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IN THE FAMILY COURT AT DARTFORD **CASE NUMBER: ME23C50205**

IN THE MATTER OF THE CHILDREN ACT 1989, SECTION 31 **[2024] EWFC 209 (B)**

AND IN THE MATTER OF M, A CHILD

BEFORE HER HONOUR JUDGE COFFEY

RE M (A CHILD)(NON-ACCIDENTAL INJURIES; WIDER CANVAS)

B E T W E E N:

KENT COUNTY COUNCIL

Applicant

-and-

The Mother

First Respondent

-and-

The Father

Second Respondent

-and-

M

(By his children's Guardian)

Third Respondent

-and-

A and K

First and Second Interveners

-and-

O

Third intervenor

JUDGMENT

Fact Finding Hearing

7 May 2024 – 22 May 2024 (10 days)

1. The child

1.1 The court is concerned with the welfare of M. This is the Local Authority's application for care orders dated 25 July 2023.

2. Parties and representation

2.1 The applicant is Kent County Council. The allocated social worker is referred to as 'the allocated social worker'. Representing the Local Authority is Louise MacLynn KC leading Steven Ashworth; their solicitor is Lucy George (Invicta Law).

2.2 M's mother is referred to hereafter as 'the mother', represented by Tina Cook KC leading Kate Kochnari; her solicitor is Louise Duckett.

2.3 M's father is referred to hereafter as 'the father', represented by Professor Delahunty KC leading Delia Minoprio; his solicitor is Ryan Booth.

2.4 The first and second intervenors are the paternal grandmother and paternal grandfather, hereafter referred to as 'A' and 'K' respectively, and 'A and K' when referred to together. A and K were joined as intervenors on 2 October 2023. They act in person. K was discharged as an intervenor on 7 May 2024.

2.5 The third intervenor is the maternal grandfather, hereafter referred to as 'O'. O was joined as an intervenor on 8 December 2023. O also acts in person.

2.6 The children's Guardian is referred to hereafter as 'the Guardian', who is represented by Annie Dixon and Tony McGovern, solicitor.

2.7 I am grateful to all the advocates and indeed their instructing solicitors for their assistance to the Court.

3. Background

3.1 This family have not previously been known to Children's Services. This is a single-issue case, following M's presentation to Hospital on 17 July 2023 with what were subsequently diagnosed as 6/7 fractures:

a. A metaphyseal corner fracture of the right proximal humerus (the bone of the upper arm adjacent to the shoulder);
b. A fracture of the left posterior sixth rib;
c. Metaphyseal corner fractures of the right distal femur and proximal tibia (at the knee);
d. A metaphyseal corner fracture of the right distal tibia (at the ankle); and
e. Metaphyseal corner fractures of the left distal femur and proximal tibia (at the knee).

3.2 No parent or caregiver has been able to explain how M sustained these fractures, which by their location in a baby of 4 months of age are highly suspicious for non-accidental injury. The hospital made a safeguarding referral to the local authority and a joint section 47 investigation commenced. The parents were arrested on 20 July 2023 and released on police bail following interview. They signed a section 20 agreement for M on 21 July 2023, albeit he was not discharged from hospital until 28 July 2023. He moved to the care of the paternal great aunt and uncle at this time under an interim care order, which was made by this court on 26 July 2023. M changed carers to the Mother's maternal cousins on 13 January 2024 following issues in the first placement. M has remained in this placement to date, enjoying extensive supervised contact with both parents and extended family members.

4. Evidence

4.1 I am grateful to the Local Authority for the provision of two Egress bundles; a full bundle (3307 pages) and amended supplementary bundle (334 pages), along with paper bundles for the witnesses.

4.2 There are a number of additional documents and files which have been sent in electronically via Egress, notably the Kent Police videos of the parents' interviews along with a number of videos extracted from the parents' phones and three short videos submitted by O. The Court also has two colour photographs of M taken on 17 July 2023 and I was given a beautiful family photograph album to review.

4.3 The court was also referred to three articles which were shared with some of the experts prior to their cross-examination; these will variously be referred to as the "Fleishman", "Wang" and "Malchodi" papers. I have considered these papers but defer to the relevant experts in their interpretation of them.

4.4 I have considered all the relevant documents and taken the time to watch all of the videos. I am grateful to Mr Ashworth for forwarding the 111 audio recordings, which were not initially accessible in a compatible format. I will refer to pertinent documents where relevant in this judgment.

5. The Law

5.1 In relation to the law regarding fact-finding hearings, Baker J (as was) gave a succinct summary of the legal principles in **A Local Authority v (1) A Mother (2) A Father (3) L & M (Children, by their Children's Guardian) [2013] EWHC 1569 (Fam),** which was reviewed by Lieven J in **A Local Authority v AA and Anor [2022] EWHC 2321 (Fam)**.

5.2 The burden of proof is on the Local Authority and the standard of proof is the balance of probabilities, with findings being binary in nature.

5.3 In this case the Local Authority seek to rely on the Schedule of Allegations dated 15 March 2024 at A(i)3-6. Criticism was made of this not being in tabular form, but I consider it to be a concise and accessible document, with appropriate citation of the expert evidence relied on, in compliance with ***Re A (A child)*** **[2015] EWFC 11**.

5.4 I remind myself to look at the broad canvas of evidence when making findings of fact. The court must only proceed on findings of fact and inferences properly drawn from fact (not suspicion or speculation).

5.5 In considering making findings of fact in non-accidental injury cases I remind myself that all medical or expert evidence forms only part of the evidential jigsaw and all the evidence has to be considered. I must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the Local Authority has been made out on the balance of probabilities.

5.6 I also remind myself of the need to assess the evidence of the parents and carers to form a clear assessment of their credibility and reliability.

5.7 In relation to expert and medical evidence, I note in particular the fifth, six and ninth principles:

> 49. Fifthly, 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. It is important to remember that the roles of the court and the expert are distinct and it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision.
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> 50. Sixth, cases involving an allegation of non-accidental injury often involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others.
>
> …

53. Ninth, as observed by Dame Elizabeth Butler-Sloss P in an earlier case: "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."

54. 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. In that case a mother had been convicted of the murder of her two children who had simply stopped breathing. The mother's two other children had experienced apparent life-threatening events taking a similar form. The Court of Appeal Criminal Division quashed the convictions. There was no evidence other than repeated incidents of breathing having ceased. There was serious disagreement between experts as to the cause of death. There was fresh evidence as to hereditary factors pointing to a possible genetic cause. In those circumstances, the Court of Appeal held that it could not be said that a natural cause could be excluded as a reasonable possible explanation. In the course of his judgment, Judge LJ (as he then was) observed:

"What may be unexplained today may be perfectly well understood tomorrow. Until then, any tendency to dogmatise should be met with an answering challenge."

55. With regard to this latter point, recent case law has emphasised the importance 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 at paragraph 1:

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

56. In **Re R, Care Proceedings Causation** [2011] EWHC 1715 (Fam), Hedley J, who had been part of the constitution of the Court of Appeal in the Henderson case, developed this point further. At paragraph 10, he observed,

"A temptation there described is ever present in Family proceedings too and, in my judgment, should be as firmly resisted there as the courts are required to resist it in criminal law. In other words, 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."

5.8 In that case Hedley J found that the cause of subdural haematomas in a baby was of unknown aetiology, and in relation to a leg fracture, although the expert evidence was that the accidental explanations would be inherently improbable, such accidents being extremely rare, he concluded that the fracture had been caused accidentally.

5.9 Ms Cook KC pointed me to ***Devon County Council v EB & Ors*** **[2013] EWHC 968 (Fam),** where Baker J (as was) considered at first instance a case with strikingly similar facts to this one, and exceptionally positive wide canvas evidence. He said:

> "This brings me to the wider canvas. It is an important part of the evidence in this case that, save for the injuries, there is not one scintilla of criticism of the way in which the mother and father have cared for these children. In the period leading up to the admission of the children in hospital, and in the 19 months since that admission, their care has been observed and scrutinised by a large number of professionals and the picture that emerges, not least from the highly positive assessment carried out on behalf of the Local Authority, is that these are doting parents who are devoted to the children and provide them with a very high level of care. This was obvious to me throughout the hearing, from the way they spoke about the children, the large numbers of photographs taken and produced in the 19 albums, the huge book of artwork, the DVD of the children and the smiles on their faces on the many occasions when the children are being spoken of, not least as I am giving judgment. Put simply, this couple are simply dotty about their children".

5.10 I am mindful of the recent authority of the Court of Appeal on good character; ***J, P And Q (Care Proceedings)*** **[2024] EWCA Civ 228** and am clear that in family proceedings such evidence forms part of the wide canvas of evidence and there is no need for a formal direction in relation to good character.

5.11 Looking at the identification of perpetrators, Baker J's final principle points to the test of whether a particular person is in the pool of possible perpetrators being whether there is a likelihood or a real possibility that he or she was the perpetrator. In order to make a finding that a particular person was the perpetrator of non-accidental injury the court must be satisfied on the balance of probabilities.

5.12 I am mindful of the clarification by the Court of Appeal of the law in relation to this by virtue of **Re A (Children) (Pool of Perpetrators) [2022] EWCA Civ 1348,** which follows on from **Re B (Children: Uncertain Perpetrator) [2019] EWCA Civ 575**, and reflects on the original dicta of Wall LJ in **Re K (Non-Accidental Injuries: Perpetrator: New Evidence) [2004] EWCA Civ 1181**. King LJ was clear that judges should no longer direct themselves on the necessity of straining to identify a perpetrator:

> "The unvarnished test is clear: following a consideration of all the available evidence and applying the simple balance of probabilities, a judge either can, or cannot, identify a perpetrator. If he or she cannot do so, then, in accordance with ***Re B*** **[2019]**, he or she should consider whether there is a real possibility that each individual on the list inflicted the injury in question".

