SN's paralegal provides Dr A with father's statement and video/photo exhibits.
2nd July 2021- 12.30pm- hard copy letter providing Dr A with details of order made, availability for experts meeting for August -September and confirmation he can attend the finding of fact hearing on day 4.
5th July 2021- 10.25am- SN's paralegal emails Dr A a copy of the sealed order of 15th June 2021. Copy also sends first class post.
5th July 2021- 3.47pm- SN's paralegal send Dr A a copy of Mothers statement with video. Also sent by first class post.
9th July 2021- 10.44pm- SN's paralegal sends Dr A a copy of Dr Jeanes' addendum report. Also sent by first class post.
19th July 2021- 11.07am- SN's paralegal emails Dr A a copy of Professor Sullivan's report. Also sent by first class post
auto out of office received from Dr A- he will return 3/8/2021)
28th July 2021- 11.50pm- SN's paralegal emails Dr A a copy of Dr Jeanes addendum. Also sent by first class post.
1 August 2021- 12.31- Dr A emails SN and her paralegal confirming that he is conscious that he has not answered the further questions, asks for them to be resent and that he will attend to them this week, also asked for the court date.

2 August 2021- 11.07am- SN- resent clarification questions by email to Dr A, also reconfirmed final hearing dates, asked if he can attend remotely to give oral evidence, reminding him of the hearing on 20th August, asking for availability for experts meeting for August – September and also asking for confirmation as to when we will be receiving clarification questions.
auto out of office received from Dr A- he will return 3/8/2021
2 August 2021- 11.40am- Dr A emails SN to confirm he can attend remotely on Teams/Zoom, flexible after 6pm 3/4/5/10/11/12/17/18 August for experts meeting, will try to sort out clarification questions by the end of this week.
9TH August 2021- 4.31- SN's paralegal sends Dr A a copy of Dr Allgrove's report. Also sent by first class post.
9th August 2021- 4.37- SN emails Dr A asking when we will receive clarification questions.
16 August 2021- 5.05pm- SN emails Dr A reminding him of hearing this Friday and notifying him of advocates meeting this Wednesday. Requests that he urgently sends his report dealing with the clarification questions by Wednesday.
19th August 2021- 10.56- SN emails Dr A indicating concern as not had his report
19th August 2021- 1.07PM- SN sends Dr Saggar's report to Dr A and asking when he will be in a position to provide his report. Also sent by first class post to his home address.
20th August 2021—9.42am- SN emails Dr A reminding him of the hearing today and putting him on notice that the parties may invite the Court to direct that he attends a hearing to explain the reason for his failure to provide a report. Explaining that if he provided his report, it would avoid the need for him to attend Court.
20th August 2021- 10.57- SN telephoned Dr A's mobile and left a voicemail asking him to call SN on mobile to confirm when he can report by and reminded him of hearing at 2pm today.
20th August 2021- 2.31pm- SN's paralegal telephoned Dr A's mobile and left a voicemail asking when his report would be ready.
20th August 2021- 2.38pm- SN's paralegal telephoned Dr A's hospital
23rd August 2021-5.06pm SN telephones Dr A and left a voicemail asking him to return her call
23rd August 2021-5.44pm- SN sends email to Dr A's personal and work email addresses detailing outcome of hearing on the 20th August 2021
24th August 2021-9.28am- SN's paralegal sends Dr A a letter detailing the outcome of the hearing that took place on the 20th August 2021 via first class post to his home address and emailed to both personal and Work email addresses.
24th August 2021-14.11pm- SN's paralegal telephoned Dr A's mobile and left a voicemail explaining that the Judge had emailed Dr A directly that morning enquiring whether his report would be ready by the 3rd September.
27th August 2021-12.28pm- SN sends Dr A an email to his personal and work email addresses requesting him to contact the office. Received out-of-office response (out-of-office until 21/09/21). SN's paralegal sends Dr A a letter requesting the same sent via first class post to his home address.
3rd September 2021- 10.24- SN's paralegal telephoned Dr A's mobile and left a voicemail explaining that he had previously been sent emails from both SN and HHJ Walker asking him to prepare his report by today. SN's Paralegal left a voicemail asking if his report would be ready, and if not, he would need to attend court on the 17th September to give an explanation as to why it was not ready.
3rd September 2021-12.16pm- SN sent Dr A an email to his personal and work email addresses reminding him that his report was due to be filed with the court on this date, concerned that he had not responded to any communication and asked for confirmation that he would be providing SN with report.

