IN THE FAMILY COURT AT SUSSEX Neutral Citation Number [2024] EWFC 374 (B) Case No. SD24C50075
Re a Child

Before: HHJ EARLEY

APPROVED FACT FINDING JUDGMENT
Hearing dates: 16, 17, 18, 23, 24 September and 8 October 2024

This judgment was handed down to the parties in unredacted form on 28 October 2024
and was released to the National Archives thereafter once anonymised

IMPORTANT NOTICE

This judgment was given in private. The court permits publication of this judgment on condition that (irrespective of what is contained in the judgment) in any published version of this judgment the anonymity of the child and members of their family must be strictly preserved. All persons, including the parents, their legal representatives, legal bloggers and representatives of the media, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

HHJ EARLEY:

1. The child in these proceedings will be two years old in a few weeks; I will refer to the child as R. Since March 2024, R has been living in foster care under an interim care order, after the discovery of multiple bruises to his face, head and torso and an injury to his femur. R is represented in these

proceedings by his Guardian, Jonathon Shone, and counsel Ms Harris.

2. R’s mother is in her early 30s and R is her first child; I will refer to her as M. M is represented in these proceedings by Ms Taylor. M underwent a cognitive assessment at the start of these proceedings which confirmed she does not have cognitive functioning difficulties, however she does find it more difficult to understand, process and retain verbal information, to solve more complex problems and reasoning tasks. M had a positive childhood and retains good relationships with her parents and wider family. She suffers from low level anxiety and stress migraines which are controlled with medication and she was supported by the Perinatal Mental Health Team during pregnancy and following R's birth. She is employed as a care worker supporting vulnerable adults.

3. R’s father is also in his 30 and R is also his first child; I will refer to him as F. F is represented by Ms Forster. A cognitive assessment highlighted that F does not present as having any significant deficits in respect to his intellect. However, he does struggle to attend to, encode and recall information on the tests of (episodic-declarative) memory. On these tests he attained an aggregate score at just a fraction of the first centile and has difficulties with his overall memory. F also underwent a psychiatric assessment which advised that he suffers from generalised anxiety disorder with panic attacks, alongside recurrent depression. F experienced a difficult childhood and sustained physical and emotional abuse from his father; he spent a period of time in foster care before returning home. F is not in employment due to his mental health difficulties, he claims PIP (personal independence payments) and Universal Credit. F is currently under investigation by the police for an offence of indecent exposure. This fact finding hearing did not explore the facts alleged in that matter, however some of the timings and events are inextricably linked to the matters I am determining.

4. The local authority who brings these proceedings is West Sussex County Council represented by Mr Butler of counsel.

5. This fact-finding hearing took place over 5 days in September 2024. During the course of the hearing I heard oral evidence from Dr Watt (consultant paediatric radiologist), Dr Greenshaw (consultant paediatrician), two treating doctors X and Y (consultant paediatricians), social worker Ms Hope and the parents. I have also read the bundle which contains in excess of 1700 pages and viewed material held in a multi-media bundle. This judgment sets out the factual findings I have made in relation to R's injuries.

6. Throughout the proceedings, and until the conclusion of the oral evidence, the local authority case was that both parents were on the list of potential perpetrators of some, or all, of R's injuries. This was the justification for separating R from his mother, who had been his primary carer for the majority of his life. Before oral submissions were delivered, the local authority reflected on the oral evidence and amended their schedule to remove the mother as a potential perpetrator.

7. In summary the local authority now seek the following findings:
(i) R has been subjected to abusive treatment from his father on more than one occasion resulting in an injury to his femur and multiple and extensive bruising to his face and head. This is denied by the father.
(ii) In the alternative to (i), and also in addition, the father failed to properly supervise R resulting in him sustaining injuries from accidental falls and/or accidents. This is accepted by the father.
(iii) Both parents failed to seek appropriate medical attention for R's injuries. This is accepted by both parents.
(iv) In the event that the court finds the injuries were abusive, the mother failed to protect R. This is denied by the mother.
(v) The parents used cannabis when caring for R. The parents accept the use of cannabis in the evenings when R was in bed.

<u>Relevant Chronology</u>

Jan 2022 Parents commence relationship after meeting at work, do not use contraception and M pregnant within a few weeks

Aug 2022 M stops work
21.10.22 R born 5 weeks early by emergency c-section after traumatic labour and birth; R and M discharged after a week, live with maternal grandparents. F invited to move in but did not, visited 3-4 times each week to see R.
Christmas 22 F experiences panic attack and attends hospital. Thereafter does not see R and M for 6 weeks.
Dec – Jan 23 Repeated incidents of F attending GP surgeries seeking assistance with incontinence pads. Concerns as to whether events were sexually motivated.
Jan 2023 Referral to CSC following police involvement with R in light of above incidents.
11.1.23 GP referred F for support with his mental health
9.2.23 F commences CBT – attends 7/12 sessions
Feb 2023 M, F and R begin meeting in park to spend time as family
April 2023 Referral to Children's Services from peri-natal health to alert that F now having weekly contact with R
May 23 F enters into behaviour agreement in relation to his attendance at GP surgery *following incident of interaction that occurred with the patient in one of the corridors of our practice with our nurse. The nurse had been alone in the corridor at the time and had felt uncomfortable and vulnerable about being asked by a young male to assist with a continence pad. The incident was reported to the Police who dealt with it.*
Oct 2023 M, F and R move to flat rented from maternal grandparents
Nov 2023 C&F Assessment undertaken. Case closed with safety plan in place *should parents struggle with a period of poor mental health in the future they follow their safety plan, use their support network and seek appropriate support to ensure R is not exposed to this and kept safe.*
Christmas 23 Family friend gifts parents ride on toy car for R

