IN THE SWINDON FAMILY COURT Case Number

B E T W E E N:

WILTSHIRE COUNCIL Applicants

and

MOTHER First Respondent

and

FATHER Second Respondent

and

THE CHILD Third Respondent
(By the children's guardian)

and

MATERNAL GRANDFATHER Fourth Respondent

WRITTEN JUDGMENT OF HIS HONOUR JUDGE EDWARD HESS

(Delivered to the parties by email on 26th February 2021)

INTRODUCTION

1. I have before me an application brought by a local authority, to whom I shall refer in this judgment as "the local authority".

2. I have heard the application over ten days on 15th, 16th, 17th, 18th, 19th, 22nd, 23rd, 24th, 25th and 26th February 2021. The evidence was completed on 24th February 2021. The advocates produced written submissions to me on 25th February 2021. I have handed down this written judgment by email at 2.00 pm on 26th February 2021 and the parties have been asked to appear before me at 3.30 pm on 26th February 2021 to discuss what should now happen in the light of this judgment.

3. The application relates to one child: The child born in 2019, a girl now aged approximately 1½ years, to whom I shall refer in this judgment as "The child".

4. The Respondents are:-

    (i) Mother (born in 1993, now aged 27), to whom I shallrefer in this judgment as "the mother";

    (ii) Father (born in 1991, now aged 29), to whom I shall refer in this judgment as "the father";

    (iii) The child herself, represented by her children's guardian of CAFCASS; and

    (iv) Maternal grandfather (born in 1973, now aged 47), to whom I shallrefer in this judgment as "the maternal grandfather".

5. The representation before me has been as follows:-

    (i) The local authority was represented by Ms Julie McKenzie (Counsel);

    (ii) The mother was represented by Ms Maria Gallagher (Counsel) instructed by Wansbroughs Solicitors;

    (iii) The father was represented by Mr Christopher Butterfield (Counsel) instructed by Wollens Solicitors;

    (iv) The maternal grandfather represented himself as a litigant-in-person; and

    (v) The child was represented via the children's guardian by Mr William Heckscher (Counsel) instructed by Royds Withy King Solicitors.

    I want to thank all the advocates for their considerable assistance in this case. All worked assiduously hard and with great skill and sensitivity. As is so often the case in this area of law, the court is fortunate to be presented with first class legal representation and advocacy in these difficult cases which involve so much emotional entanglement and have so much at stake for the parties. I want also to thank the maternal grandfather for his sensible non-confrontational contribution and his dignity in dealing with some difficult and challenging personal situations during the hearing.

6. It may be helpful for any reader of this judgment for me to mention at this stage a number of other people who are not parties but have played a part in the developing events which have been at the heart of this case:-

    (i) The maternal grandfather's wife (born in 1970, now aged 51). They live together. The maternal grandfather's wife has a number of adult children from a previous relationship: A (27), B (25) and C (20). I shall discuss in some detail below certain aspects of the maternal grandfather's wife's life, their relevance to the current situation and the difficulties she has had in being open and honest about them and coping with questions about them which she regarded as intrusive; but it is in any event common ground with everybody that she has given a huge amount to the care of the child sinceJanuary 2020 in a selfless, generous and committed manner.

    (ii) The "maternal grandmother" (born in 1971, now aged 49). The maternal grandmother's husband (born in 1971, now aged 49). They live together. They have two minor children living with them: D (12)and E (8). In addition, the maternal grandmother has another adult daughter F (27) from a different relationship. I shall discuss in detail below the maternal grandmother's past, present and possible future involvement with the child.

7. In considering this application I have considered a bundle which contains a very large amount of material running to over 3,000 pages, which I have had in the form of an electronic bundle, together with a significant amount of additional material supplied to me in the course of the hearing, the totality of which can perhaps be summarised (non-exhaustively) as follows:-

    (i) Various material from the local authority, including a final schedule of findings sought and various responses to it.

    (ii) A collection of applications and orders in these proceedings.

    (iii) Material from the local authority allocated social worker,consisting of:-

        (a) statements dated 3rd January 2020, 22nd May 2020, 18th June 2020 and 18th December 2020 (the latter accompanied by a care plan and a care plan analyses by her also dated 18th December 2020); and

        (b) a viability assessment of the maternal grandmother and her partner dated 3rd May 2020.

    (iv) A parenting assessment of the mother and the father from the local authority assessing social worker, dated 26th March 2020.

(v) An SGO/fostering assessment of the maternal grandfather and maternal grandfather's wife from the local authority assessing social worker, dated 24th March 2020 and an addendum dated 12th May 2020. A curious feature of this case was that these documents in their original bundle form were heavily redacted. I shall discuss the significance of this below. In the course of the hearing the SGO assessor produced some papers from the local authority's fostering panel's deliberations (including unredacted versions of the above) on the issue of whether approval should be given to the maternal grandfather and maternal grandfather's wife as foster carers (they were not so approved as I shall discuss further below).

(vi) An SGO/fostering assessment of the maternal grandmother and her husband from a different local authority assessing social worker, dated 6th August 2020. A curious feature of this case is that this important document was not in the trial bundle and had been 'forgotten' about by the children's guardian, facts which emerged only during the final hearing. I shall discuss the significance of this below.

(vii) Extensive medical evidence, including material from:-

(a) Dr Oystein Olsen, Consultant Paediatric Radiologist, as a jointly instructed expert, dated 2nd May 2020, 8th September 2020, 7th December 2020, 11th February 2021 and 18th February 2021;

(b) Dr Anil Shenoy, Consultant Paediatrician, as a jointly instructed expert, dated 12th May 2020, 3rd June 2020, 15th September 2020 and 11th February 2021;

(c) Dr Patricia May, Consultant Paediatrician, as a treating doctor at the Hospital, dated 10th June 2020;

(d) Dr Paul Skett, a Forensic Pharmacologist, dated 22nd June 2020 together with a number of medical journal articles relevant to his evidence;

(e) Dr Anand Saggar, Consultant in Clinical Genetics, dated 28th August 2020, 20th November 2020 and 14th January 2021 together with a number of medical journal articles relevant to his evidence;

(f) Dr Seb Gray, Consultant Paediatrician and safeguarding and treating doctor at the Hospital, dated 29th December2019; and

(g) a collection of medical notes and radiology images.

(viii) Statements from the mother dated 22nd January 2020 and 8th February 2021.

(ix) Statements from the father dated 22nd January 2020, 13th May 2020, 21st May 2020 and 2nd February 2021.

(x) A joint statement from the maternal grandfather and maternal grandfather's wife dated 29th May 2020 and an email dated 22nd February 2021.

(xi) A statement from the maternal grandmother dated 4th June 2020.

(xii) A statement from a potential alternative carer dated 4th June 2020 (although in the event she has not featured really at all in the course of the final hearing).

(xiii) A statement from a Major dated 16th February 2021 togetherwith an army annual appraisal of the father signed off by a 2nd Lieutenant on 26th January 2021.

(xiv) A CAFCASS final case analysis from the children's guardian,dated 15th February 2021.

(xv) Extensive disclosure from the Police. This includes transcripts of police interviews by the mother and the father and various selections of text and What's App messages between the mother and the father and others (the selections themselves are a small portion of a huge body of material extracted from various electronic devices).

(xvi) A Collection of photographs and video clips of the child.

(xvii) A scrapbook of photographs and memories centring on the child's lifebeautifully prepared by the parents.

8. I have also heard oral evidence, subjected to cross-examination, from:-

(i) Dr Oystein Olsen (day 1);

(ii) Dr Anil Shenoy (day 1);

(iii) The key social worker (days 2, 4 and 6);

(iv) The parent assessor (day 2);

(v) Dr Paul Skett (day 3);

(vi) Dr Anand Saggar (day 3);

(vii) the maternal grandfather (day 4);

(viii) the maternal grandfather's wife (days 4 and 6);

(ix) The SGO assessor (day 5);

(x) the maternal grandmother (day 5);

(xi) the maternal grandmother's husband (day 5);

(xii) the mother (day 7);

(xiii) the father (day 7); and

(xiv) the guardian (day 8).

9. Since the conclusion of the live evidence I have had the benefit of full written submissions from all the advocates and from the maternal grandfather. I have also received some responses to the others' submissions. I have considered all of these documents.

10. I am delivering this judgment in the afternoon of 26th February 2021 having had the opportunity to consider all the representations made and to reflect on all the evidence received.

BACKGROUND CIRCUMSTANCES

11. The mother was born in 1993. Her father worked in the RAF and later the construction industry, but her parents separated when she was aged just 2. Her mother was her primary carer thereafter, but she had a good amount of contact with her father as well and seems always to have been close to both of them. She appears to have had a generally happy childhood and, although her parents both had a number of other partners over the years, there seems to have been no great problem with this. She has a large number of family members of both her mother and her father's family and reports suggest that the family meet up a lot together and that
there are quite a number of other children of about the child's age. The mother left schoolafter GCSEs, started but did not finish a number of training courses and had various
jobs including a children's services administrator, a member of staff at a night club, a court usher and most recently a prison officer. She particularly enjoyed her work as a prison officer, and although she had to give this up when the child was born so as to care for her, she would like to return to this work at some stage. She has had no criminal convictions or cautions, no history of substance misuse and no significant mental health issues. The impression I have of her is of a likeable person who speaks her mind and 'wears her heart on her sleeve' at times, but is generally confident, gregarious and friendly.

12. The father was born in 1991. Like the mother, his parents separated when he was very young and he was primarily brought up by his mother (to whom he remains very close); but had a good amount of contact with his father as well. Like the mother, he

appears to have had a generally happy childhood and was generally comfortable with the other partners his parents had over the years (although recently has had something of a falling out with his father and has, for the time being anyway, ceased seeing him). He enjoyed school, achieved some GCSEs and then trained as an electrical engineering technician, later joining the Army through which he has served overseas in areas including Canada and South Sudan. The Major (his commanding officer) has described him as "*a good junior NCO, he had not been in any trouble andworks really hard…some people did think he was maybe a bit of an odd fish"*, but as at December 2019 the Army had had some concerns for his mental health, and the Major noted that "*he currently sits on our Vulnerable Risk Register due to an attempted suicide which had taken place approximately a year before*" and that "*we needed to keep an eye on him*". The father's January 2021 formal assessment notes
that he is "*a fit and robust individual, he sets an excellent example…he is a popular and approachable member of the battery…gains my strongest recommendation for promotion*". The father has confirmed that "*I have also suffered from anxiety, depression and OCD. In 2018 I did try and end my life through taking a lot of sleeping tablets…symptoms very rarely flare up and I am able to deal with these*". He has had no criminal convictions or cautions and no history of substance misuse. The impression I have of him is of an affectionate and loving person, probably a more emotionally complicated person than the mother; but generally gentle and caring. He has described some physical problems in his own health which it is suggested are related to Ehlers-Danlos Syndrome (which I shall discuss further below).

13. The mother and the father initially met as teenagers in about 2008, but did not then start a relationship, though kept in touch. They did commence a relationship in about August 2017 and became engaged to be married in early 2018. They lived in different parts of the country at this point (he with the Army and she near her maternal family) so generally saw each other only atweekends. The mother became pregnant in late 2018 and both parents were very happy with this news, indeed were already contemplating IVF treatment before the news arrived. Both by then in their mid-twenties, they seem to have felt ready to settledown as a family. In July 2019 the father was posted by the Army.

14. In summer 2019 the child was born in a hospital. It was a difficult birth involving two days of pre-birth hospitalisation, an emergency Caesarian section under general anaesthetic and a five day post-birth hospital stay for mother and baby. Despite this, there was no suggestion at the time that the child had suffered any injuries connected with the birth. From the accounts I have heard, my impression is that the normal temporary but physically disabling and painful effects of a Caesarian birth on a mother did make life challenging for the mother in the early weeks of the child's life, especially as the family were living in a third floor flat with a broken lift and this may have contributed to the mother's sense of post-birth low feeling, which is of course not uncommon in new mothers.

15. Immediately after the birth the father had a month of paternity leave which he spent with the mother. On his return to work the parents remained living

mostly apart during the working week, but spent the weekends together. The mother spent a good deal of time during the week with the maternalgrandmother at this stage, my impression is this was a large part of almost every day. My strong impression is that the mother was heavily emotionally supported by the maternal grandmother and that the child and the maternal grandmother established a strong bond during this period.

16. On November 2019 the parents were married. On the night before the wedding the child was looked after by the father's sister. The night after the wedding the child was looked after by the maternal grandmother. The wedding was by all reports a happy affair and the families seem to have been united in support of the newly married couple.

17. The plan was to move almost straight away into married quarters in military accommodation. The parents left the child with the maternal grandmother for two nights around 20th November 2019 to prepare their new home for the child's arrival and on about 22nd November 2019 the couple with their new baby moved into their new home . I observe that these few months between August and December 2019 involved very significant life changes for the mother. In quick succession she ceased work which she enjoyed, became a new wife, became a new mother and moved from one area to a different area of England, well away from her roots and her family (in particular her own mother). It is clear that the mother, perhaps understandably, found these changes challenging and difficult and some of her contemporaneous text messages (of which more below) illustrate moments of unhappiness for her as she contemplated the effect of the changes on her lifestyle and life enjoyment. To add to the challenging nature of this period the child had some health issues (which I discuss in detail below) and the mother made the discovery (in general terms in October 2019 and in detail on 6th December 2019) that after the time of the commencement of their relationship (in about November 2017) the father had had a sexual liaison with a female. The mother was understandably upset by this discovery and for a while seriously contemplated leaving her new husband. The text messages suggest that the maternal grandfather was supportive and comforting to her at this difficult time. Notwithstanding these challenges, and all the pressure arising from the matters which subsequently emerged, and which are the direct subject matter of this case, the parents remain together in what I have been able to observe (over the course of these proceedings and this hearing) as a loving, supportive and affectionate relationship. Sometimes in these injured baby cases the parents split up as a result of the pressure involved in court proceedings and specifically and angrily blame each other for what has happened – that is not the case here.