5.13 I also remind myself that there is no duty on the Mother and Father to disprove the allegations; this would amount to a reversal of the burden of proof; per Ward LJ in ***Re M (Fact Finding hearing: Burden of Proof)*** **[2013] 2 FLR 874**, at §16:

> …"that absent a parental explanation, there was no satisfactory benign explanation, ergo there must be a malevolent explanation. And it is that leap which troubles me. It does not seem to me that the conclusion necessarily follows unless, wrongly, the burden of proof has been reversed, and the parents are being required to satisfy the court that this is not a non-accidental injury".

6. Hearing

6.1 The mode of hearing, by the parties' agreement, has been a hybrid hearing, with all experts and treating clinicians giving their evidence remotely via the Cloud Video Platform and the remainder of the witnesses giving their evidence in person. Remote attendance was permitted on the days the evidence was remote by request and on an ad hoc basis for a variety of reasons. I am satisfied this did not impact on the fairness of the hearing or the evaluation of the evidence.

6.2 Participation directions were not given, there being no evidence to support Rule 3A FPR being engaged. The parents did not require intermediary or interpreter assistance in order to engage fairly in the hearing, albeit the Father had questions read out in light of his dyslexia. I am satisfied they both understood and were able to answer questions fully and sought clarification where necessary.

6.3 I am grateful to counsel for being mindful of A and O's status as Litigants in Person. This was particularly difficult to manage in a case of this complexity. The Intervenors were provided with a bespoke bundle and supported to understand the process. I am satisfied they were put on an even footing insofar as the court was able pursuant to the Overriding Objective.

6.4 K was permitted to continue attending the hearing having been discharged as an intervenor, following the court's review of his limited care of M during the relevant period and the court being appraised of issues with his capacity pursuant to the cognitive assessment of Dr Bayliss. No formal declaration as to K's capacity was made by the court prior to his discharge as intervenor.

6.5 In addition to the written evidence I heard oral evidence in accordance with the witness template, as revised. A typed note of all the evidence was taken during the hearing, to which I have been able to cross-refer in my deliberations.

6.6 I remind myself of the need for care when assessing a witness's demeanour, and the words of Macur LJ in **Re M(Children)[2013] EWCA Civ 1147**, as reviewed by Peter Jackson LJ in **Re B-M (Findings of Fact)[2021] EWCA Civ 1371**:

> "It is obviously a counsel of perfection but seems to me advisable that any judge appraising witnesses in the emotionally charged atmosphere of a contested family dispute should warn themselves to guard against an assessment solely by virtue of their behaviour in the witness box and to expressly indicate that they have done so."

6.7 I note Peter Jackson LJ's emphasis on the word "solely". I am also mindful of the vagaries of memory, which do not necessarily indicate untruthfulness, alongside the importance of contemporary documents where available. This was particularly pertinent in this case, where the parents were being asked to recall events which took

place at a time when they were sleep-deprived and, on and after 17 July 2023, at a highly emotional time for them.

6.8 Written submissions were prepared by the represented parties, which I have considered with great care alongside the authorities referred to. The parties were given an opportunity to respond to submissions and the intervenors given the opportunity to provide submissions orally and/or in writing, or to ask any questions. Their election not to along with their lack of cross-examination is not suggested by any party linked to any form of acceptance on their part of the Local Authority's case against them.

7. Findings Sought

7.1 The findings sought by the Local Authority have been condensed into the Schedule of Allegations dated 15 March 2024, which in turn reflects the conclusions of the experts in their joint meeting on 8 February 2024. The Local Authority seeks findings in relation to the fractures outlined at §3.1 above, maintains that the fractures were sustained on a minimum of two occasions and were not birth-related.

7.2 The Local Authority asserts that the metaphyseal corner fractures were caused by an abusive twisting, pulling or shearing motion by an adult carer and the left posterior rib fracture was caused by an adult carer squeezing M's chest forcefully with their hands. Such force would be grossly excessive and unreasonable, outwith normal or rough handling.

7.3 In submissions the Local Authority stood by the allegations in the Schedule and confirmed in writing to the parties on 16 May 2024 and the court on 17 May 2024 that it pursued its case against the parents and the intervenors.

7.4 In submissions the "real possibility" test is not directly addressed by the Local Authority, albeit at §119 it says "there is a significant amount of evidence pointing towards the mother being the most likely perpetrator; she had sole care of M for the vast majority of the time and had the most stress to manage of all those within the

family". It likewise points to the evidence of the Father and the grandparents as being "unsatisfactory". It does not seek a finding of failure to seek medical attention from any person who did not inflict M's injuries and there is no finding sought in relation to failure to protect.

7.5 In response the parents and indeed the intervenors deny inflicting injuries and contend that the Local Authority have failed to meet the legal test, taking into consideration the broad canvas of evidence. There has been criticism on the part of the Father's team throughout this hearing that the Local Authority has pursued this case in a dogmatic and prosecutorial way, but ultimately it is for the court to test the experts' hypothesis that these are non-accidental injuries against all of the evidence seen and heard.

7.6 The Guardian has somewhat unusually departed from a position of neutrality in putting a positive case that the injuries are inflicted, not having been persuaded by the evidence in relation to unknown cause. She does not advance a positive case however that either parent knowingly deliberately inflicted fractures with the intent to cause such serious injuries; in fact, she does not analyse the evidence of the parents at all, or explain how she has reached her conclusions in light of the broad canvas of evidence. The Guardian's view is that, subject to the court's consideration of the evidence, it is possible to exclude both A and O from the pool of perpetrators.

7.7 Ms Dixon was criticised for a legal inaccuracy in her submissions, which I accept was an error which does not go to the validity of other points in the document. The use of the phrase "truth" is something the court exercises caution over; the court applies the legal tests and reaches a decision on the balance of probabilities; no more and no less.

7.8 This is by no means a detailed analysis of the parties' submissions, which will be further explored in my evaluation. Given the number of issues raised I am mindful of Baker LJ's comments in ***J, P And Q (Care Proceedings)*** **[2024] EWCA Civ 228** confirming Lewison LJ's view in ***Fage UK Ltd v Chobani UK Ltd*** **[2014] EWCA Civ 5** is still good law, that a judgment does not need to cover every aspect of the evidence nor every point raised in submissions; the trial judge [only] needs to

provide the reasons in sufficient detail to show the parties and, if need be, the Court of Appeal the principles on which she has acted and the reasons that have led her to her decision (§115).

8. Medical Evidence

Dr Jones

8.1 Dr Jones, Consultant Paediatric Radiologist, shared with the court that in 10 years as a consultant he has only come across one incident of accidental injury causing a metaphyseal fracture. He shared in the experts' meeting that metaphyseal corner fractures are the most specific form of fracture that is seen in inflicted injury, and outside a horrific fall down the stairs with limbs trapped underneath a child, underneath a parent that's landed on them, he could not think of another explanation, certainly not for multiple limbs [E324]. He said it is very difficult to cause a shearing injury across the growth plate of the bone (the metaphysis) and the force would be outside normal or even rough or inexperienced handling of a child.

8.2 Likewise for the rib fracture the likely cause is either a squeezing force to the chest either circumferential or front to back, and posterior rib fractures are extremely uncommon outside an inflicted cause, so a non-accidental cause. In such a young infant bones are very bendy and they bend a lot more before they break.

8.3 In oral evidence Dr Jones also confirmed his view [at E90] that even where there is a bone density problem it manifests in the long bones, where shaft fractures occur, not metaphyseal fractures.

8.4 Dr Jones was able to assist the court by placing the fractures into three distinct groups:

a. Left sixth posterior rib arc fracture ('the rib fracture') – signs of healing and new bone formation.
b. Right humerus and left tibia metaphyseal corner fractures ('the healing metaphyseal fractures') – show healing and new bone formation.

c. Other lower limb metaphyseal corner fractures (distal right tibia, proximal right tibia, proximal right femur, proximal left femur, 'the lower limb metaphyseal fractures') – no healing reaction.

8.5 There is difficulty with dating the metaphyseal corner fractures because they sometimes don't create new bone around them when they heal. This makes the general rules for aging fractures less helpful, albeit Dr Jones said that the shoulder x-ray did produce evidence of new bone formation which was useful. He described the timing of fractures as an "inexact science" or an "opinion-based sport"; explaining the differences in opinion between him and Dr X, renowned Consultant Paediatric Radiologist who was asked for a second opinion by the Hospital. Dr X was not instructed as an expert pursuant to Part 25 FPR on this occasion and therefore did not have all the case papers, he did not set out detailed reasoning for his views and he did not attend the subsequent experts' meeting, nor did he attend for cross-examination.

8.6 There were three areas of difference between the opinions of Dr Jones and Dr X:

a. With regard to the fracture of the right distal tibia;
b. With regard to the timing of the fracture to the right proximal humerus and left proximal tibia;
c. With regard to whether there were at least two separate times when the fractures were sustained or whether they could have been sustained on the same occasion (albeit with different applications of force).