5.2.24	M returns to work as carer for vulnerable adults, general work pattern 3 x 8 hour shifts per week
18.2.24	Reported incident of R falling in cot and banging face and eye when in care of F; M at work
11.3.24	Reported incident of R crashing into chest of drawers whilst using toy car and hurting head /face when in care of F; M at work
16.3.24	Reported incident of R falling from toy car onto door step / pathway when in care of F; M at work
18.3.24	F arrested for indecent exposure – this matter remains under police investigation
21.3.24	Child Protection visit to R – parents ask to meet in pub rather than home; R wearing woolly hat and bruising seen to his face and head when hat removed.
22.3.24	CP medical undertaken by Dr X - multiple facial bruises noted to face, head and body
22.3.24	First skeletal survey – subperiosteal new bone formation seen along diaphysis of right femur
23.3.24	Dr X reviewed photographs of R's bruises and noted additional bruises to left ear which had not been seen when undertook CP medical
23.3.24	R placed in foster care under s.20 agreement
3.4.24	Second skeletal survey – periosteal reaction to left femur confirmed with slightly increased cortical thickening
4.4.24	Proceedings commenced
19.4.24	F discharged from mental health support for non-engagement
29.7.24	R observed to have unexplained bruising to rear of left leg during contact
3.10.24	26 weeks expires

Relevant legal principles

8. I distil the principles below on which I determine the issues in this case:

    a. The court only needs to make findings to the extent that they go to prove the threshold criteria of significant harm caused, or likely to be caused, by unreasonable care and, if that is proved, to inform risk assessment for the purpose of making a welfare decision.
    b. The burden of proof lies, throughout, with the person making the allegation.
    c. The court needs to be vigilant to the possibility that one or other parent may be seeking to gain an advantage in the battle against the other. This does not mean that allegations are false, but it does increase the risk of misinterpretation, exaggeration, or fabrication.
    d. It is not for either parent to prove a negative; there is no 'pseudo-burden' on either to establish the probability of explanations for matters which raise suspicion. Where the local authority seeks a finding that injuries are non-accidental it is for the local authority to prove its case. It is not for either parent to disprove it. In particular it is not for a parent to disprove it by proving how the injuries were in fact sustained.
    e. Neither is it for the court to determine how the injuries were sustained. The court's task is to determine whether the local authority has proved its case on the balance of probability. Where there is a degree of medical uncertainty and credible evidence of a possible alternative explanation to that contended for by the local authority, the question for the court is not 'has that possible alternative explanation been proved' but rather it should ask itself, 'in the light of that possible alternative explanation can the court be satisfied that the local authority has proved its case on the simple balance of probability'.
    f. The court can have regard to the inherent probabilities of events or occurrences; the more serious or improbable the allegation the greater the need for evidential 'cogency'.
    g. Findings of fact in these cases must be based on evidence, including inferences that can properly be drawn from the evidence and not on

suspicion or speculation; it is for the party seeking to prove the allegation to "adduce proper evidence of what it seeks to prove".

h. A finding that a parent has failed to protect their child must be based on evidence as to what the parent knew or could reasonably have thought might happen; it must not be added simply as bolt on finding unless supported by evidence.
i. The court must consider and take into account all the evidence available. My role here is to survey the evidence on a wide canvas, considering each piece of evidence in the context of all the other evidence. 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 person making the allegation has been made out to the appropriate standard of proof.
j. The expert evidence is part of a wider canvas and expert opinions need to be considered in the context of all the other evidence. The judge is the decision maker, the expert is not.
k. 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.
l. An expert is not in any special position and there is no presumption or belief in a doctor however distinguished he or she may be. It is, however, necessary for a judge to give reasons for disagreeing with experts' conclusions or recommendations.
m. The evidence of the parties themselves is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability.
n. It is, of course, not uncommon for witnesses to tell lies in the course of a fact-finding investigation and a court hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear, and distress. I am conscious that the fact that a witness has lied about some matters does not mean that he or she has lied about everything. A lie does not go to support an allegation unless it is found on evidence to be a lie, was

deliberate, it related to a material issue and was motivated by desire to avoid the truth.