18. The parents spent four nights over Christmas 2019 in a hotel and spentthe time during the day with members of their families. This seems to have been a happy time. Nobody has reported observing any particular problems with the child's health or wellbeing over this period. They returned home on 27th December 2019. Possibly because she had slept a lot in the car on the journey South, the child did not sleep well when they reached home on the night of 27th December 2019.

19. At about 10.00 am on the morning of 28th December 2019 the father took the child for a drive in an attempt to settle her. The plan was successful and she fell asleep in her carseat. The father says that when he took the child out of her car seat without waking her atthe end of this drive her left arm was caught in the strap of the car seat and she cried, but she was consolable and she went back to sleep. Later in the day the parents noticed that the child's arm was limp and at about 3.00 pm, concerned about this, they took her to Hospital. At the hospital the child was x-rayed and found to have a fracture of the left humerus. The arm was appropriately placed in plaster. The father'sexplanation for the injury was accepted by the treating doctors and the child was discharged home.

20. The following day, 29th December 2019, a paediatric consultant at Hospital, was contacted by the orthopaedic consultant on call. The x-rays from the day before had been reviewed and there were concerns that there were old rib fractures. The parents were requested to return to the hospital, did so without demur, and a child protection medical assessment was undertaken, including a full skeletal survey on 30th December 2019. This revealed a large number of other fractures (mostly of ribs), the full details of which are discussed below. The initial reaction of the consultant paediatrician in charge of safeguarding children, was that "*the constellation of findings here is strongly suggestive of inflictedinjury*". The matter was referred to the local authority. The child remained in hospital while the matters were investigated and while the local authority made arrangements for the child's care in the light of these developments.

21. On 6th January 2020 the local authority issued care proceedings in the Family Court. An urgent hearing was conducted on 7th January 2020 before DJ Crooknorth at which an interim care order was made with an interim care plan for the child to be looked after by the maternal grandfather and maternal grandfather's wife and it is common ground from all involved that they have given excellent care to the child ever since. At this early point in the investigation the local authority took the view that the maternal grandmother could not be considered as an interim carer because she had had sole care of the child in the possible injury window and so had to be considered, untilfurther investigation, as being in the pool of possible perpetrators. It was difficult for the parents to challenge this view at this early stage and they were no doubt given legal advice that a challenge would be unlikely to succeed. Given the choice between foster care and care by the maternal grandfather, the parents had no difficulty in supporting the family option, but this immediate choice has had consequences further down the line, as we shall see below.

22. The early case management was conducted by DJ Crooknorth and Recorder Leong, and the initial plan was for me to conduct a fact-finding hearing in the week commencing 11th May 2020; but the arrival of Covid-19 coupled with significant delays and complications in the police disclosure (in particular the analysis of electronic records) and in the medical evidence (in particular the need to ascertain with a full and fair investigation whether the child had had any underlying bone fragility

which might have explained her injuries) soon made this not a viable option and the plans had to be reformulated. The case was re-timetabled through to an IRH on 23rd October 2020, by which time it was believed the medical investigations would be complete.

23. As time moved on through 2020 the initial decision to place the child with the maternal grandfather and his wife proved to be more and more unwelcome to the parents and, as the maternal grandmother seemed less and less likely to be a possible perpetrator, a challenge was made to the interim position. The parental unhappiness with the interim position was, it seems to me, exacerbated by the onset of Covid-19 and the restrictions that placed on direct contact and also the maternal grandfather's wife's reluctance to supervise interim contact, insisting that only professional supervisors should be involved, which made contact more difficult to arrange. These interim issues were considered at an interim hearing before Recorder Bradly on 22nd June 2020, who decided that the child should remain in her placement pending the final hearing. One factor in this decision was that the maternal grandmother had not by then been formally removed from the pool of perpetrators and this did not in fact happen until December 2020 (a fact which has drawn criticism from the parents' lawyers). Notwithstanding the practical difficulties caused by Covid-19 and the distance between one county and the other, the level of contact between the parents and the child has been at a fairly high level, with direct supervised contact two or three times per week and video contact on most other days. It is common ground that this contact has been very positive for the child, with regular illustrations and love, affection and suitable stimulation in both directions. I want to give credit here to the maternal grandfather who has played a major role on a practical level in ensuring that this contact has happened. Without his involvement my impression is that this contact would have been much more limited. Some of this contact has also involved the maternal grandmother, who has been able to maintain the bond she made with the child in the months immediately after her birth.

24. By the time the case reached IRH on 23rd October 2020 it was clear that there was no consensus on either threshold or welfare decisions and that a full contested hearing was inevitable and I decided to list a combined fact-finding/threshold/welfare hearing with a 10 day time estimate at the first available time, which was the 10 day period commencing on 15th February 2021. The time estimate has turned out to be broadly accurate, including time for the delivery of judgment.

25. I want to record that in making the case management decision to conduct a combined fact-finding and welfare hearing in this case, I agreed with and followed the thinking of Ryder LJ in *Re S* [2014] EWCA Civ 25, when he said:-

> *"the case raises yet again issues of case management relating to split hearings which ought to be addressed given that the social care context was missing from the consideration of the pool of perpetrators and from any consideration of factors that may have caused secondary facts to be found from which an inference of primary fact could have been made…It is by no means clear why it was thought appropriate to have a 'split*

hearing' where discrete facts are severed off from their welfare context. Unless the basis for such a decision is reasoned so that the inevitable delay is justified it will be wrong in principle in public law children proceedings. Even where it is asserted that delay will not be occasioned, the use of split hearings must be confined to those cases where there is a stark or discrete issue to be determined and an early conclusion on that issue will enable the substantive determination (i.e. whether a statutory order is necessary) to be made more expeditiously. The reasons for this are obvious: to remove consideration by the court of the background and contextual circumstances including factors that are relevant to the credibility of witnesses, the reliability of evidence and the section 1(3) CA 1989 welfare factors such as capability and risk, deprives the court of the very material (i.e. secondary facts) upon which findings as to primary fact and social welfare context are often based and tends to undermine the safety of the findings thereby made. It may also adversely impinge on the subsequent welfare and proportionality evaluations by the court as circumstances change and memories fade of the detail and nuances of the evidence that was given weeks or months before…It ought to be recollected that split hearings became fashionable as a means of expediting the most simple cases where there was only one factual issue to be decided and where the threshold for jurisdiction in section 31 CA 1989 would not be satisfied if a finding could not be made thereby concluding the proceedings…Over time, they also came to be used for the most complex medical causation cases where death or very serious medical issues had arisen and where an accurate medical diagnosis was integral to the future care of the child concerned. For almost all other cases, the procedure is inappropriate. The oft repeated but erroneous justification for them that a split hearing enables a social care assessment to be undertaken is simply poor social work and forensic practice. The justification comes from an era before the present Rules and Practice Directions came into force and can safely be discounted in public law children proceedings save in the most exceptional case…Social work assessments are not contingent on facts being identified and found to the civil standard…Social work assessments are based upon their own professional methodology like any other form of professional risk assessment. In care cases, an appropriate social work assessment and a CAFCASS analysis should be undertaken at the earliest possible opportunity to identify relevant background circumstances and context. In so far as it is necessary to express a risk formulation as a precursor to an analysis or a recommendation to the court, that can be done by basing the same on each of the alternative factual scenarios that the court is being asked to consider".

I have found it helpful overall to have all matters considered at the same time and I retain the view that to deal with this as a split hearing would, in the circumstances of this case, have created significantly more delay for the child in a case which is already inweek 60 as I write this judgment.

26. As the evidence has been gathered and delivered, the positions of the parties have crystallised as follows:-

    (i) On the fact-finding issues, it is the local authority's case in broad terms that the parents (or one of them, they cannot identify which and, if I have correctly understood Ms McKenzie's submissions correctly, seek a pool finding) inflicted significant injuries on the child in the period leading up to 28th December 2019. The guardian also broadly supports this position. The parents do not accept this. They do not deny that the child sustained the identified injuries, but they say that the local authority have not establishedthat the injuries were inflicted and suggest that issues of bone fragility and/or unknown aetiology arise. They have maintained a united position and defiantly declined to blame the other for the injuries. The maternal grandfather would like to be able to support the parents on this, but in reality takes a fairly neutral position.

    (ii) On the welfare/disposal issues the local authority and the guardian suggest that I should now make a Special Guardianship Order in favour of the maternal grandfather and his wife. This is supported by the maternal grandfather. The parents' primary position is that the child should be returned to their care. Their secondary position is that the making of a final order should await a further assessment in the form of the 'Resolutions Approach'. Their tertiary position is that I should now make a Special Guardianship Order in favour of the maternal grandmother and her husband. Failing all of the above, they would prefer the local authority approach to any final care order being made which involved removing the child from the family. The guardian has suggested that if I was considering making a Special Guardianship Order in favour of the maternal grandmother and her husband then I should not do this straight away, but instead should adjourn for a period of assessment.

27. All these matters bring in dispute, the first matter I have to decide is whether or not the threshold criteria under Children Act 1989, section 31 are made out. Section 31 reads:-

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

    I remind myself that the date for making this assessment is the date that the local authority first took protective measures, which is late December 2019 in this case.

28. In this case the threshold criteria really stand or fall on my analysis of what happened to the child to cause her to sustain the identified injuries.

FACT-FINDING LAW

29. In so far as I am making findings of fact then I need to remind myself of some law pertinent to fact-finding.

30. A useful source of the relevant law is the judgment of Baker J (as he then was) in *Re IB and EB* [2014] EWHC 369 (Fam):-

"81. The law to be applied in care proceedings concerning allegations of child abuse is well-established.

82. The burden of proof rests on the local authority. It is the local authority that brings these proceedings and identifies the findings that they invite the court to make. Therefore, the burden of proving the allegations rests with them and to that extent the fact-finding component of care proceedings remains essentially adversarial.

83. Secondly, as conclusively established by the House of Lords in Re B *[2008] UKHL 35, the standard of proof is the balance of probabilities. If the local authority proves on the balance of probabilities that the injuries sustained by I and E were inflicted non-accidentally by one of her parents, this court will treat that fact as established and all future decisions concerning the children's future will be based on that finding. Equally, if the local authority fails to prove that the injuries sustained by I and E were inflicted non-accidentally by one of her parents, this court will disregard the allegation completely.*

84. In this case, I have also had in mind that, in assessing whether or not a fact is proved to have been more probable than not,

> *"Common-sense, not law, requires that in deciding this question, regard should be had to whatever extent is appropriate to inherent probabilities," (per Lord Hoffman in Re B at paragraph 15)*

85. Third, findings of fact in these cases must be based on evidence. The court must be careful to avoid speculation, particularly in situations where there is a gap in the evidence. As Munby LJ (as he then was) observed in Re A (A Child) (Fact-finding Hearing: Speculation) *[2011] EWCA Civ. 12,*

> *"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can be properly drawn from the evidence and not on suspicion or speculation."*

86. Fourth, when considering cases of suspected child abuse, the court "invariably surveys a wide canvas," per Dame Elizabeth Butler-Sloss, P, in Re U, Re B (Serious *Injury: Standard of Proof)* [2004] EWCA Civ. 567*, and must take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth observed in* Re T *[2004] EWCA Civ.558,*

> *"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of*

evidence to other evidence and exercise an overview of the totality of the evidence in order to come to the conclusion of whether the case put forward by the local authority has been made out to the appropriate standard of proof."

87. Fifth, amongst the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental head injury, is expert medical evidence from a variety of specialists. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. In A County Council v K D & L *[2005] EWHC 144 (Fam) at paragraphs 39 and 44, Charles J observed,*

> *"It is important to remember (1) that the roles of the court and the expert are distinct and (2) it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. The judge must always remember that he or she is the person who makes the final decision."*
>
> …

88. Sixth, in assessing the expert evidence I bear in mind that cases involving a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem, the court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others (see observations of Eleanor King J in Re S *[2009] EWHC 2115 Fam).*

89. Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must 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 (see Re W and another (Non-accidental injury) *[2003] FCR 346)*

90. Eighth, 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 that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (see R v Lucas *[1981] QB 720).*

91. Ninth, as observed by Dame Elizabeth Butler-Sloss P in Re U, Re B, *supra*

> *"The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research would throw a light into corners that are at present dark."*

92. This principle, inter alia, was drawn from the decision of the Court of Appeal in the criminal case of R v Cannings *[2004] EWCA 1 Crim. Linked to it is the important point, emphasised in recent case law, of taking into account, to the extent that it is appropriate in any case, the possibility of the unknown cause. The possibility was articulated by Moses LJ in* R v Henderson-Butler and Oyediran *[2010] EWCA Crim. 126, and in the family jurisdiction by Hedley J in* Re R (Care Proceedings: Causation) *[2011] EWHC 1715 (Fam):*

"there has to be factored into every case which concerns a discrete aetiology giving rise to significant harm, a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."