17th September 2021-5.06pm- SN emails Dr Austin notifying him of the order made today by HHJ Walker
27th September 2021-11.07am- SN's clerk sends Dr A a letter detailing the outcome of the hearing that took place on the 23rd September 2021 and notifying him of the witness summons via post to his home address and email to his personal and work email addresses. Received out-of-office response (out-of-office until 4/10/21)
27th September 2021-1.08pm- SN's paralegal telephoned Dr A's mobile and left a voicemail explaining that Judge had granted a witness summons at the hearing on the 23rd September for Dr A to attend a hearing on the 15th October at 9am. SN's Paralegal explained that he would need to attend to explain why he has not prepared his report or replied to the Judge's email.
27th September 2021-2.41pm- SN sends email to Coventry Court with attached witness summons for Dr A for Court to issue. SN requested that it be issued so it could be served on Dr A in readiness for hearing on the 15th October 2021.
27th September 2021-2.49pm- SN's paralegal called Wirral University teaching Hospital to be put through to the legal department to send letter informing of Dr A's summons- was put through to Information Governance and was told to send any legal letters to wcnt.yourexperience@nhs.net.
27th September 2021- 3.41pm- SN's paralegal sends letter to Wirral Community Health and Care NHS Foundation Trust's Information Governance department via email and first class post informing them of Dr A's witness summons.
27th September 2021-5.33pm- SN makes arrangements for Dr A to be personally served with the witness summons.
28th September 2021- SN's clerk sends Dr A letter referencing outcome of hearing on the 23rd September 2021 and enclosing witness summons via first class post to his home address by first class post and by recorded delivery. (A copy was also given the to the process server for personal service)
29th September 2021- SN received a call from the process server confirming that Dr A had been personally served with the witness summons
30th September 2021- SN receives email from process server with attached statement of service.
7th October 2021- 4.24pm- SN's paralegal sends Dr A a letter enclosing details of the hearing to take place on the 15th October 2021.
12th October 2021-3.22pm- SN's paralegal telephoned Dr A's mobile and left a voicemail reminding him of his summons to attend hearing on the 15th October 2021 at 9am.
12th October 2021-3.35pm- SN's paralegal telephoned Dr A's hospital, reminding Dr A of hearing on the 15th October at 9am at Coventry Family Court.
14th October 2021- Court office sends Dr A the Teams link for the hearing at both his home and work email addresses
15th October 2021- Dr A fails to attend the hearing and in breach of the witness summons.
9 November 2021-12.45pm- Email from SN to Coventry Court with attached witness summons for Dr A, for it to be issued and sealed.
9 November 2021-2.13pm- Email from Coventry Court with attached sealed witness summons for Dr A
9 November 2021-5.17pm- Email from SN to process server requesting that he serve Dr A with attached letter addressed to Dr A and witness summons.
10th November 2021-12.02pm-Letter sent to The General Medical Council, informing them of Dr A's witness summons. Sent via post and email
10 November 2021-12.48pm- Letter sent via post and email to Royal College of Paediatrics and Child Health regarding Dr A.

11 November 2021-10.22am- Letter and email to Dr A from SN with attached updated response documents from parents. Email also contains explanation that Dr A is required to give oral evidence at Coventry Family Court at 9am on the 30th November 2021.
12 November 2021-11.06am- Call to SN from process server confirming service of witness summons on Dr A.
16th November 2021- Letter to Dr A enclosing court order dated 9th November 2021. Sent via post and email
26th November 2021- Letter to Dr A reminding him of witness summons details and where/when to attend. Sent via post and email
22nd December 2021- Letter to Dr A confirming the outcome of the finding of hearing.
6th January 2022- Letter to Dr A enclosing court orders. Sent via post and email
19th January 2022 - Letter enclosing Judgment. Sent to Dr A via post and email