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

Evaluation of Medical Evidence

9. The initial child protection medical report was prepared by Dr X. She noted that despite being 17 months old R was not able to pull to stand, nor stand unaided and concluded that he was developmentally delayed, with delayed speech and language and motor development. She undertook a full body examination at 10.15am on 22 March 2024 and recorded 13 marks on R’s body. These can be categorised as follows:
   - 6 bruises to R’s head / face
   - Bruising to both shins
   - Bruise to left forearm
   - Bruising to lower back over bony prominence
   - 2 scratches to his head / face
   - Area of discolouration under hair on left side of head

10. Only M was present during the examination as F had left the hospital feeling stressed and anxious. Prior to leaving he told Dr X that the bruising

was sustained when R was in his care and had an accident, falling from his toy car out of the side door to the property. The only other explanation offered by the parents was R banging his head in the cot.

11. On 25 March 2024 Dr X reviewed photographs of injuries to R taken by her colleague, Dr Y on 23 March. This was part of a consultant safeguarding peer review. She concluded that there was additional bruising, which she described as 2 purple bruises and some yellowish discoloration on the posterolateral aspect of his left ear pinna, and in the crease of his neck on the left hand side.

12. In her child protection (CP) medical, dated 28 March 2024, Dr X concluded that some of the injuries were likely to be accidental (large bruise to centre of forehead, bruises to shins) and that the bruise to the lower back could have been caused by an accident, but not via the fall from the car as described, as R reportedly fell on his front. Dr X's opinion was that the pattern of bruises to R's cheeks, jawline and on, or close to, his ears was highly concerning for non-accidental or inflicted injuries. She also advised that he had a traumatic injury to his right femur which was not consistent with a fall from a toy car.

13. Testing at the time of his admission showed that R was deficient in vitamin D and iron and he was prescribed supplements to boost this after his discharge. No medical professional or party to these proceedings suggest that his bruising or femoral injury are linked to these deficiencies.

14. Dr X attended court to give oral evidence on day 2 of the hearing. I found her to be a straightforward and reliable witness. She confirmed that she has been a consultant paediatrician for 19 years and a named doctor for safeguarding for 7 years. She acknowledged that she had not seen the mark to R's neck and left ear during her examination and therefore had no opportunity to scrutinise these marks. She explained that her usual practice would be carry out a close inspection of any mark to look at colour and pattern and she may touch or press the mark to look for blanching; it is

these characteristics that enable her to categorise a mark as a bruise.

15. In her oral evidence Dr X reflected on a number of the marks listed in her CP medical report. In relation to the mark to R's neck she accepted that she could not be confident this was a bruise; similar to the area of discolouration on his head under his hair. In relation to the marks to R's left ear Dr X was clear these were not there when she examined him on 22 March and considered it likely these had evolved since she examined R and become more apparent. She did not consider it likely that these marks were caused after R's admission to hospital as his care had been fully supervised since that time.

16. Dr X was confident that the marks to R's left ear were bruises, despite the fact she was not able to carry out an examination of the marks. She based this on the purple colour seen in the photos and the location of the marks. However, Dr X was willing to acknowledge the challenges of diagnosing bruises from photographs, commenting that photos can be hard to interpret and can be dependent on many factors, such as lighting, quality and how child was held. These challenges were evidenced when she was asked to consider an image [at H436 of the bundle] and commented that she would not conclude that an area of discolouration close to R's eye was bruising, but she *could see why someone else might.*

17. In relation to potential explanations for R's injuries, Dr X was clear she was only offered a fall from the toy car and R banging his head on the cot as possible causes. She did not consider that these events explained the number of injuries that R had. Dr X was willing to accept that accidental injuries can occur to any part of a child's body, however she commented that she would expect a carer to provide a consistent and clear explanation.

18. Dr Y gave brief evidence on day 2 of the hearing. She confirmed that she took photographs of any marks that looked unusual or abnormal on R.

19. At the CMH on 12 April 2024 I acceded to the parties' joint application to instruct Dr Greenshaw to undertake an expert paediatric overview of R's injuries and his developmental delay. I was satisifed that it was necessary for an expert paediatrician to consider R's injuries and the explanations provided by the parents, in order to advise the court whether there was evidence of abusive or neglectful parenting. I had no prior knowledge of Dr Greenshaw but was satisfied from her CV that she had the necessary experience and training to provide evidence as an expert witness. I will return to her evidence in due course.

20. I also agreed to the instruction of Dr Watt to provide an expert report in relation to the skeletal surveys that were undertaken and whether R had sustained any bony injuries, the potential causes and dating thereof.

21. In his written report, filed on 8 July 2024, Dr Watt advised as follows:
    - There is established periosteal reaction along the shaft of the right femur on 22.03.24 with some minor remodelling on 03.04.24
    - No fracture line or bony angulation is seen on any of the images.
    - The appearances could represent a healing undisplaced fracture or a gripping injury to the femur where the outer layer of the bone is injured by a forcible grip.
    - In general, fractures heal by periosteal new bone formation (callus) which only becomes visible after 1 week in most cases (the accepted range is a minimum of 5 days and a maximum of 11 days before periosteal reaction is visible).
    - Based on the radiographic findings alone and assuming the appearances are traumatic in origin, the injury is probably between 2 and 6 weeks old on 22.03.24.
    - The mechanism for this injury type is difficult to determine. A forcible grip of the thigh could have caused a periosteal injury with resultant bony healing. It is also possible that an impact to the upper leg could have caused an undisplaced fracture although no fracture is visible.