93. Finally, 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 (see North Yorkshire County Council v SA *[2003] 2 FLR 849. 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 (see* Re D (Children) *[2009] 2 FLR 668, Re SB (Children) [2010] 1 FLR 1161)".*

30. I propose to add the following additional observations:-

(i) I remind myself of the judgment of Ryder LJ in *Re S (A Child)* [2014] EWCA Civ 25:*"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)."*

(ii) I remind myself that, in saying that the burden of proof lies on the local authority, it follows that there is no pseudo-burden or obligation cast on the respondents to come up with alternative explanations: see *Lancashire County Council v D and E* [2010] 2 FLR 196 at paras [36] and [37]; Re *C and D* (Photographs of Injuries) [2011] 1 FLR 990, at para [203]: "There is in my judgment an obvious disadvantage to parents in an approach which requires that they provide an explanation for even the smallest bruise failing which there will be an automatic presumption that that bruise must have been an inflicted injury. Such an approach subtly changes the burden of proof and puts the onus on the parents to provide a credible explanation. As a matter of law, it is not for the parents to disprove the suggestion that the general bruising is non-accidental but for the local authority to prove that it is.' *In* Re X (Children) (No 3) *[2015]*

EWHC 3651 these thoughts were endorsed by Munby P: "It is the local authority that seeks a finding that FM's injuries are non-accidental. It is for the local authority to prove its case. It is not for the mother to disprove it. In particular it is not for the mother to disprove it by proving how the injuries were in fact sustained. Neither is it for the court to determine how the injuries were sustained. The court's task is to determine whether the local authority has proved its case on the balance of probability. Where, as here, there is a degree of medical uncertainty and credible evidence of a possible alternative explanation to that contended for by the local authority, the question for the court is not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability'." In similar vein are the words of Peter Jackson J (as he then was) in Re BR (Proof of Facts) [2015] EWFC 41: *"When assessing alternative possible explanations for a medical finding, the court will consider each possibility on its merits. There is no hierarchy of possibilities to be taken in sequence as part of a process of elimination. If there are three possibilities, possibility C is not proved merely because possibilities A and B are unlikely, nor because C is less unlikely than A and/or B. Possibility C is only proved if, on consideration of all the evidence, it is more likely than not to be the true explanation for the medical findings. So, in a case of this kind, the court will not conclude that an injury has been inflicted merely because known or unknown medical conditions are improbable: that conclusion will only be reached if the entire evidence shows that inflicted injury is more likely than not to be the explanation for the medical findings."*

(iii) I remind myself of the words of Peter Jackson LJ in *B (Children: Uncertain Perpetrator)* [2019] EWCA Civ 575: "*Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool': see Re S-B at [43]. Approaching matters in that way risks, as Baroness Hale said, reversing the burden of proof. To guard against that risk, I would suggest that a change of language may be helpful. The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: Re D (Children) [2009] EWCA Civ 472 at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'.*

(iv) I remind myself that where there are multiple injuries sustained at different times the court must consider separately the question of who is the perpetrator of each injury. If the court is able to identify the perpetrator of

one injury, the question would then arise as to the extent to which the court is entitled to rely upon that finding in order to identify the perpetrator of other injuries. That issue was considered by the Court of Appeal in *Re M (A Child)* [2010] EWCA Civ 1467. Wilson LJ (as he then was) said: "*The first basis of the cross-appeal is the father's responsibility for the October event. Is it likely, asks Miss Hodgson on behalf of the mother, that, within the space of less than seven weeks, the partial suffocation of a baby is caused by one parent and yet injuries to his body are, or even just may be, perpetrated by the other? It is certainly not unknown for judges to give a negative answer to that type of question and, by reference to it, to proceed to identify the perpetrator of a second non-accidental injury. When they do so, their reasoning is – in my view – in principle valid".*

(v) I remind myself of the need for caution in making 'failure to protect findings': see *Re L-W (Children)* [2019] EWCA Civ 159 where King LJ stated: *"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. 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. 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."*

FACT FINDING IN THIS CASE

31. I propose to divide this section of my judgment into my answers to the following questions:-

    (i) What injuries did the child sustain?

    (ii) When did the child sustain her injuries?

    (iii) By what mechanisms did the child sustain her injuries? Did the child have any underlying conditions which may have caused or contributed to orotherwise explained the mechanism involved in her injuries?

    (iv) Who caused the child's injuries?

    (v) Are there any 'failure to protect' findings to be made here?

What injuries did the child sustain?

32. Dr Olsen has given a full account of the investigations into the child's bony injuries, in particular the x-rays of the upper left arm on 28th December 2019 and 7th January 2020, full radiographic skeletal surveys on 30th December 2019 and 9th January 2020 and CT scans on 30th December 2019.

33. Dr Olsen's written opinion, upon which the local authority base their case, is that, on a balance of probabilities, the child sustained the following 21 bone fracture injuries:-

    (i) *"Seven rib fractures close to the spine, one in each of the 6th to 8th and 10th left and 7th, 8th and 10th right ribs.*

    (ii) *Ten fractures in other locations in ribs, two in each of the left 5th and right 4th ribs, and one in each of the left 3rd, 4th, 6th and 9th, and right 5th and 6th ribs.*

    (iii) *A spiral fracture of the shaft of the left upper-arm bone (humerus).*

    (iv) *A forearm fracture, which technically consists of buckle (incomplete) fractures of the shafts of the left radius (the thumb-side bone of the forearm) and ulna (the little-finger-side bone of the forearm).*

    (v) *A fracture of the metaphysis (the part of a long bone that joins the shaft to the knuckle) at the upper end of the right shin.*

    (vi) *A fracture of the first metatarsal bone (one of five bones that form the arch of the foot and each connect the hindfoot to a toe) of the right foot."*

34. Dr Olsen did not change his opinion on any of this in his oral evidence. Further, there was no disagreement between the medical experts about the existence of these injuries and no challenge from anybody to their existence. Accordingly, I can safely make findings on a balance of probabilities that the child sustained injuries as set out above.

35. I note in passing that, after a proper investigation on 30th December 2019, there were no head injuries, bony or otherwise, detected in the child.

36. I also note in passing that, in the investigations on 30th December 2019, two bruises were noted, one (measuring c 1 cm) on the right side of the child's abdominal wall andanother (measuring c 4 cm to 5 cm) on the upper left arm. No findings are sought inrelation to these bruises and they have played no significant part in the investigation before me, but I mention them for the sake of completeness.

When did the child sustain her injuries?

37. Dr Olsen's written opinion, upon which the local authority largely base their case, is set out as follows:-

    (i) On the rib fractures: "*The following observations can be made in the child's x-ray examinations… All of the rib fractures demonstrated a fairly similar degree of healing on all reviewed examinations. On 30 December 2019 there was hard, rather well-defined callus, and most of the fracture lines remained visible. On 9 January 2020 callus was not much changed, but the fracture lines were less distinct…It follows, in my opinion, that:-*
    - *The rib fractures cannot be dated individually.*
    - *The fractures were at least about 3 weeks old on 30 December 2019; and*
    - *The fractures were no more than about 1½ months old on 30 December 2019.*
    - *Due to the poor granularity of radiological fracture dating, no date is more likely that any other date in this interval."*

    (ii) On the long bone fractures: "*The fracture of the left upper-arm bone showed no sign of healing on 28 December 2019. On 9 January 2020 there was some soft callus. It is therefore my opinion that this fracture was acute — no more than about 1½ weeks old on 28 December 2019 by radiological criteria alone. The fracture of the left forearm, i.e. of the shafts of the left radius and ulna, did not demonstrate any callus on 30 December 2019 or on 9 January 2020. On the former x-ray examination there was an abrupt, well-defined cortical discontinuity, which is typical in an acute fracture. It is therefore my opinion that the forearm fracture was acute on 30 December 2019, and no more that about 1½ weeks old on 9 January 2020. Both of the fractures of the child's left arm may therefore have been sustained on the same date but, again, it cannot be proved radiologically whether that had been the actual case."*

(iii) On the metaphyseal fractures: "*The relevant fractures are those at the upper end of the right shin and of the 1st metatarsal bone of the right foot. Metaphyseal fractures (fractures between the shaft [made of bone] and knuckle [made of cartilage] in infants) may heal without visible periosteal reaction or callus. It has been suggested that most metaphyseal fractures disappear on x-rays after about 4 weeks. Both metaphyseal fractures remained visible on 9 January 2020. It is therefore my opinion that neither fracture had been sustained earlier than about a month prior to 9 January 2020."*

(iv) He then gave a dating summary: "*Since fracture dating is not an exact science, it is in my opinion not justified to define exact intervals for when individual fractures had been sustained. In this section I have set out approximate intervals for the fractures. It must be emphasised that there remains uncertainty in respect of the end-points of all the intervals; more so for the earlier dates. Other experts may, depending on the findings within their areas, suggest narrowing of one or more of the date intervals suggested here. That would not conflict with my radiological opinion. Finally, there is in my opinion no doubt that the rib fractures had been sustained before the fractures of the left arm. The metaphyseal fractures may have been as old as the rib fractures but may also have been as acute as the fractures of the left arm".* In his oral evidence he clarified that *"I am more certain about the 3 week date than the upper limit of 1½ months. Over time the differences grow".*

38. Dr Olsen did not change any of this in his oral evidence and there was no other contradictory evidence. With one eye on Dr Olsen's caveats about the lack of fine precision in dating fractures radiologically, I can safely make findings on a balance of probabilities that the child sustained these injuries on the timescales set out above, i.e. broadly as follows:-

(i) All the rib fractures occurred between about mid-November 2019 and about 9th December 2019.

(ii) The left upper arm fracture occurred between about 17th December 2019 and 28th December 2019 (note that this range includes the possibility of 28th December 2019).

(iii) The left forearm fracture occurred between about 27th December 2019 and 28th December 2019 (note that this range includes the possibility of 28th December 2019).

(iv) The metaphyseal fractures occurred between about 9th December 2019 and 30th December 2019.

39. I note that this broad analysis is not inconsistent with the proposition that all the injuries were caused on two dates: one event on or before about 9th December 2019 and another event on or about 28th December 2019. Another possibility is that the injuries were caused on more than two dates, but the evidence rules out the possibility that all the injuries were caused on just one date.

40. It follows from this analysis that none of the injuries can have occurred at the time of the child's birth.

By what mechanisms did the child sustain her injuries? Did the child have any underlying conditions which may have caused or contributed to or otherwise explained the mechanism involved in her injuries?

41. The answer to these questions is to be found by looking at radiological and clinical factors, by considering the various medical opinions and by considering the histories given by the parents in their oral and written evidence. There are a number of aspects of these questions which fall to be considered both separately and together (globally) and I shall deal with the live issues in the succeeding paragraphs.

42. The opinion of Dr Olsen on this subject notes: "*My assessment assumes there was no bone fragility since there is no evidence of the same radiologically. It must however again be emphasised that bone fragility may not be evident on x-rays or scans. It is in my opinion important to exclude this possibility, and such exclusion cannot be done radiologically. I therefore defer to other experts*." An essential starting point, therefore, for any analysis of the above question must be to consider whether or not the child suffers or suffered from any underlying condition which might explain the mechanism of her injuries or be relevant to an explanation. This is a serious question in this case and there are a number of different possibilities which have been investigated and (to a greater or lesser extent) pursued before me and which I shall deal with under the following broad headings, each of which justifies its own separate paragraph: Ostea Imperfecta, Ehlers-Danlos Syndome, Omeprazole and Unknown Aetiology. There are also references in the papers to the possible significance of a marginally raised platelet count and a possible scoliosis, but the evidence overall has not suggested that these are of any significance in the context of my investigation and have not been actively pursued.

43. I shall first consider Ostea Imperfecta:-

    (i) It is clear from the bundle documentation that Dr Saggar, the Consultant in Clinical Genetics, has thoroughly researched the possible relevance of Ostea Imperfecta. Dr Saggar was an impressive witness and I can properly attach significant weight to his opinions. He has stated: "*"Clinically, the child does not have the appearance of a child with OI. …It is my opinion that the fractures did not occur spontaneously but occurred following a precipitant force or memorable event, given that a spontaneous new*

mutation in one of the rare OI genes or recessive genes has been excluded by further genetic testing…Any history of continued fracture whilst in foster care should be explored. It would be very unlikely in a short time frame, that any tendency to easy fracture would resolve if there was a true genetic susceptibility, particularly as the child is now more mobile and active, assuming the same forces are still in operation…In my opinion a diagnosis of OI is no longer a realistic possibility. No further gene testing is required."

(ii) Mr Heckscher's excellent submissions document, picking up parts of Dr Saggar's written evidence, deals with this matter as follows:-

"Following specific testing, a diagnosis of OI is no longer a realistic possibility. The most probable explanation for the fractures is a force of injury as precipitant. The lack of any other suggestive or supporting features for OI (except for the numerous fractures); the normal LRP5 and recessive gene mutation results; the lack of any osteoporosis or reduction in bone density on the x-rays leaves a much less than 1% residual risk of OI… the diagnosis is no longer a realistic possibility."