8.7 Dr Jones indicated that his overall view was that the difference between him and Dr X was not that significant, but the court was concerned to note that Dr Jones did not pick up the difference in opinion about the distal right tibia fracture. Dr Jones did apologise to the court but, given that it is both considered by Dr X [E31/E60] and the treating radiologist, an explanation would have been expected for this difference in opinion. The court recognises that sometimes radiological opinion differs, but this should have been addressed to evidence thorough consideration of the evidence and because an additional fracture is significant for M.

8.8 In relation to timing for the proximal right humerus fracture, the initial evidence of Dr X was 2-4 weeks [E60] whereas Dr Jones was less than two weeks. Clarification was sought and Dr Jones indicated they had broadly similar opinions in relation to age. This is a critically important issue when looking at opportunity in relation to the intervenors, and Dr Jones' comment that he has taken a "wider view" does not make sense – he took a different initial view, which he appeared to repeat in the experts' meeting. He did take a wider view than Dr X with the proximal right tibia fracture – Dr X said 2-4 weeks, whereas Dr Jones said less than 6 weeks.

8.9 With regard to the remaining lower limb metaphyseal fractures, with no healing bone formation, Dr Jones said that they were no older than 6 weeks at the time of the second skeletal survey, and when asked if this meant they could be very recent (cross-examination by Ms MacLynn KC) he answered yes. This accords with Dr X's view that these fractures were up to 4 weeks old at the time of the first skeletal survey, but that in the absence of any healing reaction it was not possible to be more precise [E60].

8.10 These differences may be explained by the subjectivity of radiological interpretation but the position is complicated in relation to the possibility of acute injury when incorporating Dr Cleghorn's evidence in relation to swelling, which pointed to a 24-hour window. Dr Jones confirmed in oral evidence that he had not identified any acute fractures (cross-examination by Professor Delahunty KC) which is clearly inconsistent, both with Dr Cleghorn's evidence on soft tissue swelling and his own.

8.11 There were further questions around whether Dr Jones had been sent the imaging from 17 July 2023; certainly his analysis appears to be missing if he was sent the imaging. I understand that his area of expertise is radiologically noted swelling as opposed to clinically noted swelling, but I note the reference in the report at J54/K116 to "there is significant swelling and probably effusion in the left knee" which is, I assume, radiologically noted swelling. Dr Jones went on to state that soft tissue swelling was a red herring in this case, that none of it was related to fractures, in direct counterpoint with Dr Cleghorn's evidence.

8.12 In relation to the crawling video of M (taken after he was removed from his parents' care) guarding his upper left limb, Dr Jones deferred to clinical colleagues but confirmed failure to weight bear could be seen in a child with a fracture, and further injury may lead him to re-evaluate his conclusion. Unfortunately it is too late to x-ray.

8.13 As to the bicycle manoeuvre hypothesis Dr Jones confirmed that if the bicycle motion was carried out with sufficient force it could cause a fracture. However lots of children have that manoeuvre performed and metaphyseal fractures are not seen. Likewise occult rib fractures do not tend to be seen, despite the number of babies and young children having x-rays. A 30-40 % loss would be required before bone density loss would be visible on x-ray.

8.14 Dr Jones was cross-examined in relation to the research papers and although professing this was not his area of expertise, when considering the potential impact of Omeprazole he confirmed that the effects would be most greatly seen in the growing portions where the bone is turning over fast, namely the metaphyses and the epiphyses, if the theory that PPIs affected osteoclasts and osteoblasts was correct, and would be applicable in theory to a child less than six months. He stated "When we are dealing with bones which are weaker, the effect of that would be greater, where greatest turnover of bone, particular areas of bone may be more affected than others." He added "At the end of the long bones, the cartilage turns to bone all the time. Everything from the end of the bone down to the growth plate will have more bone turnover than the shaft of the bone. The metaphyses. The ends of the bone." He did question whether M would have had that much PPI from whatever source. He referenced the papers relating to those taking more regularly and longer. He said "the question is if PPI at sufficient dose could alter the way the bones react to being put down and taken up and whether that could alter the fracture propensity, my answer is maybe. If you're going to alter bone turnover, there is a potential for fracture disposition to be affected." This would not in any event explain the rib fracture. Dr Jones was not aware of tests that could determine the impact of Omeprazole on a bone.

8.15 The court's impression in relation to Dr Jones' evidence is that he did take a linear approach to causation, he made avoidable errors which do give the court reason to question whether Dr Jones reflected comprehensively on the evidence sent to him with an open mind, specifically in relation to lines of potential further enquiry, which is critical in a case where the radiological evidence is pivotal.

Dr Ellis

8.16 Dr Ellis agreed that the Mother has Ehlers Danlos Syndrome type III and that M had a 50% chance of inheriting it, but this would not predispose children to bone fragility. He confirmed that genetic testing only picks up 95% of genetic disorders that would lead to increased bone fragility.

8.17 Dr Ellis qualified this in terms of the family history raising nothing pointing towards increased bone fragility, however he did agree that testing may not have been as prevalent historically. He would have expected shaft fractures if M did have some unidentified genetic predisposition to fracture; broken wrist, arm or leg which we haven't seen; "what we are thinking is this is a family with propensity to metaphyseal fractures which is almost sub-clinical".

8.18 Dr Ellis was challenged in relation to the Mother having shown him bruises which he had not written down. I note the Mother was not challenged on this in her evidence and it is abundantly clear that this mother has been assiduous in trying to bring to the attention of healthcare professionals anything which would give rise to answers in relation to how M sustained these injuries. Further, we know that the Mother's statement about the marks and bruises was sent to Dr Ellis and he indicated his opinion was unchanged, whereas in cross examination from the Mother he said he could not see the images well enough to comment. This begs the question why he did not say this in response to the Mother's statement.

8.19 Dr Ellis did agree that if there was evidence that M had sustained another fracture this would change his opinion, but was in difficulties through want of evidence about this. He qualified this by saying there had been no other fractures since,

particularly as M has become more mobile, but ultimately the Court does not know this as there have been no further x-rays.

Dr Skett

8.20 Dr Skett's late instruction on the application of the Guardian was approved by the Court following the dissemination of Dr Y's report and in light of evolving research in particular about the use of Proton Pump Inhibitors leading to risk of fracture. Dr Skett was asked to comment on the Mother's reported medication use for her and M, and although there is a dispute of fact, it is the Mother's case that M was taking Omeprazole for 35 days. The Fleishman paper in particular speaks to a significantly higher rate of fractures among paediatric patients with exposure to Proton Pump Inhibitors compared to those without exposure, and the location of fractures is statistically different than those patients without exposure, with lower extremity, rib and spine fractures being more common. Increased risk was identified from as little as 30 days consumption.

8.21 Dr Skett's opinion was that none of the medications given to the Mother or M had any significant effect on bone growth, development or fragility. He preferred the Wang paper over the Fleishman paper as there were bigger cohorts and Wang identified no increased risk in the 0–6-month cohort.

8.22 Dr Skett confirmed that Omeprazole is not licenced for under one-year olds, perhaps reflecting a lack of testing but this is speculation. Although he confirmed that M's dose was well below the dose that could be given, he agreed that a safe dose for one child can be an unsafe dose for another, due to differing rates of absorption and expulsion, and he further agreed that there is currently no test for this that he was aware of. Fractures are specifically identified as a side effect for PPI's under the NICE Guidelines – this is for adults but given it is unlicensed for under ones there will necessarily not be any NICE Guidelines for this age group. Submissions on behalf of the Father suggest that the British National Formulary for Children also lists the common side effects of Omeprazole as including fractures, but Dr Skett did not have access and could not confirm the same.

8.23 This is a developing field and there is still no established causal link between Omeprazole and fractures, but this research combined with Dr Jones' late evidence explaining why the metaphyses may be more impacted due to growth turnover gives rise to a question about whether this may have been relevant for M, who was prescribed an unlicenced drug at a very young age.

8.24 There is further no evidence which evaluates all relevant comorbidities, including the significant prospect of him having EDS III in light of his noted hypermobility and independently observed signs of propensity to bruise/mark (with the caveat expressed about babies being hypermobile), the leg swelling on 17 July 2023 if not an acute fracture in accordance with Dr Jones' evidence, the initially raised APTT (albeit subsequently normal), his dairy allergy and feeding issues with associated Omeprazole prescription, his slight prematurity and difficult birth (by forceps) and sufficient concern in respect of the family's medical history that stem cells were taken at birth. A common feature in these cases is that no concerns have been noted in a child post-removal, but in this case a number of concerns have been raised, most notably in relation to M's arm but also in relation to unexplained marks and bruises. Dr Cleghorn was unable to attend the experts' meeting and, although a paediatrician would normally give an overarching view, concern was expressed on behalf of the parents that Dr Cleghorn approached this case without an open mind.

8.25 The court is ever mindful of the need to consider the "outlier child", taking into consideration the wide range of responses from children, as espoused recently by Lieven J in **A Local Authority v AA & BB & Y through her children's Guardian [2022] EWHC 2321 (Fam).** The Court of Appeal has considered an appeal very recently on similar facts concerning the use of Omeprazole in fractures to a baby, **W (A Child), In the Matter Of (Inflicted Injury - Delay) [2024] EWCA Civ 418,** where King LJ criticised the first instance judge's compartmentalised analysis of the medical evidence.

8.26 This case also considered forensic pharmacological evidence and the Malchodi paper in particular. I note the child in that case would have been excluded from the study due to a number of reasons, including prematurity, low birth weight and

fracture below one year of age. It is not for this court to criticise these research papers but I do make the observation that it would appear dangerous to place wholesale reliance on their conclusions when a child with M's comorbidities does not appear to have been evaluated by reason of those comorbidities.