- At the time the injury was sustained there was likely to have been some pain and possible loss of function; thereafter there may not have been significant ongoing pain or loss of function.
- A fall off a plastic car, a few days before presentation, is unlikely to be the cause of the periosteal reaction as the incident does not provide an appropriate mechanism and there would have not been enough time for bony healing to occur.

22. Dr Watt confirmed these opinions in his oral evidence which was helpful and balanced. I summarise the important points from his oral evidence as follows:
    - There is no radiological evidence of a physiological or medical cause for the periosteal reaction.
    - The ageing of fractures is imprecise. The guidance given in relation to dating healing fractures applies were one to be sure this is a fracture.
    - On the balance of probabilities there is no fracture, and the periosteal reaction is a result of a bony injury.
    - The most likely explanation is an adult forcibly gripping R's thigh and pulling or twisting. A forceful grab on its own would be unlikely to result in bone damage leading to a periosteal reaction, but this is not impossible.
    - If a child were falling and a carer grabbed the leg with force, that would be a credible explanation.
    - It is possible the injury was a week old at the time of the first scan, but this is less likely than an older injury (in excess of 2 weeks).
    - Toddler falls do cause fractures to the femur; however, it would be unusual to have a fracture caused in the way described by R sliding off the car and onto the step.
    - If there is no fracture, a bony injury with resulting periosteal reaction is more likely to have been caused by a gripping / grabbing mechanism, than a low level fall.

23. Dr Greenshaw filed her report at the end of July 2024 and addendums in August and September to address additional points raised by the parties. Upon consideration of her main report I had a number of concerns. The

first was that she set out in her report measurements of the toy car and the back door step. I was unclear where these were from, as no measurements were provided in the evidence within the court bundle. Further, Dr Greenshaw referred to internet reviews of the car, highlighting comments from customers that it was unstable and tilted easily. Again, this evidence was not in the court bundle.

24. Further, having reviewed the photos taken by Drs X and Y, Dr Greenshaw *identified a number of previously undocumented bruises*. She stated in her report *R sustained 21 visible injuries in a period of 6-weeks, between the 9/2/24 and 22/3/24*. Within her written report Dr Greenshaw raised no caution about diagnosing bruises from photographs, including additional bruises not seen by paediatricians who examined the child at the time. Dr Greenshaw advised *taking into account the number of bruises found in clusters, their location (mainly to the face/neck and ears) and their size, I am of the opinion that the majority of bruises are suggestive of being finger-grip marks. They look to have been caused when the child was excessively firmly held and thus are likely to be non-accidental.*

25. My concerns in relation to Dr Greenshaw's evidence increased during and after her oral evidence. I set out these concerns in full as follows:
(i) Despite confirming that she had seen the whole bundle and read the parents' statements it became apparent that this was either not correct, or Dr Greenshaw had forgotten information contained therein. During her oral evidence Dr Greenshaw was taken to photographs, taken by the police, that were in the bundle; she stated she had not seen these, however they were in the bundle at the time Dr Greenshaw prepared her report. She was also asked about a potential explanation of R hitting his head on a chest of drawers in the parents' hallway; in response she asked whether there were any parts that stuck out; however, there were multiple photos in the bundle of this chest of drawers which showed the knobs and sharp corners at R's head height. My impression was that when giving her oral evidence, Dr Greenshaw was not aware of these or the father's statements setting out his accounts of this incident in detail (despite the fact that Dr Greenshaw considered and discounted this explanation in her written report).
(ii) It transpired during her oral evidence that she had purchased a toy car and measured it as part of her assessment. She had done so without

informing the parties or making this clear in her written report. At the start of her report she set out the material she had considered and states *I was provided with access to relevant information on Caselines (the main document and the multimedia bundle) and the maternal GP notes*. She did not include her actions of purchasing and examining a toy car and did not inform her instructing solicitor of these investigations. The morning after her oral evidence Dr Greenshaw emailed Ms Harris and provided a link and photos of the toy car that she purchased for her investigations; this was not the same model of car as used by R. The email can only be described as very defensive and it was clear that Dr Greenshaw felt criticised. The purpose of my questions were not, at that stage, to be critical but to clarify what had happened and to suggest to Dr Greenshaw that it would have been better if she had made clear in her report the full extent of her investigations.
(iii) Dr Greenshaw's oral evidence was, at times, dogmatic and defensive. An example is when she was asked whether a fall onto gravel could explain some of the bruises to R's head and face. Her response was that a fall onto gravel can cause bruises, but not the circular bruises seen on R; she was not willing to consider this as a possible cause, even if not probable. Similarly, when asked about bruising from R falling in his cot, her response was that if this was causing repeated bruises the parents would have got a different cot. This response did not consider the financial strains on these parents and struck me as a glib and unhelpful response.
(iv) Within in her email sent to Ms Harris she complained of having given evidence for over 3 hours and after 5pm; this was not entirely accurate. Her evidence started at 2pm and concluded at 5.10pm, however there were multiple breaks during this period and I asked Dr Greenshaw a number of times whether she wanted a break and whether she was ok for time; she assured me she was. Given her extensive experience as an expert witness, I did not consider this a burdensome or onerous undertaking on her part.
(v) Dr Greenshaw made a number of bizarre and unsolicited comments during her evidence. For example, at the end of her evidence she was asked about the potential for bruising to be caused from a repetitive force being applied to one area. Her response included a comment that she could see everyone in court (via the video-link) and could see everyone had children, or experience of children. This struck me as a bizarre and

inappropriate assumption to make. Further, in response to a query about dating, she commented that she *hates* such questions being asked in the court arena.