(iii) I agree with Mr Heckscher on this point and nothing in the other submissions challenges these conclusions. In my view this provides sufficient material for the purposes of my investigation to rule out the possibility of Ostea Imperfecta being a relevant factor to explain the child'sinjuries or even to contribute to an explanation.

44. I now move on to consider Ehlers-Danlos Syndome:-

(i) Mr Butterfield, in his most comprehensive, learned and erudite written submissions, invites me to treat this as a relevant factor. Picking out some of his key points, he has argued:-

*" Dr Saggar has clinically diagnosed the father with hypermobile Ehlers Danlos Syndrome (hEDS)…EDS is an inherited condition affecting the collagen, which is a major component of bone. While the child does not have classical features of a connective tissue disorder, she has at least an a priori 50% risk of inheriting her father's condition. She also has certain features suggestive of a connective tissue disorder, including Epicanthic folds (a skin fold of the eyelid), Hypertelorism (widely spaced eyes), a slightly blueish-grey tinge to the scleara, possible thoracic scoliosis… possible easy bruising…It is widely acknowledged that hEDS is a very variable disorder. There is extreme variability between individuals with connective tissue disorders of hEDS**…***The gene or genes that caused the disorder have not yet been identified…In his report, he confirmed that the research shows some evidence of "higher fracture prevalence albeit similar bone density" in adults**.** He confirmed in his oral evidence that the reasons for increased fracture risk are incompletely understood. He confirmed in his oral evidence that the lack of evidence of bone mineral loss in younger children is because of the lack of research rather than*

because there is evidence of absence…Importantly, Dr Saggar accepted that there is evidence to say that children with EDS get fractures after a lesser force, but he said not with normal or rough handling…It is submitted that the following strands can be drawn together from Dr Saggar's evidence: the child's father has a confident diagnosis of hEDS, a defect of the collagen. It is a genetic condition, albeit one where the gene or genes have not been identified. The child has a greater than 50% chance of having inherited the father's condition. There is evidence in adults of anassociation between EDS and reduced bone mineral density and increasedprevalence of fractures. There is an association between EDS and fracturerisk in older children. There is no evidence at present of an association in infants, but the research is limited and there is a need to study more. Thereis evidence to suggest that children with EDS get fractures after a lesser force. However, one would expect there to be a memorable event."

(ii) While Mr Butterfield's argument is well constructed, as I would expect from him, my overall feeling is that it rather exaggerates the support which Dr Saggar felt able to give to the argument being advanced by Mr Butterfield. Dr Saggar saw the child in clinic and was able to assess her. He did not feel that that the child had any "*significant joint laxity*" and "*did not fulfil the criteria for hEDS*", her Beighton score only being 2 out of 9 and
told me in evidence "*2 is very normal*" and "*fractures do not occur spontaneously*". Dr Saggar's written report says: "*There is no specific genetic evidence to date to suggest that the child is predisposed to a greater risk of fracture for any given force or lesser force except that she has a 50% susceptibility of inheriting hypermobile Ehlers Danlos syndrome (hEDS) from her father. The child's father has hypermobile EDS and fulfils the 2017 criteria for this diagnosis. However, hEDS or the milder form of Hypermobile spectrum disorder (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…Any history of continued fracture whilst in foster care should be explored. It would be very unlikely in a short time frame, that any tendency to easy fracture would resolve if there was a true genetic susceptibility, particularly as the child is now more mobile and active, assuming the same forces are still in operation. The most probable explanation for the fractures is a force or injury as a precipitant*." In his oral evidence he noted that there had been no further reports of fractures since the child had been in care and thought this was significant. He noted that there had not been any recent skeletal survey, but felt that any fracture would have been noticed by her carers as the child became more mobile. He went on to say: "*I agree that hEDS sufferers can get fractures after lesser force, but not with normal or even rough handling*".

(iii) Although Dr Shenoy deferred to Dr Saggar on this issue he did feel able to say: "*As regards to the diagnosis of Ehlers Danlos syndrome for the father… this is outside my area of expertise. It is a relatively rare genetic disorder involving connective tissue which involves skin hyper-extendibility with joint hypermobility and tissue fragility. It is usually suspected when in the presence of joint hypermobility with multiple joint*

dislocation, poor bone healing, easy bruising and unusual scars. In my opinion, Ehlers Danlos syndrome cannot account for the multiple fractures that the child has sustained".

(iv) Again, I feel confident in attaching significant weight to Dr Saggar's opinions and I have not been at all convinced on the evidence overall that it is possible or appropriate to attribute the possible presence of hEDS in the child as a relevant factor to explain the child's injuries or even to contribute to an explanation.

45. I now move on to consider the possible significance of the fact that the child was receiving Omezaprole in the period leading up to December 2019. This area of the case was most specifically covered by Dr Skett, an impressive witness with a specialism as a Forensic Pharmacologist. :-

(i) It is common ground that on 25th September 2019 the hospital prescribed Omeprazole for the child in response to a diagnosis of Gastro-Oesophagal Reflux. It is also common ground that this is a widely used prescription in neonates and others of all ages. It is common ground that the dosage prescribed and used was suitable for the child's body weight and that she took the medicine (usually from the mother) on a daily basis from 25th September 2019 until she left hospital on 7th January 2020. It is common ground that thereafter she stopped taking Omeprazole and has nottaken it since. The parents advance the proposition (to which I shall refer as the 'Omeprazole theory') that this medication provides an explanation for the child's fractures relevant to the analysis of mechanism.

(ii) The argument in support of the 'Omezaprole theory' is again advanced with great force and lucidity by Mr Butterfield in his written submissions and I propose to set out in some detail the main thrusts of his case on this:

"The child took Omeprazole from at least 25 September 2019 until her discharge from hospital in January 2020. She had therefore been taking it for at least 13½ weeks by the time of her admission to hospital on 28 December 2019 and for at least 7½ weeks by the time of the start of Dr Olsen's window for the fractures. Omeprazole is a proton pump inhibitor which was prescribed in the child's case for reflux. Although in his report DrSkett indicated that Omeprazole was licensed for use in an infant under 1 year of age he confirmed in his oral evidence that in fact Omeprazole is not licenced for use in infants of this age, although it is recommended for use in this age. In his written evidence Dr Skett wrote that: Omeprazole "may affect bone development, bone growth and fragility….It is my opinion that the omeprazole given to …the child…had a very small chance of having a deleterious effect on bone growth, development and fragility. These effects if present, would be manifest during treatment and may take some time to diminish (and some may be persistent well after cessation of treatment."

"In his report, he opined that:"The rates of absorption of omeprazole are erratic and do not follow classic pharmacokinetic principles. Studies have shown marked interindividual variability in both the rate and extent of absorption." In his cross-examination, Dr Skett told the court that we do not know why rate of absorption of Omperazole are erratic. He noted that an article by Gunaekaran et al (2018) urges "caution in the use of PPI in infants under 6 months due to the differing pharmacokinetics of the drugs at this age. Infants of this age can be exposed to greater amounts of omeprazole due to immature enzyme capacity." Dr Skett confirmed, when cross-examined on behalf of the father, that two children, and particularly two infants, given the same dose of Omeprazole, will absorb different amounts and that the pharmacokinetics of the drug (the way it moves around the body) meant that we do not know in he child how much she absorbed and how it moved around her body. Importantly, Dr Skett accepted in cross-examination that what is generally considered a safe dose of Omeprazole could have a deleterious consequences in a particular individual infant due to differences in the rate of uptake and metabolism. The fact that the child had what is considered a safe dose does not mean that she could not have suffered side effects."

"In his written evidence Dr Skett noted that, according to EMC (Electronic Medicines Compendium), an uncommon side effect of Omperazole is the "fracture of wrist, hip or spine"…An uncommon side effect is…more common than a rare or very rare one. Between 1 in 100 and 1 in 1,000 patient who take Omeprazole therefore suffer fractures as a result. That data covers all patients, most of whom are adults. In his oral evidence, Dr Skett confirmed that the British National Formulary for Children ('BNFC'), which relates specifically to children and in run by the National Institute for Health and Care Excellent ('NICE'), lists the common side effects of Omeprazole to include "fractures" generally, not simply fractures of the wrist, hip or spine…The research which is examined below also supports an association between fractures more generally and the use of PPIs. Bone fractures are therefore a recognised side effect of the use of Omeprazole; one that patients and doctors are warned about explicitly."

"Dr Skett confirmed that the state of the research at present establishes a small but significant statistical association between Omprazole and bone fractures. In children, the research is at an early stage, although we are fortunate to have two large-scale studies which establish a small but statistically significant association between proton pump inhibitors (including Omeprazole) and bone fragility: (Malchodi et al: "Early Acid Suppression Therapy Exposure and Fracture in Young Children" and Wang et al: "Association Between Proton Pump Inhibitor Use and Risk of Fracture in Children)…The Malchodi and the Wang studies were…designed to examine the hypothesis of an association between the use of PPIs and bone fractures more rigorously. In examination in chief, Dr Skett described the paper by Wang et al as: "A well researched and well controlled study. They've taken 116,000 children treated with PPIs and matched to 116,000 as closely as possible who haven't taken PPIs.

You have a very very good control set of data here…Dr Skett therefore confirmed when asked questions by Mr Heckscher that the likelihood of any fracture occurred in an infant up to 6 months old is 1.14 (i.e. a 14% increase). While Pantaprazole has a higher risk, Omeprazole still shows a small but significant association with bone fractures.
Dr Skett confirmed that there was a small but significant increased risk of fracture associated with the use of Omeprazole. In light of the very large scale studies, he described this as a "robust finding". The research demonstrates that the "hazard ratio" for a child who has used Omaprezole for between 31 and 364 days is 1.14, so represents a 14% increase in fractures. He also confirmed when being asked questions by Mr Hecksher that in the Wang paper in the age group of up to 6 months, the likelihood of any fracture occurring is 1.14, i.e. a 14% increase in infants up to age 6 months."

"Dr Skett indicated his report that: "These effects, if present, would be manifest during treatment and may take some time to diminish (and some may be persistent well after cessation of treatment)."…In terms of how quickly Omeprazole could have an effect on bone fragility, Dr Skett confirmed that the studies show a small but significant association between PPI use and bone fragility quickly after use. The Wang study show a hazard ratio of 1.08 (an 8% increase in risk) for children who had been using PPIs for less than 30 days and 1.14 (a 14% increase) for children using PPIs for between 31 and 364 days. The child had been using itfor at least 7½ weeks by the start of Dr Olsen's fracture window. In his oral evidence, when asked questions by the court, he stated that:"The effect of Omeprazole would wear off relatively quickly. I wouldn't expectit to be more than a couple of days. How long the effect of the bone if there is any would go on, I would think that effect would go on longer." However, he was unable to assist with how long the effects would take todiminish as it fell outside his area of expertise. However, the fact that theeffects would diminish after the cessation of treatment (in the child's case almost immediately after she left hospital in January 2020), may explain why there is no evidence of repeat fractures in the child after her placement with the maternal grandfather and his wife in January 2020."

"Dr Skett was clear that while the research shows a statistically significant association between proton pump inhibitors and bone fracture, it does not yet establish a link. That is not because the research shows there is not a link; there is simply no research either way. He opined that the Wang and Malchodi papers are suggestive of a link but not probative. In his examination in chief, Dr Skett said:"The interesting thing about PPIs is they inhibit an enzyme called the proton pump. There is a very similar enzyme in bone. We think PPIs affect enzyme in bone rather than anything to do with effect on stomach." In cross-examination, he indicated that: "Research is heading towards PPIs not having an effect via stomach acid, there is evidence of effect directly on the bone. The only way to investigate fully would be to try in some way to test the bone development and break down rates. Very preliminary studies suggest that PPIs may have an effect on osteoblast activity, cells that build up bone." The

possibility of a causal link was explained in the Malchodi paper (p5, 3rd column) as follows:"The exact mechanism linking AST [acid suppression therapy, including PPIs] with bone health is unclear; however, biologically plausible hypotheses exist. It was previously postulated that PPIs could impair calcium absorption because of their effect on gastric acid secretion, leading to compensatory hyperparathyroidism and increased osteoclast activity. Adult studies, however, revealed no significant difference in bone density or blood calcium levels in patients on long-term PPI therapy versus none. Another theory is that PPIs change osteoclast activity and viability. Osteoclasts have a proton pump on their surface, which, if inhibited, could lead to osteoclast dysfunction and unopposed osteoblast activity resulting in a disorganized and potentially more fragile bone matrix. "Dr Skett confirmed the osteoblasts synthesise (build up) bone and osteoclast break them down again. This is a continually evolving process. When asked whether it was conceivable that it may have an effect on bone fragility in a way that we can't yet identify that could mean that fairly minor handling in a child with this condition could cause fractures, he responded "That is certainly a possibility, yes."