Dr Cleghorn

8.27 Dr Cleghorn did not have the benefit of having heard the other experts' oral evidence , which necessarily limited her ability to reflect save where specific points were put to her in cross examination. She had likewise been unable to attend the experts' meeting although the transcript is in the bundle and she was able to comment thereafter. Dr Cleghorn considered the swelling and reduced movement in M's leg on 17 July 2023 appeared to be associated with a fracture to his left leg. She stated that swelling often starts within the first 24 hours but may not be noticed by parents or carers in that time period; they may not pick up on it until there was an obvious difference. There are no other clinical signs apart from the point at which the parents see he stops using his leg.

8.28 Dr Cleghorn was cross-examined in relation to the known unknowns but stood by her opinion. She said it was a possibility which was not excluded by her opinion, but that from her perspective it was still more likely to be an inflicted injury given these are metaphyseal fractures in a non-mobile infant with normal bones (from what we know) and no appropriate explanation.

8.29 In relation to mechanism, Dr Cleghorn considered the bicycling motion and said if doing it properly you would not be twisting at the same time, however if you were not a "practiced" parent you may twist the legs and cause the fractures, but this would be outside the range of normal handling and there would be an immediate sign of distress. Similarly the "onesie" explanation – manipulating M's leg to free a trapped leg could provide a mechanism for a metaphyseal corner fracture, but it too would require a force outside of normal handling.

8.30 Dr Cleghorn opined on pain response and indicated that where a fracture happens there is some additional distress that parents will pick up on, that it would not be

hidden in other distress and that even when a child has increased propensity to fracture, they are still painful. This opinion was limited to the time of fracture; a carer who had not directly witnessed the event may not necessarily know that something had happened to cause this distress.

8.31 Calpol is an extremely good pain reliever for babies, as is ibuprofen; it would reduce some of the pain of the fracture but not so much that you don't see the pain. A baby can settle down quite quickly after such analgesia. Cuddles, feeding and soothing can be enough to settle a child but all children are different.

8.32 Dr Cleghorn was not persuaded the independent observation about M crying loudly every time his nappy was changed was significant, as it is not unusual for some babies to do this. However if a fracture occurred in that moment, there would be some additional distress which it would be difficult for carers to identify.

8.33 Turning to the reduced movement in M's arm captured on video, Dr Cleghorn had previously recommended paediatric assessment and stood by that position, maintaining an assessment could not be undertaken from a few seconds of video. She had been careful not to put a long list of possibilities given the potential for tumour or stroke was up there, but fracture was a possibility further down her list.

8.34 Turning to the post-removal photographs, Dr Cleghorn was unwilling to comment on photographs and noted that M had appropriately been seen by the GP who was not concerned.

8.35 Dr Cleghorn was asked about the Omeprazole prescription and said you would normally try Omeprazole for a couple of weeks but she would have probably said four weeks, perhaps start with a two-week prescription and ask the GP to give two weeks. It was therefore feasible that the Mother was told it might take up to four weeks for it to be effective. Dr Cleghorn observed the notes said two weeks and you would not normally advise to try both Omeprazole and hydrolysed milk at the same time; it is written clearly to try one and then the other.

8.36 Dr Cleghorn clarified in cross examination from the Father that her comments were made on the assumption of normal bones, and that she hadn't excluded "the

possibility something else is going on". She acknowledged that medical science is evolving and the impact of PPI's on fractures is recent research. She also agreed there are outliers and those who behave differently in relation to all medical issues.

8.37 It was of some concern therefore that Dr Cleghorn became defensive in cross-examination, a process which rightly and fairly tests a party's case and an experts' conclusions.

8.38 The court was concerned about Dr Cleghorn's apparent unwillingness to accept a need to revisit her conclusions in the event of further injury to M post-removal. Her lack of open-minded approach was further exemplified in her response to questions from the Father's team about the steps the parents had taken to bring the injuries to light; she would only answer that "they were appropriate responses by parents with concerns about their child" (four times in response to five questions).

8.39 Similarly when Professor Delahunty KC took Dr Cleghorn through the checklist guidance for NAI, no features in relation to which were present, Dr Cleghorn appeared to take the criticism personally and said that "it would have been a lot easier today if I had". She stated that she would not normally include such assessments in her reports, she had not plotted a centile chart for M, nor could she help the court with what that may show about underlying issues in M. She concluded by saying "then I need to stop doing this don't I? Please don't instruct me in the future, that is absolutely fine".

8.40 The concern of the court in relation to these comments is less about the omissions from her reports but more about her apparent unwillingness to take on board the criticism and approach the case with an open mind, particularly given the additional evidence which – as is often the case – was raised shortly prior to or at the trial. Dr Cleghorn's evidence is a key aspect to the Local Authority's case and the court is left with the impression that Dr Cleghorn was unable to move away from her starting position that metaphyseal fractures in a non-ambulant infant are likely to be inflicted, and that M would have been in immediate and obvious distress. This is a complex case medically and the court needs the assistance of the experts instructed to contemplate all hypotheses.

Treating Clinicians

8.41 There were a number of treating clinicians on the witness template, not all of whom were subsequently called, whose evidence spoke to their respective notes in the medical records. No treating healthcare professional makes any comment of concern in relation to the behaviour or demeanour of the parents at the hospital at any point. This was obviously a highly stressful and upsetting experience for them and their behaviour was evidently appropriate and cooperative. M is noted at M72 to be well kempt, and at K158 Dr S records "parents informed and co-operating well with the plan" on 18/07/2023. Nurse Y notes M was "making eye contact with parents, myself and drs and has been smiling and making happy noises" [K148].

8.42 An "After Action Review Report" was prepared [K246] by the hospital following concerns that M was discharged home without discussion with a Paediatric Consultant or request to the Radiology team to review the x-rays as at M's age bones are not fully calcified and fractures can be easily missed.

8.43 Concern was raised that M had been put at risk as "the family of the patient had the opportunity not to return to hospital with the patient" [K247]. However the parents did bring M back when they were contacted to do so, just as they had been proactive in taking M to hospital in the first place, when other parents such as the paternal aunt said she would not have done so. The Local Authority suggests that, had either of the parents cause M's injuries, they would have raised immediate suspicion or concern in the other parent had they not been keen to seek medical attention for a swollen leg on 17 July 2023. This is true, particularly in light of the Mother's tendency to seek medical advice for more trivial matters, but the nature of the medical attention sought is not given, for example either parent could have accepted the offer of a GP appointment in two days' time rather than head straight to the hospital, not waiting for a call back from NHS 111.

8.44 This document also refers to Dr T having a personal bias in wanting to consider other possibilities for the injuries for the patient "due to not feeling that these had been caused by the mother of the patient". Dr T was not called so the context of this

statement was not explored, save that it is noted "the mother of the patient had gone dairy free and it was felt that this was a big commitment for someone who would then hurt the patient. A request was made for genetic tests to be completed and blood was taken from the patient and this was sent but was not able to be processed for legal reasons". Likewise it is recorded at K222 that "the triage nurse did not expect there to be any maltreatment from the parents, and they had observed the baby as being cared for".

9. The Parents' Evidence

The Mother

9.1 It is not lost on the court that the Mother has found these proceedings highly distressing, particularly when M's injuries have been discussed. In her own evidence the Mother was at times unable to answer questions in cross-examination for want of memory, in contrast to her contemporaneous police interview where she was able to be much more forthcoming. Her answers in the police interview also substantively match the Father's.

9.2 The Local Authority is critical of the Mother's vagueness in submissions and suggests that both parents were evasive, that there was a sense they preferred to respond to many questions with the answer that they could not remember rather than risking giving an answer that would be damaging to their case. The court does not agree that either parent was evasive – the Father (more below) was clear at the outset of his oral evidence as he was in his police interview that he was rubbish with dates and the Mother appeared anxious to tell the truth and not give a wrong answer if she was unsure. There was no impression whatsoever of a witness seeking to withhold information. I agree with the Mother's submissions that the first weeks and months of a baby's life tend to be a complete blur and a lack of certainty around dates is more indicative of honesty and lack of fabrication.

9.3 The Local Authority cites examples of the Mother's inability to remember the physiotherapy appointment in December, which I do agree I would expect the Mother to remember if she did show the video to the physiotherapist. However I do

not criticise her for being able to remember what she was told on discharge from hospital about the Omeprazole; this was important information about a key issue in her son's life at the time, and it is a subject she was likewise able to discuss in her police interview.

9.4 The Local Authority focused in cross-examination on the Mother's difficulties in pregnancy, birth and motherhood and the impact on her of the Father working nights. The Court's impression from the evidence and notably the exchange of messages between the parents is of a committed mother of a much wanted and loved baby whose experience fits squarely within the normal parameters of motherhood. She was getting out and about with M, including to baby massage, seeing friends and their children, enjoying day trips and short holidays and spending lots of time with family.

9.5 The example of "I feel like an awful mum" at P234 is a comment in the context of M's milk being microwaved and the Mother's concerns about the removal of antibodies and nutrients in the milk. The Mother was clear that she was not suffering from post-natal depression and she had been up front with the midwife about her anxiety diagnosis [L1], albeit she had not been able to complete her therapy with her working commitments and did not think the prescribed medication would work.