(vi) There were also times that Dr Greenshaw laughed inappropriately during her oral evidence. I was not sure whether this was because of nerves, uncertainty about the answers she was giving or is just part of her usual demeanour. She was asked whether the bruises seen on R could be explained by one incident and her response was that one fall could *certainly not* cause 17 bruises as he *could not bounce off 17 surfaces.* She made these comments whilst laughing incredulously and both the language and light tone with which she gave this response struck me as inappropriate. After giving her view that the toy car was unsafe and unstable she laughed when stating she had bought one for this case and then gave it to a charity afterwards.

(vii) In relation to her willingness to diagnose bruising from photographs I was concerned that she described photos of marks to R's legs taken in July 2024 as *poor,* in terms of quality, yet she was willing to conclude the marks were bruises. When asked to compare a number of photographs of R, taken at different stages, she seemed to become flustered and exasperated and commented *I am not making it up.* Dr Greenshaw then seemed to be aware that this response was not appropriate as she acknowledged that *no one is infallible* and stated that she *accepts being asked questions.*

26. In my judgment the matters I have highlighted above would be inappropriate from any expert, but given Dr Greenshaw's experience and expertise in safeguarding and of being an expert witness I was surprised and troubled about her evidence. I shared this view with the parties upon receipt of her email and queried whether there would be any applications forthcoming, anticipating one of more parties may seek an adjournment to enable further expert evidence to be obtained. There were no such applications, which would have caused significant delay for R and his family. However, all advocates accepted in their submissions that there were difficulties with Dr Greenshaw's evidence and agreed I should be cautious accepting her opinions and conclusions. The local authority, who bear the burden of proving their allegations, invite me to accept Dr Greenshaw's expert opinion in relation to the location and mechanism of accidental versus inflicted bruising, which they state is in line with mainstream medical opinion in relation to bruising on children of R's age and mobility. However, in relation to her conclusions about additional

bruises, not seen by Dr X, and her consideration of mechanisms provided by the father, the local authority, together with the other parties, urge me to be cautious about accepting her evidence.

27. Given that all parties invited me to instruct an expert paediatrician on the basis it was *necessary to resolve the proceedings justly* I remain concerned that, at the end of the fact finding hearing, I do not have the views of an independent paediatrician that I am confident to rely on. Despite the absence of an application from the parties, I have considered whether in the interests of justice I should adjourn for further expert assessment. However, having considered all the evidence I am satisfied that this is not necessary and I can draw factual conclusions in relation to threshold, on the basis of the evidence before me and my knowledge and experience of paediatric injuries from medical and legal literature.

<u>Evaluation of Social Work Evidence</u>

28. During the course of the fact finding hearing I heard from Ms Hope. She confirmed she carried out a Child in Need visit to R on 21 March 2024. The visit was initially arranged to take place at the family home, however the mother rearranged this to take place at a local pub stating the father did not like people coming to the home. The visit was arranged in light of the father's arrest for indecent exposure and the social workers were not initially aware of injuries to R. This became apparent during the visit when R removed a woolly hat he was wearing. Ms Hope was concerned that the hat was put on to cover the bruises, as the weather was not cold enough to justify a woolly hat. Having seen the bruises Ms Hope arranged for a child protection medical to be undertaken.

29. During this visit it became clear that F had not told M the reason for his recent arrest. M shared with the social worker that F told her he was arrested in relation to a stolen car. It also became clear that F had given M misleading information about his behaviour agreement with his GP Surgery. She believed this was due to F shouting at staff when his mental health was low and she was not aware of the allegations of sexualised behaviour.

30. Ms Hope confirmed in her oral evidence that M was fully cooperative with safeguarding professionals and there were no concerns about her interaction with R. In relation to F, Ms Hope observed that he seemed

nervous during their discussions at the pub and expressed he was embarrassed and ashamed about M finding out the reasons for his arrest. She described him as *stressed and fidgety* the following day at the hospital and he left before R was examined. She recalled that during the visit at the pub R reached out for his father, but F effectively ignored this and did not respond to R. This behaviour is consistent with what can be seen on the BWVs from the police attendance at the family home on 18 March; F is pre-occupied with his own worries and welfare and, at times, ignores R's distress or leaves him with a police officer who was unknown to R.

31. A parenting assessment was filed in August 2024. This noted a number of concerns about F's honesty and the consistency of his accounts and his ability to prioritise R. F did not attend contact for months following R's placement in foster care, stating he was struggling with his mental health. There was also an observation that F does not always supervise R appropriately during contact time. F told the social worker he never felt ready to care for R alone and struggled with this when M returned to work. In contrast M has been fully responsive to R's needs during contact time and presents as a loving and devoted mother.