"In summary, Dr Skett said that there is (a) a small but significant association between PPIs and bone fracture; and (b) a possible biological mechanism, but that the research has not yet put those two things together scientifically. Dr Skett confirmed in his oral evidence that there is no research on Omeprazole and multiple fractures. "The data does not address multiple fractures. It does not help us." That does not mean the data shows that fragility caused by Omeprazole cannot result in multiple fractures, it simply means the research has not been done. Dr Skett rejected the assertion that you could extrapolate from the research to say that if there are 20 fractures, that makes it 20 times less likely: "You cannot go down that route." In answer to questions from the court, Dr Skett indicated that if there was a bone fragility in the child as a result of Omeprazole, "there is no reason why it should be specific to any particular area…. There is no reason why every bone should not be affected to some extent." In response to a question from the court, Dr Skettconfirmed that researchers have done a lot of testing of blood, serum calcium, vitamin D etc to look at causation and have not yet found a causal link between Omeprazole and bone fracture. Dr Skett was not aware of any test that could have been carried out on the child to ascertain whether Omeprazole had an effect on her bone; he was not aware of any test available to test osteoblast activity. Is therefore not surprising that thetests that were carried out on the child had normal results. Dr Skett confirmedthat at this stage of scientific knowledge and in a child of the child's age, it would be unethical to do any of the studies which would be needed, to extract bone cells and to test them."

"In summary, it is submitted that the following threads can be drawn together from the evidence of Dr Skett and from the research: There is clear evidence of an association between the use of proton pump inhibitors (PPIs) and susceptibility to bone fractures in adults (see the list of side effects). There is a small but statistically significant association between

the use of PPIs and susceptibility to bone fractures in children (see the papers by Malchodi and Wang). That statistically significant association is present even in children who have taken PPIs for 0 to 30 days. In children who have taken PPIs for between 31 and 364 days (as was the case for the child) the hazard ratio is 1.14 (i.e. an increase of 14%). A causal link is not yet proven. However, there is a biologically plausible mechanism involving an effect of PPIs on the proton pumps on osteoblasts or osteoclasts. If that hypothesis is correct, it would not have produced abnormal results on any of the tests undertaken on the child. The effects (i.e. bone fragility) would be manifest during treatment and may take some time to diminish… Those effects may appear fairly quickly (i.e. there is a statistically significant association after less than 30 days of use) and Dr Skett is unable to help with how quickly the effect would diminish. However, he indicated that studies suggest that an increased risk in the first 6 months of life may be due to rapid bone turnover in the first year of life.." If there is a bone fragility associated with the use of Omeprazole there is no reason why every bone would not be effected to some extent."

(iii) It would be correct to note that Dr Skett helpfully, constructively and intelligently considered all the points put to him, but it would not, I think, be right to categorise him as a proponent of the 'Omeprazole theory'. In his written report he went no further than saying: "*the omeprazole given to the child had a very small chance of having a deleterious effect on bone growth, development and fragility. These effects, if present, would be manifest during treatment and may take some time to diminish (and some may be persistent well after cessation of treatment)".* In summary he was noting that there was a small statistical association between the use of PPIs and increased risk of bone fracture, that this statistical association occurred in children and adults, but that the current state of knowledge does not provide any established causative explanation for the association. Dr Skett was not suggesting that it could be established to any degree of likelihood that the use of Omezaprole had in fact contributed to the fractures in this case.

(iv) The case for the opposition to the Omeprazole theory was fairly strongly put by Dr Shenoy. He acknowledged that the research referred to above suggested a small association between PPIs and bone fracture, but was highly sceptical that this could be relevant here. He pointed out that *"we use Omezaprole within the first week of life…It is a well recognised treatment for Gastro-Oesophagal Reflux…the identified side effect of bone fragility is recognised but is extremely uncommon and not in the first year of life…I have not come across myself or in the literature any patient with multiple fractures."* In his written report he said*:* "*In my experience, it is extremely unlikely that any of the medications could account for the multiple fractures that the child had sustained. Whilst there is a theoretical risk that Omeprazole can lead to bony fragility, this cannot account for the number of fractures that the child sustained and especially the fact that the child was just over four months of age when she had multiple fractures. In my opinion, the medications will not account for any bony fragility or risk for sustained fractures*". In answer to the question '*Please consider whether*

prescribing Omeprazole to a new born constitutes orthodox medical practice; and if so, the circumstances in which it would be safe and/or appropriate to do so' he said: "*It is well recognised to commence neonates with symptoms of Gastro Oesophageal reflux on anti acid treatment which included Omeprazole… Its use is Gastro Oesophageal Disease is well recognised*"… "*Having read Dr Skett's report*" he concluded "*the fractures were not spontaneous and were unlikely to have been caused by the effects of Omeprazole*". Dr Shenoy was an impressive witness and I felt able to attach significant weight to his overall conclusions.

(v) Having considered all of the above I have reached the conclusion that it is highly unlikely that the 'Omeprazole theory' provides an explanation for the child's injuries or even contributes to it. I found Dr Shenoy persuasive onthis point and, as I have said, I did not see Dr Skett as arguing against thatconclusion.

46. I now move on to consider whether this is a case where Hedley J's 'unknown aetilology' dicta (*there has to be factored into every case which concerns a discrete aetiology giving rise to significant harm, a consideration as to whether the cause is unknown)* should govern my thinking. As Dame Elizabeth Butler-Sloss reminded judges *"The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research would throw a light into corners that are at present dark."* While a judge should never forget the possibility that future scientific discovery will throw new light on a situation, there must be an assessment of how likely this is in the context of the known facts:-

(i) Again, Mr Butterfield's submissions deal with this intelligently and in a little detail and he makes some powerful points:-

"There is clearly significant further research that needs to be done both in respect of the association between Omeprazole and fractures and the association between EDS and fractures. Importantly, there is no research whatsoever on the interrelation between the two. The court is respectfully reminded of the extensive authorities on 'unknown' cause set out above in the section on the law. There are a number of 'known unknowns' directly relevant to the child's case. In particular: While the association between PPIs and bone fractures is now established by two good quality studies, there need to be research on the causal mechanism. However, there is a plausible biological explanation in that osteoblasts/osteoclasts have proton pumps which may be affected by PPIs. There need to be further research undertaken on any association between EDS and bone fragility in infants. The current studies have tiny samples. By way of analogy, prior to the Malchodi paper in 2018, small scale studies in relation to the association between PPIs and bone fragility in infants and children were contradictory. It is therefore quite possible that the absence of evidence about bone fragility in infants with EDS may be filled by a future large scale study in the same way. There need to be further research about the causal link between EDS and bone fragility. As Dr Saggar accepted, it is incompletely understood. There is no research on the interrelationship between EDS and Omeprazole and any effect on bone fragility. The court

must therefore bear in mind in its assessment of the remainder of the medical evidence that: The child has two potential fragilities to bone fractures;and there remains a great deal still to be researched."

(ii) It is, of course, not impossible that something will emerge from future scientific study to explain the presence of multiple spontaneous rib fractures in a non-ambulant child with the child's characteristics who has been well looked after. It is not impossible that something will emerge along the lines suggested by Mr Butterfield or indeed on some other basis altogether, but it seems to me that in the end the science of rib and other bone fractures is a generally well researched area of medicine and the chance of something emerging along these lines is somewhere between unlikely and fanciful. Certainly it is speculative. I have given anxious thought to this in the context of all I know about the parents, but in the end have decided that this is not a case where I could properly find that there was an unknown aetiology. In reaching this conclusion I have, as invited to do so by Ms Gallagher, read the judgment in *Warwickshire County Council v K, L and M (Children)*[2020] EWFC 56; but the facts in that case were very different from the present case and the judgment does not, in my view, help my investigation in any significant way.

47. Having ruled out the existence of any significant underlying condition, I proceed to consider what mechanism or mechanisms were the probable cause of the injuries. Again, it is Dr Olsen's written opinion evidence upon which the local authority largely base their case, which is as follows:-

(i) As a general observation: "*Fundamentally: In a child with otherwise normal bones, fractures do not occur spontaneously; and in pre-ambulatory children, fractures are not self-inflicted*."

(ii) On the rib fractures: "*Rib fractures are usually caused by a mechanism of compression of the chest or by a direct impact. The exact magnitude of force required to fracture ribs in general is not known. However, in an infant with normal bone strength it is generally accepted that rib fractures are not caused by normal or rough handling, but that they require substantial force. Rib fractures can be seen after cardio-pulmonary resuscitation involving deep chest compressions where the diameter of the rib cage is reduced by about one-third, which gives a rough guide as to the magnitude of force required, assuming normal bone strength. It is therefore my opinion that any action, whether accidental or inflicted, causing chest wall compression or deflection with magnitude of forces equal to or greater than those resulting from deep resuscitative chest compression may potentially cause a rib to fracture. However, special consideration is required in respect of the seven fractures close to the spine...Whereas rib fractures in general are usually caused by nonspecific compression of the chest, it is generally agreed that such mechanisms are insufficient for rib fractures close to the spine. Rib fractures in locations*

close to the spine…are thought most likely to be caused by particularly forceful compression of the chest where one of the two opposing forces is applied against the spine pushing it forward. It is commonly agreed by relevant experts that rib fractures close to the spine can be caused by vigorous shaking where the baby is gripped around the chest, thumbs against the breast bone and fingers against the spine. Such an event may also explain fractures in other segments of the rib. An indication of the force required to produce such fractures is given by Kleinman and Schlesinger: "posterior rib fractures can occur in accidental situations such as high-speed accidents in which a child undergoes marked forward deceleration into a solid object, or is struck in the front by a motor vehicle". It is therefore my opinion that the seven rib fractures close to the spine had been caused, either by violent and repeated forward and backward shaking while gripping around the chest, thumbs on the front and fingers pressing onto the spine at the back; or by a particularly forceful pressure directly onto the spine so that it had been forced into the chest cavity. It should be noted that violent shaking can be associated with bleeds on and in the brain, and with bleeds in the retinae. There is however no evidence, to my knowledge, suggesting that shaking necessarily has to be associated with intracranial or eye injury in children where the same has caused rib fractures. All the remaining rib fractures required nonspecific compression and less magnitude of force, and it is therefore my opinion that at least some of these may have been caused by an event that had been sufficient to cause the rib fractures close to the spine. Birth trauma has no known association with rib fractures close to the spine and never causes as many rib fractures as seen in the child's x-rays.In the absence of any underlying condition, 17 rib fractures is in my opinion evidence of severe crushing injury to the chest. It is very unusual to find so many rib fractures, even as a consequence of high-velocity road traffic accidents. I am therefore of the opinion that no single traumatic event can explain all of the rib fractures. I am however not in a position to suggest any specific number of events". In his oral evidence Dr Olsen confirmed that the two events could have taken place on the same date, i.e. it could have been two events in quick succession.

(iii) On the long-bone fractures: "*It is generally agreed that a fracture of a long bone in an infant most likely is caused by forceful, unnatural shearing, twisting and/or bending across the level of the fracture, or by direct impact. The x-ray appearances of the child's left upper-arm fracture strongly suggest that the causative force must have had a twisting component. This does not exclude that there had been additional unnaturalbending and/or shearing. It is therefore my opinion that the upper-arm fracture had been caused by forceful twisting of her left arm, most likely while the elbow was bent. A pure pulling force would not have caused this fracture, but if there had been simultaneous pulling and twisting, the required mechanism may have occurred. The appearances of her left forearm fracture strongly suggest that it had been caused by forceful, unnatural bending of the lower end of her left forearm. It follows, in my opinion, that two events of application of force had been required for causing both of the fractures inthe child's left arm… It is therefore my opinion that the fractures of the left arm had been caused by*

two events ofapplication of force where the magnitude of force had been equal to or greater than the force arising when a child falls off high furniture — a high-chair or a dining table, for example — onto a hard floor".

Commenting on the suggestion that these fractures were caused on 28th December 2019 by the car seat event described by the father he said: *"From a radiological point of view it is possible that one of the fractures had been caused by this event depending on whether the upper arm had been twisted or the forearm bent, but only if the force in play had been significant, well beyond what is expected from normal handling*". In his oral evidence he further opined that one of the fractures might have been caused by the described mechanism, but "*certainly not both fractures…a single event did not cause the two fractures…lifting a child out of a car seat is not high energy trauma…a very forceful twist and bend would be required*".

(iv) On the metaphyseal fractures: "*The most likely mechanism causing metaphyseal fractures is unnatural, forceful bending, pulling, rotation or a combination thereof…The exact magnitude of the force required to fracture a metaphysis is not known, but it is thought to be much greater than the magnitude of force resulting from normal handling by a reasonable carer. It is therefore my opinion that the fracture at the upper end of the child's right shin had been caused by forceful twisting, pulling and/or unnatural bending of her right knee where the force was of magnitude well beyond what can be expected from normal handling, or else by an episode of violent shaking such that her right limb had been flailing. The fracture of the 1st metatarsal bone of the right foot had been caused by forceful bending — up or down — of her right foot with a force of magnitude well in excess of what is expected from normal handling; and two events had been required to cause the two fractures*."

48. Again, Dr Olsen did not change any of this in his oral evidence and he was an impressive witness to whom I can attach weight. Nor was there any contradictory evidence from any of the other medical experts. Dr Shenoy for the most part deferred to Dr Olsen, but expressed the confirmatory view that "*it was extremely unlikely that the fractures sustained by the child could have been sustained in the course of normal handling*".

49. I have listened carefully to what the parents have said on the subject of possible mechanisms:-

(i) They describe one possible event to cause the left arm fractures, i.e. the car seat incident on 28th December 2019. I have listened to the father's oral explanation in court of what happened that morning. I have seen him demonstrate where he put his hands and how fast he brought the child out of the car seat. If I compare that to the comments made above by Dr Olsen I cannot accept that even one of the left arm fractures were caused by the level of handling described by the father. I have concluded that what he described to me was really in the category of normal handling and does not explain either fracture. Certainly it does not explain two fractures. I have

to reach the conclusion either that the car seat event did not cause any fractures and is therefore a red herring for this investigation or that the father is misrepresenting the extent of force used on that occasion.