9.6 The Local Authority's picture of a mother struggling to cope with the feeding regime and night times on her own is not borne out by the evidence. To be caring for M alone overnight is not *prima facie* stressful – many single mothers do just that - and the Mother appears to have taken the need to express milk in her stride, seeking appropriate breastfeeding support from the feeding clinic and the health visiting service and obtaining a hospital grade pump to increase her supply, latterly with the support of O [N49, N51, N54, N56 and N77].

9.7 The evidence is not clear in relation to when the feeding issues for M resolved; it appears to have been gradual after a number of alternatives were tried, culminating in M receiving exclusive breast milk (and the Mother foregoing dairy to support this). I note the Mother attended the breastfeeding clinic on 30/06/2023 where she reported M not tolerating his formula well. This lead to the loan (again) of the

hospital grade pump, with advice to power pump 2-3 times a day for two days. No red flags are noted by professionals or by any friends or family members. The Mother's commitment to her breastfeeding journey is exemplary, having stopped as recently as 5 May 2024, demonstrating that despite the stress of these proceedings and her separation from M she has continued to put his nutritional needs first. The one message shared between the Mother and the Father [P41] that "I haven't made enough milk because I didn't have any time and I'm sad about it" on 17/06/2023 (at 02:53) is prior to the Mother receiving the breastfeeding clinic support and pump loan, is an isolated concern and is resolved later that night when the Mother found time to pump enough milk for a bottle within an hour (by 03:45) having also fed him and got him down to sleep.

9.8 A critical eye may describe the Mother as a somewhat anxious parent, but this is counterbalanced by the Father's more relaxed nature, and his support and reassurance for the Mother is once more evident throughout their message exchanges. There is no doubt that the Mother (and Father) were sleep deprived throughout the first few months of M's life, but that is entirely consistent with being a new parent. The Mother had the Father's support both on his return from work in the morning and once he had woken up in the afternoon; for example when discussing M's colic with the police the Mother described days when she has been a bit upset if he has cried too much, "but it's just the fact that I can't make it better for him" [J680] and "the father will take over and I'll just have a bath or something"[J681]. I do not see the time of day to be critical in a new born child with a 24-hour sleeping/waking cycle. The Father was likewise available to the Mother when working, both in the form of his supportive messages and his review of the app monitoring M's crib. I do not consider the Father's working pattern to be a risk factor in this case.

9.9 The Mother's willingness to share her feelings with the Father is apparent from the messages, as is her strong relationship with her father, notably following the loss of her mother. O being away does not point to him being unavailable to the Mother; their regular messages exchanged on a variety of subjects speaks to this. The Mother has a strong support network and spent a lot of time with family; there are

no isolation issues in this case and M was a baby evidently much loved by the whole family and wider network.

9.10 The Local Authority seek to rely on one message from the Mother to her father after M's injuries have been diagnosed as evidence of significant stress [P345]. She says at 07:15 on 19/07/2023 "I think this may finally be my breaking point. My heart can't take any more he's the only thing keeping me going". This message was sent after child protection procedures had been initiated and is illuminated in the context of O subsequent telephone call to the ward logged by Nurse B (Qualified Nurse) [K156], that the whole family were grieving following the loss of the maternal grandmother, M's great grandad and their dog. The family had only just returned from a trip to Wales where they had scattered the maternal grandmother's ashes. The Mother is understandably heartbroken and expressing to her father that M is the only thing keeping her going, but the Mother had expressed she was upset feeling like she was a criminal. This experience would be stressful for anyone and the message sent is both justified and not indicative of significant stress. O also refers to most family members having cancer on the maternal line leading to concerns about the radiation in the CT scan for M. I note the family were prepared to consider an MRI as an alternative but ultimately accepted medical advice.

9.11 The Mother has shown in the messages a propensity to conduct extensive internet searches. The absence of any searches in relation to M's injuries prior to his diagnosis is therefore telling, and there was no suggestion put to her that she would have anticipated her phone would be seized. In fact, the Mother conducts entirely different searches on 18/07/2023 in relation to "do x-rays show blood clots" and "baby blood clot leg", which reflects O concerns about a blood clot due to the long journey back from Wales. This is strongly persuasive that the Mother did not know about M's fractures prior to diagnosis, as there has been no suggestion of fabrication. The Detective Constable also references that the Mother's phone download from 14/01/2023 contains a list of medical issues and states a deleted note from 08/12/2022 relates to another medical condition. This supports the Mother's admitted health anxiety following her bereavements [J203] and is consistent with her conduct throughout these proceedings in terms of exploring every possible avenue to get answers about M.

9.12 The parents' use of the Cubio AI app is consistent with their approach to parenting, and the Detective Constable notes at J205 O comments that the Mother is very "mum orientated" and all the equipment and care has to be "the best and the safest possible; there are no more doting parents in the world". The camera on the app monitors M's crib and recordings are kept for 30 days. The messages between the parents show the Father monitoring the app to check on M and communicate with the Mother; (P40, 43, 45, 48 and 51).

9.13 The parents were open in the sharing of their phones and passwords and could have obtained the previous 30 days of footage (possibly more if enquiries had been made with the relevant company) but the police do not appear to have obtained this. This could have been crucial footage if M had come to harm overnight.

9.14 The Mother paid close attention to M's health and was quick to have him checked out in the event of any concern. It is consistent that when his leg became swollen she and the Father took immediate steps to have this considered by a healthcare professional, in circumstances where experienced mothers like the paternal aunt gave evidence they would not.

9.15 The Mother was cross-examined closely in relation to the Omeprazole prescription from 20 April 2023. At J502 it is recorded "Prescription/medicines prepared to take away" and at J503 Dr G recorded: "Plan Home with omeprazole for 2 weeks, if helping, GP to continue prescription, if no help, to consider hydrolysed milk". The Mother reflected that she had been told it could take four weeks for Omeprazole to work, which accords with Dr Cleghorn's evidence, and that as M had settled and they were going on holiday she decided to continue with the Omeprazole. She was able to recall taking the bottle to the Isle of Wight and keeping it cool and O in his evidence spoke to assisting the mother in administering it. There was plenty of medicine in the bottle and therefore she did not need to get more from the GP when she attended on 2 May 2023 to get the hydrolysed milk.

9.16 I note the record dated 5 May 2023, 14 days post-Omeprazole notes:

> "Started Aptam l pept 2 days ago before that was screaming and in pain during bottle feed could not finish bottles. However, on this milk he is now feeding well" [M14]

9.17 There is no mention of Omeprazole, but this is not inconsistent with the Mother and indeed Dr Cleghorn's evidence that it can take four weeks to work. Given the Mother's assiduous attention to M's care it is not inconsistent that she would have continued with the Omeprazole for the four-week period whilst also transitioning to the hydrolysed milk (albeit Dr Cleghorn said in evidence she would not advise this).

9.18 I note there are some inconsistencies in the Mother's evidence as to whether M took it for 4-6 weeks (this was from a position statement not supported by a statement of truth) or in her statement confirming the 2-week prescription, plus stating on 24 July 2023 that M had stopped Omeprazole 2.5 months earlier. The Mother also recognised in the police interview that she didn't want him on the Omeprazole if she could help it, and that "it isn't very good for such a little body. It's not very good for the stomach".

9.19 On balance, both the Mother and O can recall taking the medicine on holiday to the Isle of Wight and they can be confident of the dates of that holiday, whereas other precise dates may be harder to recall without some form of marker or note. Absent suggestion that both the Mother and O are lying about their clear recollection, I prefer their clear oral evidence on this issue.

9.20 Other criticisms which the Local Authority suggest may impact on the Mother's credibility are around her failure to mention the discarding of her breastmilk when the use of opioids was postulated to Dr Skett. The Mother's team confirmed and the court recalls that the Mother was asked to put together a list urgently following the hearing on 19 April 2024 in order for Dr Skett to be instructed. The court does not consider this omission to be material; she was clear in the police interview that this is what she did.

9.21 Likewise the Mother was criticised for exaggerating her father's rheumatoid arthritis. The Mother's statement in relation to family health history was certainly

comprehensive and O reacted defensively when there was a suggestion that his condition may have had an impact on his care of M. He apologised for this and I do not consider this should impact on the Mother's credibility, as there is no suggestion O does not suffer with arthritis, which has flare ups and will therefore logically vary in how the symptoms affect O. I do not agree with the Local Authority that the Mother gave a misleading picture about this issue.

9.22 The Mother has also been criticised for the way she has dealt with the post-removal evidence. By this time M was subject to an ICO and not in the Mother's primary care. I do note that, whereas the paternal great aunt referred to M as having a leg which was a "peachy" colour, the Mother referred to it as being red and slightly swollen; in her email dated 25 August 2023 she shows a photograph from the paternal great aunt alongside a photograph of M's leg on 17th July 2023. The allocated social worker describes this in her email to the Detective Constable on 9 November 2023 [Z274] and describes the paternal great aunt having taken three photographs and "it seemed like there was also some swelling and discoloration". She described the Mother as thinking it looked similar to M's presentation on 17 July 2023 and that she had been "worried about M being in pain without her knowing", which led to the allocated social worker suggesting that the Mother contact the GP surgery, which she duly did by email. The Mother's thought processes are self-evident and her concern about M clear. It was also necessarily difficult for the Mother to deal with this whilst not having M in her physical care. The paternal great aunt did not produce evidence herself in relation to these marks and indeed the other concerns raised by the allocated social worker, in the context of concerns raised about her failure to report marks and dismissal of safeguarding queries. This is a further gap in the evidence which I note that the medical experts – Dr Cleghorn in particular – have not been able to comment on for want of evidence or sufficient evidence.