Evaluation of Parents' evidence

32. I agree with Mr Butler's submission that M gave her evidence in a straightforward and honest way. I was satisifed that she was being truthful and was trying to assist in my decision making by sharing what she knows in relation to R's injuries. In my judgment the local authority are right not to seek findings that M was responsible for the injuries sustained by R.

33. It was however clear that she has been somewhat naive in relation to F and his openness and the extent of his mental health problems. I accept the submission of Ms Taylor that M was basing her view of F on what she saw: a loving and doting father, rather than what she now knows when faced with all the evidence. Within her final statement, filed 13 September, she was open to the possibility of a future relationship with F, despite knowing of R's injuries and the lies that F had apparently told her during their relationship. However, by the end of the oral evidence, Ms Taylor was clear that M no longer wishes to resume their relationship, regardless of any findings I may make, as she does not feel she can trust him. Her priority is

to resume care of R as soon as possible.

34. It is agreed by all parties that F's evidence was inconsistent and, at times, unreliable. The local authority invite me to find that he has deliberately lied about some matters to evade or cover up the truth in relation to his abuse of R. Ms Forster submits that matters are not that simple and any lies he has told should not be used to bolster unclear facts in relation to R's injuries and how these were sustained. Ms Forster highlights the expert conclusions in relation to F's poor memory and his childhood trauma, which in isolation or combination with other feelings, such as shame and embarrassment, may provide reasons for his inconsistencies.

35. Before I turn to the inconsistencies in his evidence it is important that I set out F's possible explanations for R's injuries. In relation to the use of the toy car F recalled two accidents. The first took place around 11 March when F's friend visited. F and his friend were pushing R down the hallway on the toy car and R, whist unsupported and moving between the two adults, hit his head on the chest of drawers and fell off. The second occasion was on 16 March and F described placing R on the toy car in the entrance to open the side door and leaving him unattended and then hearing R fall off and finding R lying on the step out of the door with his legs on the step and his head on the concrete. He described grabbing R's leg and arm to pick him up. He recalled that R cried and accepted that this was not an appropriate way to pick him up. F described picking bits of gravel out of R's face and noting red marks. F also explained that on 16 March R banged his face on the kitchen floor and there were numerous times he banged his head / face on the cot.

36. F accepted in his oral evidence that he had neglected R by leaving him unsupervised and by placing him on the toy car when he knew this was unsafe. He accepted that any injuries occurred when R was in his care, but maintained that these were accidental through lack of supervision or inappropriate force and not abusive inflicted injuries. During submissions Ms Forster accepted that F should not have been caring for R alone, as his poor mental health and inexperience rendered him incapable of properly looking after his young son. F also accepted, through Ms Forster, that the

parents use of cannabis in the evenings was inappropriate and neglectful.

37. In summary, the inconsistencies in F's accounts, and his interactions with others, that do not directly relate to his explanations for R's injuries are as follows:
    - (i) F lied outright to the police by saying he did not use any drugs. He explained that he did use cannabis and lied to the police as he was ashamed about using cannabis when he had a young son and he thought he might be in trouble with the police.
    - (ii) When interviewed by the police on 18 March 2024 in relation to the allegation of indecent exposure, F told the police he could not attend hospital (despite asserting he was bleeding from his penis and had passed a kidney stone) as he had to go home and care for R. F accepted this was not true as M was not working that day. He explained he did not like hospitals and has anxiety around medical establishments. He could not explain why he lied to the police about this but did state that he found the whole interview very stressful and could not think clearly.
    - (iii) During the same interview he told the police that he told M *all about it*; this was not true and he accepted he did not tell M he was in pain and passing blood. His explanation was that the parents were *at each other's throats at the time, arguing and shouting*. He explained that he felt she did not listen to him so he stopped telling M things. He could not explain why he has never previously spoken of arguments between himself and M and denied he was making this up.
    - (iv) When the police attended on 18 March 2024 to arrest F, he stated that the maternal grandmother could not care for R as she has cancer; this was not true and whilst she did have cancer many years ago she is now in remission and fully able to care for R. F explained that he was overwhelmed and thought that R's grandmother could not look after him.
    - (v) On 21 March 2024 when he spoke to Ms Hope he told her he was receiving mental health support and he had requested increasing support. Evidence from his trearing team suggests this was not true, but F did not accept this.

(vi) F accepted he misled M in relation to his mental health by telling her he was attending for mental health support when he was not attending. He explained that he would leave the house telling M he was going there but then would not attend; he did not explain why this was but he expressed he generally felt unsupported in relation to his poor mental health.

(vii) On 18 March 2024 F told the police he stopped taking Citalopram about a month ago, after seeing his doctor, as it was *really destroying him.* F accepted this was not accurate and he had not seen his GP for a significant period. He also accepted that M was not aware he was on medication. In his oral evidence he denied exaggerating the poor state of his mental health to either prevent his arrest by the police or to explain or excuse his behaviour.

(viii) F also accepted that he misled the police during their attendance on 18 March 2024 when he told the officers that R's bruises were caused by an accident when R was with M. He stated that this was not intentional and he was overwhelmed and not thinking straight.