(ii) They describe one possible mechanism for the right foot and lower leg injuries, i.e. the child being in the 'jumparoo'. Dr Olsen has rejected that explanation and I accept his rejection. It seems to me highly unlikely that a child of only a few months could have pushed herself down on her right foot with sufficient force to cause those injuries.

(iii) There is no explanation proffered for any of the rib fractures.

50. Having gone through all the above, I have reached the conclusion on the balance of probabilities that the mechanisms which caused the above injuries are as described by Dr Olsen above. I have reached the conclusion that there are no explanations from the parents as to what happened which match Dr Olsen's description or which provide any basis for my finding (to borrow Ryder LJ's words) that the injuries were the result of an unexpected and unintentional accident without the involvement of an element of wrong.

51. As I have said, there must have been at least two occasions when injuries occurred, but possibly more. If there were only two occasions then each of these occasions probably involved more than one application of force, possibly in quick succession. I think it the most likely explanation here that the injuries were sustained as a result of a perpetrator having, on at least two occasions, a sudden and severe loss of temper, most likely occurring when the child would not settle. In such circumstances the application of force would be deliberate, but the perpetrator would be reckless as to the consequences for the child.

Who caused the child's injuries?

52. I now turn to the identification of a perpetrator or perpetrators, or a pool of possible interpreters. I shall start by first considering *"whether there is a 'list' of people who had the opportunity to cause the injury*". In the context of the present case, the answer to this question is clear and uncontroversial. The list consists of the mother and the father. It can be fairly said that they were the child's carers throughout almost of the timebetween mid-November 2019 and 28th December 2019 and that they both had periodsof time within that 'window' when they respectively had sole care.

53. The local authority have not sought to suggest that I could properly find that one or the other is the sole perpetrator and suggest that they both fall into the pool of perpetrators.

54. Nobody has sought to pursue a case before me against any other person. Whilst the local authority had not ruled out the maternal grandmother until December 2020, they did in the end rule her out and nobody has challenged that decision before me and I am happy to regard her as being entirely in the clear (notwithstanding her period of sole care in November 2019, which was within the window of the rib fractures).

55. I must ask myself therefore whether I can, as between the mother and the father, identify the perpetrator. If I can then I should make that finding, but I remind myself that I should not strain to find an individual perpetrator. I need to consider the following: "*It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so…Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'".* This may be one of those cases "*where the only conclusion which the court can properly reach is that one of the two parents – or both - must have inflicted the injuries, and that neither can be excluded."*

56. Both the mother and the father vehemently deny that they are the perpetrator, but defiantly decline to blame the other. I have given careful consideration to all the evidence in the case, stepping back and assessing each piece of evidence against all the other evidence. I have listened carefully to both the mother and the father in the witness box, being examined on their written statements and on the other material in the case, including the text and What's App messages. I have looked carefully at all the evidence which might point in favour of or against my reaching the conclusion that either the mother or the father was the perpetrator, or that they are both perpetrators or that there is a real possibility that either or both of them are perpetrators. In the end I have reached the conclusion that I cannot identify either the mother or the father individually as the perpetrator, but that both of them fall within the pool of perpetrators, there being in each case a real possibility that they are the perpetrator. In reaching this conclusion the following factors have, for me, merited particular deliberation:-

    (i) There is the obvious point here is that having reached the conclusions I have above, I cannot avoid the conclusion that one or both of them must have been the perpetrator on each of the occasions described above. I cannot avoid the conclusion also that one or both of them must be lying to the court about what has happened because neither of them has given an explanation which matches the independently verifiable facts.

    (ii) There is nothing in the personal and social background details of either party in the parenting assessments and other evidence which points clearly to one parent rather than the other being the perpetrator. Apart from the assaults on the child, the parents can both be regarded as being good and respectable people from supportive and respectable families with good working records in public service. There are no criminal records, no records of substance misuse and no serious examples of dysfunctional behaviour. I agree with Mr Butterfeld that the mental health problems the father suffered in 2018, which were appropriately treated, have little probative value on the questions I am now seeking to answer. Whilst there

have been occasional references in the evidence to the possible existence of fairly low level domestic partner violence by both parents, in fact the references have more often been against the mother than the father, no event of domestic violence has been proved before me to the proper standard of proof and, even if one or more of the allegations had been proved, I do not think this evidence would have had much if any probative value in the context of the particular allegations of assault on the child which are at the centre of my investigation. Anybody, as at November 2019, assessing the likeliness of an assault on the child would, I think, have thoughtit most unlikely that either of the parents would do such a thing; but experience teaches us that looking after young babies is a challenging experience and sometimes these losses of temper can occur in unlikely circumstances and in unlikely people. It would be wrong to reach the conclusion that somebody with a blemish-free record could in no circumstances harm a child.

(iii) I have given thought to whether or not there is any significance in this context of the unusually large number of medical attendances which the child had prior to 28th December 2019, but in the period August to December 2019. Ms Gallagher's well presented submissions contain this assertion: *"The parents were concerned about the child's health from early on and they took her to the GP and hospital on a number of occasions. They also soughtthe advice of the midwives and their health visitor as a result of their concerns. The parents took the child to hospital a number of times due to theirsignificant concerns around her being 'in pain', loose stools, bloody diarrhea, vomiting/reduced feeding and coughing and vomiting after everyfeed. The child was not a well baby and medical professionals did not suggest that the parents were anxious parents who were needlessly seeking medicalattention. There is no suggestion in any of the evidence submitted by the local authority to suggest any medical professional had any concerns about the care the child was provided by either of her parents or that they ever acted inappropriately. In fact, quite the reverse, the medical notes demonstrate loving and caring parents interacting with their child appropriately and very upset at her being so unwell*". I agree with this assertion and I have not been persuaded that these facts take the matter further in any direction in the context of this investigation.

(iv) It is undoubtedly correct to assert that the mother spent more time alone with the child than did the father. In the period from mid-November 2019 onwards she was at home during most working days, mostly in the army accommodation , and he was out at work from fairly early in the morning to about 4.00/5.00pm. Nonetheless, the father also spent times alone with the child, for exampleon the morning of 28th December 2019 which is the day the fractured arm was discovered and may well have occurred. If the injuries did occur on 28th December 2019 in the car seat incident then it is my view that the father is not telling the truth about exactly what happened in that incident,it must have been substantially more severe than he has described.

(v) It is not uncommon in these cases for a close analysis of contemporaneoustext and WhatsApp messages to throw light on what was really going on atthe relevant time. In carrying out such an analysis a court needs to be cautious about concentrating on a small number of messages (which may present an adverse picture) whilst not concentrating on a large number of other messages (which may present a positive picture) and I do bear in mind this danger. In this case there are not any messages which throw direct light on which parent was the perpetrator; but nonetheless there are some matters in these messages which are troubling in the present context and suggest a household which had its difficulties. It is clear that the mother was, at times at least, struggling to enjoy being in the South and missing the North (e.g. "*Hate the countryside, theres nothing to do. No one to see…Losing the will to live"),* struggling to cope with having care of the child (e.g. "*I am the shittest mother ever*", "*Someone is really testing my patience…I just want to run away*", "*everything is shit*", "*I've cried and twatted myself about 10 times today*") and very angry about her discovery in December 2019 of the details of the father's 2017 sexual liaison (e.g. "*when I found out I did batter him*", "*just raised his fist to me and called me a daft cunt*", "*I told him to go and fuck himself*", "*I'm thinking of the child and I don't want her round a toxic relationship*", "*I just wanna be a slag for a bit"*). On the other hand it is only fair to point out that some of the mother's messages suggest that she was able appropriately to reflect on her situation and realise that her love for the childwas the most important thing in her life (e.g. *"Theres time in the day where I feel like ripping my hair out and I'm saying "baby, please just go to sleep"!!! Then I start the thinking, "my life is shit" "I wish I was at work" but you know what, when I see the way she looks at me, it goes away. I've lost count on how many times I tell her each day how much I love her and how shes the best thing that's ever happened to me. The point is, we all have bad days and were allowed to wish we had a different or better life but how can it get better when the life you created relys on and loves you with all their heart. I might be drained 24/7, I might not have 5 minutes in the day and I might constantly worry but I supose all that comes with being a mum").* It is clear that the father at times used some surprising language to describe the child (e.g. "*Fucking hell…the little bitch*", "*the little diva she's being a right cunt isn't she tonight*"), but it is right to point out that for the most part he used affectionate and loving language todescribe her and I do not think it is appropriate to read too much into his language. In the end I am not persuaded that these text messages really help me in identifying either the mother or the father as perpetrator, but they do perhaps throw some light on a not entirely untroubled household atand around the time that the child's injuries occurred.

(vi) I need to bear in mind the possibility that one parent is deliberately, for reasons of love or loyalty or fear or chivalry or something else, taking or sharing the blame to help the other. This thought came into focus when the texts from Mr X to the father dated 21st January 2020 came to light.

At this point Mr X, who is a good friend of the father, had been told that the father was intending (dishonestly) to admit to all the injuries so that the mother could be reunited with the child. He wrote in successive messages that day: "*You're going to ruin your life*", "*If you admit to bollox you haven't done regardless when it comes out about hermedical conditions you're still fucked*", "*I can't sit by and watch you throw your life down the shitter"*. These messages apparently had the effect of changing the father's mind about what he was proposing to admit,but are these messages indicative of the father no longer being willing to admit to true things or are they indicative of the father being willing to cover for the mother or are they indicative of neither? It is hard to reach a clear conclusion, but all these possibilities are left hanging in the air.

Are there any 'failure to protect' findings to be made here?

57. In view of the pool findings I have made here I do not think it is helpful or really possible or appropriate for me to consider failure to protect findings and I decline todo so.

THRESHOLD

58. Having made these findings it will be clear that I do take the view that the threshold has been crossed. The facts that I have found above plainly fulfil the section 31 criteria.

59. I now turn to consider welfare/disposal issues.

WELFARE/DISPOSAL

60. Having made these findings of fact I now turn to welfare/disposal issues.

61. I remind myself that in deciding on welfare/disposal issues I should keep in mind all the matters in Children Act 1989, section 1 and they are as follows.

(1) That when a court determines any question with respect to the upbringing of a child the child's welfare shall be the court's paramount consideration

(2) That in any proceedings in which any question arises the court should have regard to the general principle that delay in determining the question is likely to prejudice the welfare of a child

(3) *And that in the circumstances the court should have regard in particular to the welfare checklist:*

"(a) The ascertainable wishes and feelings of the child concerned (Considered in the light of his age and understanding);

(b) His physical, emotional and educational needs;
(c) The likely effect on him of any change in his circumstances;
(d) His age, sex, background and any characteristics of his which the court considers relevant;
(e) Any harm which he has suffered or is at risk of suffering;
(f) How capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;
(g). The range of powers available to the court under the Act in the proceedings in question."

62. I also need to remind myself of the provisions of Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms:

Article 8 – Right to respect for private and family life
1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others

63. I also remind myself of a number of matters which are underlined in the former President's judgment in *Re B-S (Children)* [2013] EWCA Civ 1146. These can perhaps be summarised as follows:

(i) Intervention in the family may be appropriate, but the aim should be to reunite the family when the circumstances enable that, and the effort should be devoted towards that end.

(ii) The court's assessment of the parents' ability to discharge their responsibilities towards the child must take into account the assistance and support which the authorities can reasonably be expected to offer.

(iii) It is the obligation of the local authority to make work the order which the court has determined is proportionate. The local authority cannot press for a more drastic form of order because it is unable or unwilling to support a less interventionist form of order. Judges must be alert to the point and must be rigorous in exploring and probing local authority thinking in cases where there is any reason to suspect that resource issues may be affecting the local authority's thinking.

(iv) In most child care cases a choice will fall to be made between two or more options. The judicial task is to evaluate all the options, undertaking a global, holistic and multifaceted evaluation of the child's welfare which takes into account all the negatives and the positives, all the pros and cons, of each option

64. The facts that I have found leave me in this situation. I have found that the parents are both in the pool of perpetrators for some very serious injuries. Neither parent has sought to blame the other for the injuries (despite the objective logic of the evidence) or yet decide to end the relationship, but my findings might cause a shift in those matters. It may be that they both know what happened and have made a loyal pact to brazen things out together. It may be that only one of them knows what happened and that person is certainly being dishonest and the other person is wilfully choosing not to face up to reality, but that may change in view of the findings. On the other hand it is possible that the parents' presentation to the outside world that there is an undiscovered scientific explanation for what has happened will continue – even though I have rejected his argument, the power and lucidity of Mr Butterfield's presentation will give them a likely reference point for their own ongoing presentation. In the background to all this, of course, is the fact that the criminal investigation of this matter is ongoing and any charging decisions are awaiting the outcome of this hearing. Any perpetrator in these circumstances knows that an admission of blame is unlikely to escape the attention of the criminal investigation and might well lead to a serious criminal conviction and possibly a sentence of imprisonment. It is unrealistic to expect that this important dynamic will change or that reading this judgment will change the strategic decision of the true perpetrator.