9.23 The Mother has also been criticised for being vague about M's arm issue, when once more M was not in her primary care at this time. From the court's perspective, the Mother acted appropriately, raising the issue with her legal team and the court on 8th December 2023. She was criticised for not bringing the private physiotherapy appointment to the attention of the court, but in fact she did tell the Guardian it was

happening and the court now knows that she forwarded the physiotherapist's email to her instructing solicitor Ms Duckett once it was available. At the hearing on 8th December 2023 there was concern about M's placement and Christmas arrangements as well as the court's review of the intervenors, including the joinder of O as an intervenor. The stress of these proceedings has been evident throughout and the court is unsurprised that the Mother cannot remember whether she showed or did not show the video to the physiotherapist – who in any event was not an expert instructed in these proceedings, or a doctor.

9.24 The court also takes into consideration that even on 17 July 2023 the healthcare professionals were unable to diagnose the fractures initially even with the benefit of an x-ray. The court therefore questions how the Local Authority would expect a physiotherapist to do the same. The court also notes that M had a GP appointment on 14 December 2023 but this was for nasal congestion and cough, so the GP would not have been expected to examine M's arm.

9.25 I note that the Mother does not appear to have told Dr M or Dr F about the proximate physiotherapy appointment, but considering their letters there is no evidence of exaggeration and the video speaks for itself. Dr Cleghorn agreed that fracture was a differential diagnosis and in the court's view a paediatric review should have taken place immediately upon noticing this behaviour in order to rule further fracture in, or out, with x-rays to have been taken if considered clinically appropriate by the treating healthcare professionals. That was not done and we will therefore never know if M had sustained an additional fracture at this time.

9.26 I am not at all surprised that the Mother and indeed family members did not consider whether anyone had hurt M, nor ask directly whether they had. The evidence points strongly to a close-knit, supportive family where the possibility of non-accidental harm would understandably not be contemplated. I note that the Mother replied to the question about harm on the 111 call that it was just her husband and her who had had care of M, as if it could not be contemplated that either of them could harm him.

9.27 I do not consider the Mother's response to her father in the messages of 18 July 2023 to be odd. She had received healthcare advice upon presenting M on the 17th

and could equally have been criticised if she had gone straight back with M, or taken him to an alternative healthcare professional. Her response to wait until Thursday and call 111 appears entirely appropriate, and the Mother is equally responsive to the Father's advice to call the following day if it's no better [P342].

9.28 The onesie evidence is somewhat unusual in that there is no recorded footage on the Cubio AI camera. It is not surprising that the Father did not wake up, noting he mentioned in his police interview he had been awake a long time driving [J597]. The evidence about when the Mother told the Father is not clear and it is true that the Mother did not initially put it forward as a possible explanation, it evidently not being at the forefront of her mind on 17/18 July. In her police interview it is evident that the Mother did not initially think this incident was significant – she noticed M had trapped his foot and he was crying but "he also had a fully nappy which he doesn't like" "so we didn't think too much of the leg at the time" (the evidence established that the Mother has a tendency to say "we" interchangeably with "I"). The Mother states that M pulled his own leg back down when released and he wasn't in any pain that the Mother was aware of. The court's impression is that at the time the Mother did not consider the incident particularly significant. The Guardian questions why the Mother would review the Cubio AI footage but it appears to the court that that is entirely consistent with the Mother's parenting behaviour. There is no impression that the Mother was trying to exaggerate or over-dramatise this incident to point towards this causing one or more of the fractures, quite the reverse.

The Father

9.29 The Father was clear from the outset that he was not good with dates and his evidence was commensurately lacking in detail. He came across as a relaxed but committed father and family man who was a strong source of support for the Mother. He accepted that he had had some help with dates from his solicitor and from A in relation to the family history. Any passages of evidence for the Father were read out to support his learning style.

9.30 In relation to M being in pain on 17 July 2023, the court has been shown photographs of a happy M during that day when he attended his great-nan's house for her birthday and was passed round various family members with no evidence of distress. The Mother does refer to pain in the 111 call but that is not the predominant concern, which is rather the swelling and guarded movement. Given that the Father first noticed swelling when changing M's nappy it is unsurprising that swelling was the Father's predominant memory.

9.31 In relation to sleeping, being generally a good sleeper is not inconsistent with some night time waking in a child of this age. I agree there is a gloss in using the word "brilliant" but that is not necessarily for tactical reasons as opposed to being an adoring parent. The same comments go for the Fathers description of M being "happy as always"- all babies cry and colic is not an unusual phenomenon.

9.32 The court's impression of why the Father was not concerned about the amount of stress the Mother was under is because she was not particularly stressed, and it was clear that the Local Authority in cross-examination was seeking to exaggerate a concern which was not made out on the evidence. They likewise suggest that the Father will have found M's crying and feeding issues stressful, particularly given his long working hours combined with an equal share of night time care of M at weekends. This is conjecture; there is no evidence of the Father having either been stressed or excessively tired, and it is entirely normal for parents to deal with a grizzly teething baby from time to time, including the appropriate administration of Calpol.

10. Other Witnesses

A

10.1 A had the care of M on three occasions during the relevant period, which led to her joinder as an intervenor. She has attended every hearing as a litigant in person and has no doubt found the process both daunting and stressful.

10.2 The Local Authority criticise A for describing M as a "very happy baby" to police. Looking at the log which starts at J210, A describes discomfort teething and when he had issues with formula milk. She also adds that he has never liked having his nappy changed and cries a lot during this. She added that he kicks out a lot. Her comment is therefore a qualified and balanced one. I also note that she reported to the police what an "incredibly cautious" mother the Mother was, anti-bac wiping everything and not letting K kiss M when he had a cold sore.

10.3 A was criticised for her comments about M's nappy changes following the paternal aunt's description of M not crying. The Local Authority in submissions speak to the paternal aunt's child distracting M during a car journey but the court's clear note is that she was cross-examined on this point by Professor Delahunty KC and she said that the paternal aunt's child had distracted him by waving rattles during his nappy change and he was laughing and smiling away. The paternal aunt is a special needs teacher and may be particularly adept at the art of distraction. This does not depart from the professionals' observations at the Family Group Conference and the family's jointly held view that M tends to cry a lot during nappy changes. There is no suggestion from the Local Authority that the family have colluded in relation to this issue (or generally). The court does have a note that Ms MacLynn KC challenged the Mother in relation to whether she had inflicted the injuries (there having been a question about this in submissions).

10.4 There are conflicting submissions from the Local Authority and the Guardian in relation to whether having care of the paternal aunt's child at the same time as M would make A more stressed and more likely to inflict the injuries on M, or less likely due to having her other grandchild there. The court's impression of A is of an experienced parent and grandparent who would take the care of her two grandchildren in her stride. There is no evidence of stress – this is speculation – and there is no evidence that when A cared for M she encountered any particular difficulties.

O

10.5 O had the care of M twice during the relevant period, and produced video evidence that he was happy during this period. He spoke to the Mother's high level of organisation when he was babysitting, to the point she left him with a microwave meal and everything he needed to care for M whilst the parents went out for a meal. As with A, O has attended every hearing as a litigant in person and has likewise no doubt found the process both daunting and stressful.

10.6 O did seek to make a correction to his evidence in respect of the extent to which he was and is troubled by his rheumatoid arthritis. He admitted that he had been hasty in sending the email which appears at Z241, where, although he accepts he has reactive arthritis and his fingers are disfigured, he is not in too much pain and does not take medication. He explained that he was upset with it being suggested that his condition could be a reason for M's injuries.

10.7 The Local Authority's response to this is to suggest that O was dishonest either because he knows how M's injuries were caused because he was the perpetrator, or because he is so supportive of his daughter that he is prepared to be dishonest or exaggerate his evidence to the court to do so. From the court's perspective the material point is that there is no question about whether or not O suffers from rheumatoid arthritis; this was diagnosed in 2015. This is a condition which is subject to flare ups, and therefore it is not inconsistent that the pain will be variable. O has got disfigured fingers – he showed them to the court albeit the court does not have any rheumatological expertise – and there is no challenge as to whether he struggled to find shoes. I do not find O to be dishonest; he is a Litigant in Person without the benefit of legal advice and I accept his evidence that he sent the email defensively and in haste.

10.8 O likewise displayed heightened emotion when communicating with Nurse Q [K145] albeit under extreme pressure, not knowing that the Mother had been arrested and had her phone seized. This was a build-up of emotion over time when Nurse Q confirmed both that O frustration was understandable and his reaction was not unusual.

10.9 The Local Authority infer in their submissions that O lied in relation to the use of Omeprazole in the Isle of Wight. This was not put to this witness – nor indeed the Mother – and although Ms Dixon for the Guardian submits this is not strictly necessary I consider it to be crucially important when dealing with the Article 6 rights of Litigants in Person that they clearly know the case against them. O gave clear evidence about the practical difficulties of dealing with the syringe of Omeprazole for M and I accept he was telling the truth.

10.10 Finally I do not see any correlation between O's recent bereavements and difficulties caring for M. O shared his calendar and it was evident he was taking some time off work to travel and spend time with family and M. The evidence the court has of M in O care shows a doting grandfather and a happy baby. The allocated social worker was likewise clear that O's viability assessment would have been positive but for his imminent intervenor status.