(ix) F accepted he had not told M the truth about why he was arrested on 18 March or why he has a behaviour agreement in place with the GP surgery. He accepted he lied to M but stated this was not intentional. He explained that he found these incidents embarrassing and difficult to discuss with M.

38. In relation to R's injuries the local authority and Guardian invite me to consider whether the following were deliberate lies designed to conceal the truth of what happened to cause harm to R:

(i) During F's police interview on 23 March 2024 he explained that the incident with his friend, where R hit his head, took place on 17 March. He told the police he was sure about this date as the incident occurred the day before his arrest on 18 March. F accepted in his oral evidence that this date was not correct and in fact this incident likely took place on 11 March when M was at work. F denied that he changed the date of this accident to try and provide an explanation for some of the bruises seen to F.

(ii) During the same interview F also told the police that there were no photos and no messages relevant to R's injuries on his phone. This was not

correct. F stated that he could not remember this part of his interview and could not explain why he had said this to the police.

(iii) In relation to the incident when R fell out of the side door, in his first filed statement F stated that he left R unattended for *no more than 30 seconds.* In his oral evidence F stated he actually left R alone for much longer than this including a period when he was on his computer in the same room and then a time where he left the room. F explained that he was *not sure* when he filed his first statement but *things have got clearer now*.

(iii) At 16.07 on 16 March F sent M a photo of R and a message to say he has a bruise *in that same place again* (the photo shows a number of marks to R's forehead). When asked what happened R replies *I'm not really sure.* In his oral evidence F stated this was not correct and he did know how the injuries were sustained – via the fall off the car onto the step. He could not explain why he said this and why it took over 4 hours of messaging for him to tell M about the fall from the car.

(iv) During his oral evidence F was shown messages he sent M on 16 March in which he stated that, as well as falling onto the step, R *banged his face on the kitchen floor quite hard.* F stated that his did happen, but he could not recall how or when it happened. He accepted he had not provided this explanation to the police, to Dr X or in any of his court statements, but could not explain why this was.

(v) In relation to the fall from the car on 16 March, F stated, in his first filed statement:

R was very upset at first his cry was like normal but when I picked him up it became a deeper cry and he was cuddling into me. I could see red marks on the left-hand side of his cheek and forehead. I took off his clothes to check if he had any marks elsewhere but did not. I do recall as I picked him up in a panic I think I may have accidentally scratched him with my nail. He had gravel from outside on his face which I brushed off and a small red mark on his ear that I believe may have been from the gravel.

In his oral evidence it was pointed out to F that in his texts to M on 16 March he stated that R didn't cry, but *had a paddy.* F accepted that R did cry after the fall on the step, and he could not explain why he told M otherwise. He also could not explain why he did not tell Dr X

about the gravel on R's face, other than because he left after a very short conversation with her such were his stress levels at being in a hospital environment.

(vi) F gave a number of inconsistent accounts in relation to the position R was lying in after he fell from the car onto the step. In her hospital notes Dr X recorded that R was found *upside down, face down.* F stated he did not recall saying R was face down. In his oral evidence he described that R was found lying on his left hand side and as F went to pick him up rolled onto his back. He variously described R having an arm trapped underneath him and putting both arms up to his father. He also explained trying to pick R up behind his head and then grabbing a leg and arm in panic.

39. Having carefully considered all the evidence in relation to the fall on 16 March I remain unclear as to the precise mechanism of the fall and how R was positioned when he was found and how he was picked up. I do however accept that a serious fall did take place that day; F has been consistent about the fact of the fall since the day it occurred. I accept the fall would have induced panic in F, as he realised he had left R in a dangerous, unsupervised position which resulted in him getting hurt. I accept in that state of panic the exact positioning and handling of R are unlikely to be clear in F's mind and the variations in accounts are likely to be related to that, rather than deliberate lies on F's part. I accept that F is likely to have felt shame and embarrassment about his failure to keep R safe and this is likely to have impacted on how he shared and recalled the details of what happened and when.

40. In relation to the other lies I remind myself that F experienced a troubled and traumatic childhood, he now suffers from anxiety and depression and has been assessed as having a poor memory. I note a record from his medical notes from 2005 which reported his school stating*: he finds it difficult to accept responsibility for his actions, always has a reason or excuse as to why he did or did not do something and he also tells lies in order to escape responsibility or blame*.

41. Having watched the BWV from 18 March it is apparent that F was very stressed when the police came and unable to focus on R and dealing with the police at the same time; he was clearly overwhelmed. In my judgment it is likely that he did exaggerate the state of his mental health that day to try and avoid being arrested and taken to the police station. Similarly, his lies about the maternal grandmother's state of health and about M not being able to come home and care for R were told to try and prevent him being arrested. I do not know the truth of what happened in relation to the allegations of indecent exposure and it is not part of the remit of this fact finding hearing to investigate the facts relating to that allegation, however it is clear to me that F holds a lot of shame, fear and embarrassment about his physical and mental health issues and his lies and inconsistencies are all tied up in these complex feelings and emotions.