65. In considering what is the proper welfare outcome for this case I first want to consider the application dated 9th February 2021 brought by the father (but in reality brought on behalf of both the mother and the father) for a "Resolutions based assessment" to be carried out before any final decisions are taken in the case:-

    (i) The conventional outcome for a such a situation as this has been that professionals unite around a view that a parent in denial cannot undergo therapy which would enable the local authority or the court to feel that the situation is sufficiently safe for the child to be rehabilitated to the parents; but does the Resolutions method provide a different answer? The local authority and the guardian are strongly opposed to it in this case, as the key social worker and the guardian both made clear in their evidence. I want to say that I have in general terms an open mind about such a proposition and in the past have been persuaded that such an approach was possible and appropriate in the right circumstances and my attention has been drawn to a decision of Newton J (in *A County Council v A* [2018] EWHC 3283) where he has done the same. I note that the guardian told me in evidence that reading Newton J's decision and contemplating the child protection risks resulting from that decision made her "*blood run cold*". She accepted that there were some cases in which it might be the right decision, "*but not this case*". She acknowledged that different judges and different guardians might have differing levels of enthusiasm for the Resolutions method in principle, but "*it is not a suitable model for this case".* In her mind in reaching this conclusion were the delay that such an approach would entail, the seriousness of the injuries and the fact that they are not the product of a

once off event, the ongoing denials of the parents and the question marks about the future of the parents' marriage and accommodation.

(ii) Mr Butterfield's submissions set out the case for such an approach: "*The court is no doubt familiar with the Resolutions model which works with parents where there have been findings of significant inflicted injury but where there is a denial of those findings. It is a robust, evidence-based approach which has been used successful and safely to reunite families where there are findings of significant inflicted injuries…Even if they do not ultimately accept any findings, they are able to understand and acknowledge that the professionals have legitimate concerns; They are prepared to work with professionals in an open and honest manner; They are willing to examine the way they care for their child and make changes to care routines to ensure safety; They are willing to accept a high level of professional support and monitoring; There is a large credible support network composed of safe extended family members or friends. The court can safely depart from the recommendations of the social worker and the Guardian in this respect…The Guardian has completely closed her mind to the concept of the Resolutions approach working with (a) inflicted injuries to babies; and (b) with parents who may struggle to accept findings. That is precisely the type of case that the Resolutions model is designed for…the father's solicitors have recently made contact withI, with whom it is understood the court is familiar. She is able to start an assessment quickly in March and can report within 10-12 weeks…It is accepted that an assessment would create some delay in respect of permanence for the child. However: It may have the huge benefit of the child being able to return home to her parents, who have a great deal to offer her. Of course, the commencement of an assessment does not guarantee that, and a reunification may only be achieved after a rigorous assessment. In the meantime the child would be placed with family carers with whom she would stay permanently in the event that an assessment was unsuccessful. So, whereas her status with those carers remain unresolved, she would be with loving family members. In the event of a pool finding, the Resolutions model remains equally appropriate. The child would remain with whichever set of grandparents the court determines is most appropriate while a Resolutions assessment is undertaken to ascertain whether there can be safe family reunification*".

(iii) Mr Heckscher has responded as follows: "*The application should have been made earlier on in proceedings. Had such an application been approved by the court, the court could have considered the evidence at this final hearing; Allowing the application now would prolong proceedings that have already been extant for 14 months, with absolutely no certainty of outcome; The guardian is very concerned that neither parent is able to properly consider the risk that the other may pose; It is clear from the guardian's evidence that it is not a model she agrees with in the context of this case "The child had significant and severe injuries sustained on possibly two, possibly five occasions, more than one, heard the evidence of Dr Olsen, don't want to imagine what it was like for the*

child. These incidents and injuries are so serious and of such gravity, the parents don't own up, I don't think there could be a safe assessment with the Resolutions approach, putting the child back with parents who have done that. It's not in her best interests. Not a suitable model for this case, trying to detail the gravity of issues." The guardian accepts that the court and other children's guardians can take different views. That said, Resolutions type assessments are not suited to all cases; It is submitted that the parents' application is a little confused. The Mother said that in the event of a pool finding, the child should be placed with her maternal grandmother. In the case of findings being made in respect of one parent, both parents also said that they would separate for 'work to be done' to enable the child to be cared for by the other parent until such time as it was safe for them to reunite. Neither scenario is actually what a Resolutions assessment would set out to achieve. What the parents describe is more akin to a psychological risk assessment with anticipated work to reduce the risk; and The court is invited to consider whether the suggestion of a Resolutions assessment has enabled these parents to not have to confront one another about what has actually happened to the child".

(iv) I should only direct an assessment if I consider it "*necessary to assist the court to resolve the proceedings justly*": Children and Families Act 2014, section 13(6). Amongst the matters I need to consider any impact which giving permission would be likely to have on the welfare of the children concerned, the issues to which the expert evidence would relate and the impact which giving permission would be likely to have on the timetable for, and duration and conduct of, the proceedings,

(v) I have given this application careful thought and in the end decided to dismiss the application for a Resolutions based assessment. A number of factors have pointed me in this direction. The application was made very late in the day and will cause considerable delay to the decisions on the child's permanence, which I can otherwise make forthwith, and in any event removal of the child from the family is not being proposed by anybody as there are two family Special Guardianship Order placements available. These are very serious injuries caused on at least two occasions with no acknowledgement of blame by either parent and, on the face of it, an ongoing belief that there is an undiscovered scientific cause for the injuries. Relationships between the parents and the local authority have been tense throughout these proceedings. Relationships between different parts of the family have also been tense and may not have been assisted by some of the things that have happened in the course of this hearing. Resolutions based approaches are considerably assisted by the existence of an immediately secure accommodation arrangement for the parents with immediately available family support networks nearby to bolster any child protection measures. In this case the parents' future accommodation location is uncertain (they have said that they would like to move from army accommodation to the North, but this depends on the sanction of the army and the availability and timing of this option is currently unknown). Overall I have concluded that I can resolve these proceedings justly

without having such an assessment and have concluded that it is therefore unnecessary.

66. As I have said, nobody is suggesting here that the child should be removed from her family or, given my findings, that I should order an immediate return of the child to her parents' care, and the final part of my task is to assess the two rival Special Guardianship placements which are on offer to the court, both of which have positive recommendations. On the one hand I could make a Special Guardianship Order in favour of the maternal grandfather and his wife and on the other hand I could make a Special Guardianship Order in favour of the maternal grandmother and her husband.

67. Before I embark on an assessment of these two options – the maternal grandfather and his wife and the maternal grandmother and her husband - I want to make some comments about the way in which the local authority and the guardian have dealt with this aspect of the case:-

(i) I am afraid I have the clear impression that both the allocated social worker and the guardian have fallen short in their duty to keep an open mind as between these two options.

(ii) I note that the assessment of the maternal grandmother and her husband by the SGO assessor dated 6th August 2020 was not included in the trial bundle and emerged only after I asked about it on the first day of the final hearing. I accept that may have been an administrative error, but (worse) I have the clear impression that the key social worker did not pay much attention to it and seems to have been unware of, or alternatively ignored, the important passages in that document which made clear that the assessor accepted that, whilst the maternal grandmother and her husband hoped that a medical reason would be discovered to explain the child's injuries, they would place the child's safety above everything else and were well able to be protective of her. The key social worker relied on her recollection of an early conversation with the maternal grandmother the contents of which were denied, no contemporaneous note was ever provided and in any event (in so far as it happened at all) had been superseded by the SGO assessor's report. I think she was wrong to do so and I am afraid I have to regard this as an indication of her mindset, which was not open to the maternal grandmother and her husband. It should have been.

(iii) I find myself anyway surprised that the maternal grandmother was not removed from the asserted pool of perpetrators until December 2020, when the information from Dr Olsen which should have most influenced that decision, was available in early May 2020. I have not been given any explanation as to why this happened, but I have an uncomfortable feeling that it was more convenient to leave her in the asserted pool of perpetrators because that limited the ability to challenge the option of the maternal grandfather and his wife, which has always been the local authority's preferred option.

(iv) Yet higher in the scale of falling short of duty, in my view, was the guardian's failure to make any reference at all in her final analysis to the option of the

maternal grandmother and her husband. There is no reference to the SGO assessor report in her final analysis and no reference to the maternal grandmother and her husband at all in her permanence analysis, indeed there was a positive assertion in that analysis that there was only one full Special Guardianship analysis, the one relating to the maternal grandfather and his wife. She told me in her oral evidence that she had simply forgotten about both the assessment report on the maternal grandmother and her husband and also that this was an option to be considered. In her oral evidence she told me: "*I have to accept that my analysis in my written report is deficient*".

(v) I also have very real concerns about the way in which the Special Guardianship assessment by the other SGO assessor on the maternal grandfather and his wife , and its addendum, were so heavily redacted that objectively important information was hidden from view from the other parties and the court (until an unredacted copy was eventually supplied in the middle of the hearing). The mischief arising from this was compounded by the failure of the key social worker to comply fully or adequately with my direction (on 18th December 2020) that the local authority's final evidence should contain an explanation of why the maternal grandfather and his wife had not been approved as foster carers by the local authority's panel. Reading the key social worker's explanation in the light of seeing the full panel documents illustrated to me that the local authority strategically preferred to hide certain aspects as to what had happened rather than being transparent about it. This decision may have been taken to spare the maternal grandfather's wife some embarrassment and discomfort, but it was an unwise decision which has made rather worse the forensic experience of the maternal grandfather and his wife at this final hearing.

(vi) Stepping back at the end of this hearing I have to say that the combination of these failures has not been attractive. It has also caused me to have a degree of caution about how reliable and objective I can regard the eventual assessment by both the local authority and the guardian in the context of the assessment of the rival claims of the maternal grandfather and wife and the maternal grandmother and husband.

68. Against this background I propose to make a holistic assessment of the two options against the background of the welfare checklist in Children Act 1989, section 1.

69. I shall start with the maternal grandfather and his wife and make the following comments:-

(i) It is common ground that they have provided good care for the child from January 2020 to the present day and met her needs. Whatever else happens, they deserve the gratitude of the court and everybody else for what they have done. It is common ground that the child has thrived in their care and has a good attachment to them. In the view of the key social worker and the guardian this 'status quo' factor, and the fear that the child would suffer trauma from the disruption of this attachment by a move to the maternal grandmother and her husband, should be regarded as being of the highest importance, even the

determinative factor in my assessment. I certainly regard it as a strong factor in favour of the maternal grandfather and his wife, but it has to be weighed against other material.

(ii) In so far as this is the guardian's view I need to reflect on it alongside Ms Gallagher's comments, which I think have some force: "*The Guardian acknowledged that she had never met the child and had never observed any contact between the child and her parents, whether in person or remotely, despite there having been ample opportunity to do so in over a year of these proceedings. She had never visited the child in placement with the maternal grandfather and his wife. She accepted that she had only ever met the parents in person once at the very first court hearing in relation to these proceedings which was a stressful and difficult time. The court is invited to find that it is very unusual for a children's guardian not to have ever met a child they represent, to have failed to visit her placement and carers and to have failed to observe any contact between that child and their parents".* The guardian defended herself against the force of this attack by saying that she had cleared her approach with her line manager. I do not doubt that this is true, but (for me) this does not very much detract from the force of the comment. I do think the guardian's approach on this point is surprising, even in the Covid world which has dominated much of the lifetime of these proceedings, and it causes me to be a little more cautious about her recommendations in this respect than I might otherwise have been.