11. Wider Canvas

11.1 In considering the wider canvas I bear in mind ***Re BR (proof of facts)*** **[2015] EWFC 41,** where Peter Jackson J (as was) drew on material produced by the NSPCC, the Common Assessment Framework and the Patient UK Guidance for Health Professionals. The risk factors were:

- Physical or mental disability in children that may increase caregiver burden
- Social isolation of families
- Parents' lack of understanding of children's needs and child development
- Parents' history of domestic abuse
- History of physical or sexual abuse (as a child)
- Past physical or sexual abuse of a child
- Poverty and other socioeconomic disadvantage
- Family disorganization, dissolution, and violence, including intimate partner violence
- Lack of family cohesion
- Substance abuse in family

- Parental immaturity
- Single or non-biological parents
- Poor parent-child relationships and negative interactions
- Parental thoughts and emotions supporting maltreatment behaviours
- Parental stress and distress, including depression or other mental health conditions
- Community violence

With the exception of the Father's historic conviction for driving under the influence of cannabis on 26/06/2018 and the Mother's diagnosis of anxiety, these risk factors are not present in this case and no issues of concern were raised before M's presentation to hospital. The Mother received appropriate medication to deal with her morning sickness in pregnancy and support in caring for M after his traumatic birth. No doubt this was challenging but not exceptional in terms of pregnancy and childbirth. Importantly there is no evidence to suggest that the Mother was not coping by reason of her pregnancy and birth difficulties, nor indeed the loss of her mother. The evidence conversely speaks of M bringing joy to this family's life after the recent sadness.

11.2 The protective factors are as follows:

- Supportive family environment
- Nurturing parenting skills
- Stable family relationships
- Household rules and monitoring of the child
- Adequate parental finances
- Adequate housing
- Access to health care and social services
- Caring adults who can serve as role models or mentors
- Community support

All of these protective factors have been identified in the evidence in this case. The evidence shines out that M was a much loved and well cared-for child. The parents

were mutually supportive and had extensive support on a daily basis from family and friends and reached out to relevant professionals without hesitation.

11.3 I am reminded that Jackson J did not consider these factors determinative:

> "*In itself, the presence or absence of a particular factor proves nothing. Children can of course be well cared for in disadvantaged homes and abused in otherwise fortunate ones. As emphasised above, each case turns on its facts. The above analysis may nonetheless provide a helpful framework within which the evidence can be assessed and the facts established."*

11.4 The court is mindful that, notwithstanding the inherent improbability of otherwise good carers inflicting injuries to their child, improbable events can and do occur.

The allocated social worker

11.5 The allocated social worker is a senior social worker who has been M's allocated social worker since 8 August 2023. The allocated social worker has not to date filed any parenting assessments in this case but she has spent a significant amount of time with the parents supervising contact – more than 10 – without any concerns and she also carried out O's viability assessment dated 7 December 2023.

11.6 The allocated social worker expressed a view in this case as early as 9 November 2023 when she raised a possible organic cause with the investigating police officer, the Detective Constable [Z274 and separate case notes]. She was clear to stress she was not an expert and offered an opinion and likewise shared her experience in another case with frozen alertness.

11.7 The court is clear that this social worker is not qualified to express opinions in relation to expert medical evidence or indeed child psychology, but the court often relies on social workers' assessments of risk and looks at parents and caregivers' interactions with children in order to make recommendations around risks for contact and indeed as part of the wider canvas of evidence. I have no doubt that, had the allocated social worker expressed any concern about a family member's interaction with M, the Local Authority would be seeking to rely on it. Indeed it was

her evidence in relation to the paternal great aunt which led to the decision to change placement for M [C122].

11.8 The allocated social worker's views are persuasive insofar as they relate to matters she is qualified to give an opinion on. She is entitled to have formed an impression of this family quite separate to the expert evidence. She is the hands-on professional who has consistently been working with the family since 8 August 2023 and is the professional who knows them best. She spoke to their consistency throughout her dealings with them in oral evidence; that if they were not telling the truth, it had not come through to her. She described her opinion as her "holistic view as a social worker".

11.9 I can understand the Local Authority's concern that the allocated social worker expressed her view that this was an organic cause prior to the conclusion of the expert evidence and that her views are her personal views, not those of the local authority. However, the Local Authority declined to prepare a sworn statement from the former Social Work Team Manager– who is said not to have shared the allocated social worker's view on organic cause but who has not regularly attended hearings - or the Service Manager to comment on this evidence, nor was the allocated social worker cross-examined as a hostile witness.

11.10 The allocated social worker commented on the positive relationship between M and all family members, with a close attachment with the Mother in particular, that "he follows her and his eyes follow her". In the case note of contact on 23rd November 2023 [page 11 page 11] she notes *"M you dressed in clean age appropriate clothing and appeared quite happy and at ease in mummy and daddy's care and you enjoyed playing with your toys with grandad whiskers. You respond to your name when you are called you have good eye contact. You are pointing at things and making noises"*

11.11 Throughout all her dealings with the family the allocated social worker did not observe anything of concern. Contact time is substantial in this case – 8 hours and up to 23 hours, with overnight stays once per fortnight from February 2024 and once weekly from March 2024, all without incident. The court takes into consideration

that the Mother was not sleep deprived as she would have been at times during M's first few months but the allocated social worker agreed that this was tantamount to a shared care arrangement.

The Detective Constable

11.12 The Detective Constable, the Officer in Charge of the Kent Police investigation prepared a summary of his Investigation Strategy which starts at J230, dated 19/12/2023. I have considered it but interpret it with caution as this is his interpretation of the evidence gathered, he is not in possession of all the evidence before the court and he is looking at a different potential legal test, i.e. the criminal standard of proof. Nonetheless it is clear that he identifies only six points supporting a prosecution ("strengths") and 22 points against ("weaknesses"). The Father gave evidence that the Detective Constable had given an impression that the police would not be taking further action. Certainly no section 98 warnings were discussed or invited prior to the parents and intervenors giving their evidence.

11.13 The Detective Constable records that he observed family members change M's nappy at a Family Group Conference. He states he heard "loud distressed crying in reaction to a normal nappy changing procedure" [J233]. The Detective Constable was not called to be cross-examined in relation to this or indeed any other matter.

Healthcare Professionals

11.14 This is a case where due to the number of interactions with healthcare professionals, M was seen regularly – the Mother's team have counted 21, on average once in every five days – often naked. M was not hidden – quite the opposite is true. The midwifery records show no concerns, nor do the health visitor records. At N83 a note from 16/03/3023 records "*Both parents displayed ability to provide emotional warmth and being affectionate towards baby"*. Similarly a note from 27.04.23 at N54 records *"Loving relationship seen between Mother and baby"*. For completeness there are also no concerns noted in the GP records.

Character Witnesses

11.15 The court also has the unchallenged evidence of a number of character witnesses, which have been taken into account but are necessarily not impartial. They do speak to the high esteem in which this family are held, and the amount of support was self-evident both from the unprecedented attendance at the Family Group Conference and the offers to care for M, enabling him to stay in family placements as opposed to foster care with strangers.

11.16 The Mother evidently has many friends who speak highly of her, but of more persuasive evidential value is the statement of a former employer, the Mother having cared for his disabled children, including overnight shifts. He described the Mother as "caring, warm, funny and honest" having observed her interactions with the children at the school – where she had worked – as being "warm, friendly, supportive and caring. In her 2020 appraisal she is described as having been "very attuned to the needs of both boys". This is relevant in the context of the Local Authority suggesting the Mother was stressed as a first-time parent; she evidently has had substantial experience with children, if not necessarily newborn babies, and she evidently had the full confidence of a family with children with additional needs. There is no suggestion that the Mother was stressed whilst caring for these children, overnight or otherwise.

11.17 In the absence of collusion – which has not been pleaded by the Local Authority nor dealt with in cross-examination - both parents and intervenors are strongly supportive of it being inconceivable that any of them could have hurt M. They were respectively cross-examined about whether they had asked each other if they had inflicted the injuries, and none of them had. The Local Authority queries this given the level of police, medical and social services involvement; the family's collective response appeared to be that it was a question that did not need to be asked.

11.18 The Father stated that he trusted the Mother "with my life, with everything". He was clear he would know if the Mother was hiding something and had no doubts about her ability as a mother.

11.19 O saw M most days and likewise felt the Mother would not be able to hide from him if she had harmed M. He described the Mother as "absolutely doting, attentive to every need". Although O spent some time away from the family he equally spent extended time very close to them, notably in the Isle of Wight with the Mother and in Wales, when he babysat M and necessarily handled him, thus giving him an opportunity to note anything of concern.

11.20 A's view married with O's – these were "doting" parents and she spent time with M most days. Nothing struck her at the time or in hindsight to cause her doubt or worry.

12. <u>Discussion</u>

12.1 The Local Authority allege that one of the parents or intervenors inflicted M's injuries over a broadly 6-week period, either by at least two episodes of violent abuse or up to seven times in repeated concealed attacks, each sufficiently violent to cause a fracture. The expert evidence does not help the court with the inherent improbability of this being carried out by any of these caregivers in circumstances where M was a very visible baby, and no other person raised a single concern, or noticed that M was in pain.

12.2 The infliction of these injuries on the Local Authority's case would have involved at least three separate 'events'; one event involving both legs being twisted at the same time, possibly by two hands of a carer, which could explain the fractures above and below both of his knees and rights ankle if these injuries were not caused by separate events. A separate twisting event would have caused the injury to his left arm and a forceful squeezing of the chest caused the fracture to his rib. What the Local Authority does not do is set out, aside from proximity to M, how there is a real possibility that either parent or the intervenors inflicted these injuries. Opportunity alone is insufficient to consign any parent or caregiver to the pool of possible perpetrators; ***<u>RMM v HW & Ors</u>*** **[2010] EWCA Civ 1467** considered.

12.3 The Local Authority states at §6 of its submissions that the medical experts in this case agreed on the balance of probabilities that M's injuries did not have a medical

explanation and were therefore in the absence of any accidental explanation more likely than not to be non-accidentally inflicted. This submission falls into error in two regards; it is for the court, not the experts, to decide this on the balance of probabilities and this amounts to a reversal of the burden of proof in relation to absence of accidental explanation.

12.4 The court is in real difficulties in timing these injuries given the unresolved inconsistencies in the radiological evidence. Dr Jones is the court-appointed expert but Dr X is highly renowned and it goes without saying that the court has no radiological expertise to drawn on in order to resolve the evidential differences.

12.5 The court prefers the clear view of Dr Cleghorn in relation to the swelling appearing within 24 hours of fracture, noting there is no suggestion that M's leg swelled for a different reason. This appears to be inconsistent with the radiological evidence but that appears plausible given it is an inexact science.

12.6 If M did sustain at least one fracture in close proximity to 17 July 2023, both intervenors could not have inflicted the injuries given they did not care for M on 15-17 July 2023.

12.7 This was a weekend and, in accordance with the chronology and the parents' evidence, the Father was not working. There is no evidence of any stressors at this time; the Father had been on leave and the family travelled home from Wales on 15 July 2023. The 'onesie' incident happened overnight whilst the Mother tended to M and the Father slept. The Mother was not alone caring for M and could have woken the Father up.

12.8 16 July 2023 – a Sunday – involved a visit to a friend, who (the friend) is recorded to have removed M from his car seat and changed his nappy and not noticed any injuries. Discomfort was noted but ascribed to teething.

12.9 17 July 2023 was a busy day for M, starting with a visit to O's house, where the Mother first noted a problem with M's left leg – that he was not kicking it, and he was holding it upwards towards his body. The Father arrived and the family

travelled to the paternal great grandmother's home to join in her birthday celebrations. The photographs produced of M at this family celebration at 13:30 do not show him to be in any distress and in one picture he has his left hand in his mouth, consistent with a teething baby as described.

12.10 In accordance with the Father's evidence M was both seen and handled by multiple family members at this event, with no one raising any concern. It was the Father who changed M's nappy at 2:30pm and noticed the swelling to M's leg. This prompted the parents to take entirely appropriate action, in terms of contacting the GP, discovering there would be a two day wait and deciding to call 111, commencing the journey to hospital prior to receiving the 111 call back. The Local Authority points to a perpetrator having to take action to avoid suspicion, however some action does not equate to this level of action – which points to a particularly assiduous parent in the court's view.

12.11 The court has considered the 111 audio evidence and notes that M cannot be heard crying and the Mother's attention and response appears entirely appropriate with no signs of undue stress, anxiety or upset.

12.12 The hospital notes confirm triage at 17:42 – therefore there was no delay in presenting M – and his pain score *on movement* is noted at 8 [J501]. This resolved upon administration of ibuprofen [J497] with the leg "firm to touch, does not appear tender". On examination M "did not wince or pull away" [K276] and "was moving his legs and was playful and active" [K229], the pain having resolved to "0" on presentation on 18 July 2023 [J496], with "active movement" [K162]. This is in the court's view more than a case of good analgesia reducing symptoms of pain; M's movements are not guarded which, if M presented similarly with some or all of the other fractures, might partly explain how they went unnoticed by the parents and other caregivers.

12.13 Dr Cleghorn's evidence was that M would show additional distress at the moment of fracture, and yet no one has observed this. Whereas the court does accept the independently reported evidence in relation to M's crying during nappy changes, there is still a question mark around how the caregivers could not have observed

additional distress when these fractures were sustained even if organic. The court notes that administration of Calpol for teething may have incidentally reduced M's distress but not entirely in the view of Dr Cleghorn. Thus if the leg fractures were caused by the 'onesie' incident or through 'bicycles', one would still expect the caregiver to notice some distress on fracture. There is further an absence of postulated mechanism for the rib fracture.

12.14 Finally, the court has had regard to the parents' reactions when informed of M's injuries. They were both described as tearful upon initially learning of the fractures (pre-skeletal survey), and the Mother is recorded as having collapsed on arrest (no body worn footage has been produced) and the Father described being sick in the police cell. Both parents appeared upset during their police interviews when M's injuries were discussed.

13. Conclusions

13.1 This is a case where there is no compelling evidence in the form of text messages, internet searches, eye witness testimony or admissions. The Local Authority has pursued the fullest possible case against the parents and kept the intervenors in the pool, distancing itself from its social worker who conducted assessments on its behalf. The Local Authority has not produced any evidence in addition to the medical evidence to give rise to a real possibility that any of M's caregivers inflicted these injuries.

13.2 Turning back to ***Devon v EB***, Baker J reflects at §57 that:

> …"the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental injury includes expert 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 KD & L [2005] EWHC 144 Fam at paragraphs 39 to 44, Mr Justice Charles observed: "It is important to remember that (1) 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."

13.3 The medical evidence has problematic elements, the inconsistency with the radiological evidence and Dr Cleghorn's evidence having been discussed above. In terms of the number of fractures, the court sees no reason to prefer Dr Jones over Dr X – he has seen more of the evidence but that should not impact on his interpretation of the images. In the absence of this being addressed sufficiently or at all in the evidence, the Local Authority has not demonstrated on the balance of probabilities that seven – as opposed to six – fractures were sustained.

13.4 In terms of timing, the radiological evidence has likewise not been resolved to the point that the court can make secure findings, but I do accept and adopt the three periods of healing identified by Dr Jones, as set out at §8.4 above. It is clear that these fractures were sustained on at least two occasions, even more so if the left femur fracture was sustained within around 24 hours of 17 July 2023.

13.5 The Local Authority points to the number of fractures increasing the likelihood that M's injuries were inflicted. Absent evidence of a sustained campaign of abuse, the court's impression is that it could equally speak to a propensity to fracture and need to examine an organic cause, particularly given the post-removal concerns which have been investigated inadequately.

13.6 The court was concerned to note the short length of the experts' meeting – 24 minutes and without Dr Cleghorn's attendance as discussed – which necessarily prevented her from engaging in discussion with the other experts around the potential combination of anomalies and the potential impact on this child. The court's impression is that by virtue of these being multiple metaphyseal fractures combined with a posterior rib fracture such discussion wasn't necessary in the view of these experts. Dr Cleghorn in her conclusions relies on Dr Jones, but Dr Jones made errors in his report that Dr Cleghorn likewise does not appear to have spotted.

13.7 It is further essential that jointly instructed experts are able and willing to engage with countervailing arguments to an NAI hypothesis; if they do not, their open-mindedness is called into question, impacting on the impartiality of their evidence. The parents in this case have also lost the opportunity to determine whether M has

sustained further injuries, through no fault of their own. The result is an inconsistent and incomplete radiological and paediatric expert opinion.

13.8 The court is necessarily slow to disagree with a body of expert evidence, but it can and it can specifically do so when the rest of the evidence does not support that view (***Re B (Care: Expert Witnesses)*** **[1996] 1 FLR 667**), per Ward LJ:

> "the expert advises but the Judge decides. The Judge decides on the evidence. If there is nothing before the court, no facts or no circumstances shown to the court which throw doubt on the expert evidence, then, if that is all with which the court is left, the court must accept it. There is, however, no rule that the Judge suspends judicial belief simply because the evidence is given by an expert.".

13.9 This is a case where, standing back and looking at the totality of evidence of the parents and caregivers combined with the broader canvas points, the evidence points strongly away from inflicted injury.

13.10 The court is mindful that there is an evolving list of cases which consider the administration of PPI's such as Omeprazole and their impact on reducing bone density and consequently increasing the likelihood of fractures, notably recently the Court of Appeal's decision in **W (A Child)** discussed at §8.25 above.

13.11 It seems to the court that the conclusion of Dr Jones' evidence, where he spoke as to how the metaphyses may be more impacted due to growth turnover combined with the emerging link between Omeprazole and fractures does give rise to sufficient question over the possibility of organic cause, notwithstanding Dr Skett's view and the research papers. This is an emerging field and no doubt more research will emerge, but given the involvement of rib fractures in the research papers there remains a possibility that this could explain all the fractures, albeit the absence of discernible pain and distress is not explained. There is no burden on the parents and intervenors to explain away any anomalies but I observe that there are obvious other factors over the relevant period, notably initially digestive discomfort/colic and latterly teething.

13.12 Looking holistically, the Court concludes that the Local Authority has not discharged the burden of proof on the balance of probabilities that M's injuries were inflicted. The court is unable to identify with any specificity other than that outlined above when and how these fractures were sustained by M and, to this extent, they are of unknown cause. It follows, for the avoidance of doubt, that there is no real possibility that either of the parents or the intervenors inflicted M's injuries.

13.13 The court invites any corrections or requests for clarification within seven days. In the event there is no appeal the court invites the Local Authority to give immediate thought to a transition plan to enable M to return home. The Guardian points to the possibility of this being under a child in need plan. The court is clear that no findings have been made which meet the requirements of section 31 of the Children Act 1989. However the court notes the parents' anxiety about the way forward, particularly if M has further health issues with unanswered questions, and some support may be beneficial in relation to this.

13.14 I would be obliged if a copy of this judgment could be shared with the experts with my thanks.

13.15 That is my judgment.

HHJ Coffey