(iii)A good portion of the final hearing was taken on an analysis of the reliability of the Special Guardianship Assessment of the maternal grandfather and his wife in view of the way it proceeded through its various stages, including at the local authority fostering panel. Again, Mr Butterfield has written a comprehensive account of this matter from the perspective of the parents in his closing submissions: *"It is clear that the maternal grandfather's wife has presented the local authority with a tissue of lies in respect of marriages and previous relationships. It is clear that she has lied about or withheld significant additional information in relation to previous local authority involvement and her police caution. Even at trial, the maternal grandfather's wife flatly refused to answer perfectly relevant questions. The court is perfectly able to draw the adverse inference that she is still hiding significant matters about her past. Her account of her own life history must be treated with the utmost caution. It is submitted that the court cannot be confident that anything asserted by the maternal grandfather's wife in this respect is true without cogent corroborative evidence. Her efforts have ensured that the local authority has been unable to perform previous partner checks in respect of any of her previous marriages or relationships. This is important as there is virtually no corroborative evidence about anything that is asserted by the maternal grandfather's wife. The court can conclude that the maternal grandfather his and wife (his wife in particular) are unlikely to be able to work consistently openly and honestly with the local authority going forward. The argument that she simply struggled to be open about a single difficult period in her life does not hold true. She has told lies and withheld information about a vast swathe of her life from her marriage in 1988 up to her caution in 2009 and her marriage in 2000. In essence she has told lies about her entire adult life prior to meeting the maternal grandfather. Any carer*

for the child will need to be able to work openly and honestly with the local authority. For example, if there are difficulties about contact, the carers will need to be able to work openly and honestly to ensure they are resolved. Secondly, if there are difficulties with the maternal grandfather's wife's health, they will need to seek support openly and honestly. The court cannot be confident that that would happen. It is plain that two of her children had significant issues in their teenage years involving violence, concerns about sexualised behaviour, risk-taking behaviour. Importantly, there have been previous concerns about A being under too much pressure to support her mother due to her mother's health needs. The court is left with very little information about the maternal grandfather's wife's adult life. Even now at this late stage it knows virtually nothing about two marriages and still had no details of the court case involving two of her children. This matters because the court is being asked by the local authority to approve a placement for the child for the next 17 years. The fact that the maternal grandfather's wife may be able to parent the child as a baby does not mean that she can provide for all of the child's needs as the child grows older and particularly as she goes through puberty and becomes a teenager. It is quite clear that her daughter (and son to a lesser extent) had significant issues as teenagers. These were not straightforward issues that were simply part of growing up. They involved associating with known drugs users and possible using drugs; running away from home; living in a homeless hostel; entering into a relationship with a man that the maternal grandfather's wife herself had been in a relationship with. Without a proper understanding of her adult life, it is not possible for the professionals or the court to unpick the reasons why her own children had difficulties in her teenage years. The court should not take the risk of leaving the child with the maternal grandfather and his wife." In my view all these points are well made and I find myself surprised that these matters, and in particular the maternal grandfather's wife's failure to be open and honest about these matters, has not raised more alarm bells for the local authority or the guardian. I can, of course, understand that the maternal grandfather and his wife feel not a little resentful that the forensic process has rather turned on them in the course of the final hearing, and don't understand why her background should be so scrutinised, but I would have expected a rather more measured, mature and sensible response to this both in court and out of court and I have been very concerned about the maternal grandfather's wife's reaction to these matters having been pursued at trial, including that she unexpectedly and unnecessarily turned up at a supervised contact session on 21st February 2021 and behaved inappropriately in the presence of the child. As I write this judgment, I have been told that the local authority have sought to cancel contact this coming weekend on the basis of the maternal grandfather's wife's hurt feelings. For me, all these pointers create a level of worries which I am surprised have not caused more concern to the local authority and the guardian. I am also concerned as to the effect of all this on contact between the child and her parents if she resides with the maternal grandfather and his wife. It may be that things will settle down once this hearing is out the way, but it is by no means impossible that the challenges to the maternal grandfather and his wife in the course of this week have done permanent damage, at least to the relationship between the parents and the maternal grandfather's wife. If that is the case, future contact arrangements could be difficult.

(iv) In the maternal grandfather's closing submissions he said: "*Mr Butterfield and Mrs Gallagher again over the days of evidence gathering repeatedly wanted to raise the issue regards previous relationships however I say again the same level of attention has not been applied to all parties who have undertaken the SGO or parenting assessment process, a clear unfair balance that is negatively biased against ourselves. There has been no real regard given to why any information has been withheld and instead it has been used to continually discredit ourselves… We have admitted that we were not truthful regards certain elements regards two of my wife's ex marriages but this was due entirely to embarrassment and forgetfulness in one case and previously highlighted unwillingness to discuss another and neither with nefarious motives as neither relationship would have bearing upon the care provision for the child and the continual attack on both our characters for judicial gains, the defence barristers also attempted to expand these omissions to create a picture of ourselves as being wholly unsavoury people with no regard for motive or reason and certainly zero in sensitivity in dealing with these matters, they did however again acknowledge the high level of care we have provided for the last 14 months to the child*". I can, of course, understand the pain felt by the maternal grandfather and his wife, but I am afraid I do not accept that the process, requiring as it does a proper investigation of a carer, has been unfair to them or that the reasons for being untruthful are sufficient to deflect the criticism. Mr Butterfield and Ms Gallagher were in my view entitled to make a forensic challenge to what was being presented and an open and transparent and honest response would have been better.

(v) Without wishing to cause more unhappiness and pain to the maternal grandfather's wife, my feeling is that the local authority and the guardian have not given as much thought as I would have expected to the possible consequences of a future deterioration in the maternal grandfather's wife's Multiple Sclerosis. Again, Mr Butterfield has written about this from the perspective of the parents in his closing submissions: *"The maternal grandfather's wife suffers from relapsing-remitting multiple sclerosis. She permanently takes morphine based pain relief to deal with the pain in her leg, although she asserts that may be due at least in part to cancer. She accepted in the witness box that: In relapsing-remitting MS patients may have remissions lasting up to several years and they relapses. Many patients with relapsing-remitted MS go on to develop secondary progressive MS in which the condition becomes progressively worse. Her MS may well go along that path. The maternal grandfather's wife needed support with her MS from children's services in 2002. Further it is apparent from a later assessment that A felt under undue pressure to support her mother due to her health needs. Given her age and her acceptance that her MS may well become progressive, there is a real likelihood that her health may prevent her from caring for the child in the way that she wants within the next 17 years. The maternal grandfather's wife is undoubtedly the child's primary carer; she was clear in the witness box that he was the financial provider. The child should not have the risk of a further and potentially repeated periods of instability due to her health. This is a significant vulnerability inherent in any placement with the maternal grandfather and his wife. Again, the fact that she has managed for the past year does not mean that she will be equally well able to manage for the next 17 years with what is a progressive and degenerative*

illness. It was further concerning that in her evidence she started to protest that MS affected her memory, something that had not previously been disclosed." In my view all these points are well made and I find myself surprised that these matters have not raised more alarm bells for the local authority or the guardian.

(vi) Another possibly negative feature of placement with the maternal grandfather and his wife is the fact that they live a fair way away from where most of the family members of the maternal grandmother and maternal grandfather live and where the parents say they would like to live. My sense is that the child is likely to spend a lot more time with her birth family if she lives with the maternal grandmother and her husband rather than the maternal grandfather and his wife.

70. I shall now turn to the maternal grandmother and her husband and make the following comments:-

(i) Having read the report from the SGO assessor and heard the oral evidence of both the maternal grandmother and her husband I am satisfied that their attitude towards the future protection of the child from possible future harm caused by the parents is entirely sensible and appropriate. I am satisfied that they will act appropriately and sensitively to ensure that the child is not put at risk of harm. I am also satisfied that they have a great love for the child and are committed to looking after her during her childhood if authorised by the court to do so.

(ii) Ms Gallagher has written: "*The court has a positive Special Guardianship assessment of her maternal grandmother and step-grandfather about whose ability to provide safe and long term care for the child is without question. They have asked the court to have deemed them to have made an application for a Special Guardianship Order. It is submitted that with a careful and sensitive transition plan the child will be able to move placement with no short or long term harm to her emotional well being. It is also clear that within this placement the child will be able to safely maintain contact with all her wider family."* I agree with this. Just as very young children routinely and successfully move in a planned and child-focused transition from a temporary foster placement to a permanent adoptive placement after the conclusion of care proceedings, usually without suffering trauma, and usually managing to transfer a secure attachment, I find it difficult to see why that could not happen here. In the present scenario we would have the additional positive features than the child has an established relationship with the maternal grandmother and also should continue to have regular contact with the maternal grandfather and his wife on an ongoing basis.

(iii) Mr Butterfield has written: "*In contrast to the very complex situation regarding the maternal grandfather and his wife , the maternal grandmother and her husband are straightforward. They are a loving couple in a stable relationship. They have two children together and the maternal grandmother has two older children. None of the children has had any local authority involvement. Neither maternal grandmother nor her husband has any significant health issues*". I agree with this.

(iv) I have heard evidence about the availability of toys in the maternal

grandmother's household, the SGO assessor appearing to suggest that their house was over-tidy and that there was an absence of toys. Having heard what the maternal grandmother had to say about this I am satisfied that this should not be regarded as a matter of concern.

(v) Mr Heckscher has written on behalf of the guardian in his closing submissions: "*The guardian acknowledges the positive special guardianship assessment of the Maternal grandmother and husband and agrees that they have an important role to play in the child's life. The guardian has been clear in her evidence that the maternal grandmother and her husband would be the preferred option to care for the child were it not for the fact that the child has been placed with the maternal grandfather and his wife hitherto. It is submitted that the guardian and Local Authority were right to be concerned at the maternal grandmother's husband's refusal to allow the SGO assessor to speak to D and E alone. However, this does not detract from their suitability as potential carers for the child. Whilst not an insurmountable consideration, the court may be concerned that the child would be expected to share a bedroom with D who is 12 years of age. The guardian would hope that a division of the room, with something more than a blind, could be achieved if necessary."* I agree with these comments.

(vi) Another potentially positive negative feature of placement with the maternal grandmother and her husband is the fact that they live where most of the numerous family members of the maternal grandmother and maternal grandfather live and where the parents say they would like to live. My sense is that the child is likely to spend a lot more time with more members of her birth family if she lives with the maternal grandmother and her husband rather than the maternal grandfather and his wife.

71. Having considered all the above points, and making a balanced and holistic assessment of the options, I have in the end reached a clear conclusion, which is that the child's best interests will be best served if I make a Special Guardianship Order in favour the maternal grandmother and maternal grandmother's husband and that the child should move into their care fairly quickly, but with a planned and child-focused transition over a number of weeks. I consider that this is a proportionate intervention in the family of the parents.

72. In the eventuality which I have now reached Ms McKenzie for the local authority and Mr Heckscher for the guardian have both suggested that I should delay making a final order and instead adjourn so that a trial period at the maternal grandmother's can be carried out and assessed. Mr Heckscher put it like this: "*If the court is not with the guardian in saying that the child should remain with the maternal grandfather and his wife, the guardian would support a move to the maternal grandmother and her husband. The guardian would want to see a special guardianship support plan and transition plan. The guardian would also want to see a period of 'settling in' and the placement being tested. In these limited circumstances, the guardian would urge the court not to make final orders until these issues have been addressed. The guardian would not support the making of a special guardianship order in the absence of these steps. The court will also note the limited involvement the maternal grandmother and*

her husband have had in these proceedings. See for example the Court of Appeal decision in P-S (Children) [2018] EWCA Civ 1407."

73. I have considered these comments and also what the Court of Appeal said in *P-S (Children) [2018] EWCA Civ 1407*. I have decided that the child's best interests are served by there not being such a delay and a further assessment. The child is not a stranger to the maternal grandmother and has an established relationship with her and, although the maternal grandmother has not formally been a party in these proceedings, she and her husband have both appeared as witnesses and have asked for me to deem it that they have made an application for a Special Guardianship Order. I am not persuaded there is any good reason for delay.

74. I do agree, however, that there needs to be a Special Guardianship Support Plan (indeed there should have been one already, but there is not). I could be persuaded that a very short adjournment (measured in a few weeks) to draw up this document, also for the maternal grandmother and her husband to be given the opportunity to take some legal advice on its contents (for which I would recommend the local authority agree to fund up to a modest level). This would also give an opportunity for preparations to be made at the maternal grandmother's home for the child's arrival and also for a clear transition plan to be discussed and hopefully agreed.

75. I conclude with my observations on contact:-

    (i) I very much hope that it will be possible for the maternal grandfather and his wife and the maternal grandmother and her husband to reach an informal agreement that the child will have good and regular contact with the maternal grandfather and his wife in the new scenario. It would be a good idea for them to discuss the transport mechanisms and the broad frequency, but it should certainly include staying contact which is consistent with, or perhaps even slightly more generous than, normal grandparent-type contact for a young child. Plainly it will have to be reviewed and develop over the years ahead, but I would be pleased to be told that there were plans for the maternal grandfather and his wife have a good and full relationship with the child in the months and years ahead.

    (ii) Arrangements should also be made for contact between the child and the parents. No doubt this will depend to some extent where the parents end up living, and it will need to be kept under review and may very well change over time and therefore would be better dealt with informally rather than in a court order. The parents need to acknowledge that the maternal grandmother and her husband will (subject to any court order) have the ultimate decision over contact levels and the fact that the child is now permanently living with the maternal grandmother and her husband needs to be respected in any contact negotiations. Contact should for the foreseeable future be supervised by the maternal grandmother and her husband and they should be aware that the local authority, or another local authority, are likely to have concerns if this requirement is loosened without the specific approval of a social worker in full possession of the facts (though nobody has suggested that it would be appropriate to make a supervision order).

Subject to these comments I see no reason why the contact should be limited to six sessions per year and a regime of fortnightly or even weekly contact may well be entirely appropriate if it is working for the child.

(iii) In so far as it is the guardian's case that the parents have little to offer the child in the future because of what has happened, I disagree with that view. They remain her parents and their remains a mutual love and bond between them which, in my view, would not be properly sustained if contact was limited to six sessions per year.

(iv) As discussed in court it would be a good idea to move gradually down from the current interim levels of contact towards what I have just suggested. This can be discussed as part of the transition planning.

(v) In due course there should be nothing to prevent the child having good and normal contact with the wider family, provided of course the maternal grandmother and her husband are vigilant to ensure that the child is protected from unsupervised contact with her parents.

76. I am circulating this judgment by email. I take the view that it should be sent straight away to the maternal grandmother and her husband. In due course it would be a good idea for the local authority in the maternal grandmother and her husband's home area to be briefed on what has happened, including receiving a copy of this judgment.

77. I would need to be addressed on any wider circulation, though I imagine the Police would be interested in seeing a copy and no order is required for that if the local authority wish to provide them with a copy (which I imagine they will do).

78. I invite all parties to read as much as they are able of this judgment by 3.30 pm, at which time we can discuss at the Teams meeting what orders now need to be made.

His Honour Judge Edward Hess
Family Court
26th February 2021