42. I am also conscious that his second police interview on 23 March 2024 took place between 11pm and 12.19am. This was at the end of a long day where the parents had taken R to hospital for a child protection medical. I accept that F finds hospitals and medical establishments stressful and anxiety provoking. I accept this is the reason he left shortly after arriving, rather than because he was trying to hide anything or driven by guilt. I note that he had no recollection of taking R's nappy bag with him when he left and am satisfied this was because he was not thinking clearly and was panicked about the situation. I am satisifed that this state of panic continued throughout his police interview that night and is relevant to some of the information he gave which later transpired to be incorrect.

43. I note what F says in his second statement: *I do suffer from stress and panic attacks at times. These affect my heart rate and breathing and my mind can go blank or I cannot think clearly. When I panic, I tend to talk fast and non-stop which at time can be about things that seem irrelevant. I am not saying this as an excuse at all, but I want to be clear that this is how I am quite a lot of the time. I think when I am panicking or feeling stressed, I do get confused and my memory is affected.* This was apparent at multiple times throughout his oral evidence. When asked by Mr Butler to look at a photo of injuries to R, F's response was that he was *certain* it showed the injuries sustained during the accident when his friedn was present. The date of the photo was 18 February, so this could not be correct. The more

questions asked, the more confused F became about what he was looking at, and when it related to, and it was clear that he struggling to follow or provide a proper explanation. I am satisifed this was genuine confusion rather than an attempt to mislead or fabricate. A number of times during his police interview and his oral evidence F conflated the two incidents of R falling from the car and gave confused responses as to what happened when. Again, I am satisifed these were genuine responses and not deliberate lies which are probative of the truth as to how R sustained his injuries.

44. At times during his evidence I was struck by F's sadness at the injuries sustained by R and I was persuaded that this was genuine and he was remorseful about his role in these injuries. F accepted that he did not prioritise R and did not properly ensure he was stimulated and supervised. This included leaving R awake and fussing in his cot for extended periods, having R sit and watch a screen for longer than is appropriate for a young child and leaving R unsupervised and unsupported resulting in falls and injuries. I need to consider whether these accidental falls provide a credible explanation for R's injuries and whether any lies F has told increase the likelihood that the injuries were abusive rather than accidental.

45. F also accepts that he failed to seek appropriate medical attention for R after he hit his head on two occasions. It is apparent from the parents' messages that M raised the issue of taking R to the doctor, in light of him hitting his head, being sick and falling asleep. It is now accepted by all parties that medical attention should have been sought. F stated in his oral evidence that he thought that M would take R if she felt he needed to go; he explained he was not able to take R because of his anxiety around medical establishments. It was F who told M that R did not need medical attention and it was only him who knew exactly what happened to cause injury to R. At the very least I am satisfied that in failing to seek medical attention F was prioritising his own needs over R's; I also need to consider whether his actions were driven by F trying to cover up his abusive parenting of R.

Wider Canvas of evidence

46. In seeking to determine whether R has sustained accidental or abusive injuries I have surveyed the wide canvas of evidence available to me and note the following points.

47. There is no evidence of F being violent or physically abusive to M or R. F has a conviction for battery from 2013, however this appears to relate to a fight between F and his abusive father. His other criminal offences relate to matters of dishonesty, such as theft.

48. M has reported observing a loving and close relationship between R and F. She has provided no evidence of F losing his temper or patience with R. Similarly, since contact has resumed there have been no concerns for F's interactions with R, other than a lack of appropriate supervision. None of the professionals who saw R in F's care in March 2024 observed R being fearful of his father; in contrast R was seen to turn to his father seeking comfort.

49. Throughout the period from when M returned to work until R underwent his CP medical F was consistently taking photos of injuries to R and sharing these with M. In my judgment it is unlikely that he would have done so if he was causing these injuries abusively. On 17 March F took photos of R in his highchair wearing a woolly hat; he messaged M to say R was wearing the hat as his bruises did not look nice. In his oral evidence F stated he put the hat on R because he did not like seeing the bruises as they made him feel upset. He accepted he was focused on how he was feeling, rather than how R would have felt, but he was not seeking to hide these feelings from M.

50. It is, however, apparent that F was really struggling with the full time care of R when M was at work. This is apparent from messages he sent on 9 February 2024 when R sustained a cut lip from falling and banging his mouth on his cot, when M was at work. F's messages highlight his focus on himself and how he was feeling rather than R. He photographs the blood, and R in distress, rather than picking R up to comfort him. He also messages M that it is making him feel *sick* and *I'm very to close too - too much xx I know your going back to work etc But I may not be able to keep*

this up xx. F made clear in his statements and his oral evidence that he felt unprepared and unable to provide appropriate care to R In his oral evidence he described feeling *struggling, panicked and overwhelmed* at times he was caring for R.

51. I am also concerned that both parents were using cannabis, despite caring for a young and vulnerable child. Whilst they state they used in the garage in the evenings and R was asleep and he always slept well, there was always the possibility that he would be unwell or upset during the evening, or the night, and his parents would have been under the influence of cannabis and therefore not able to properly meet his needs. Substance misuse is also a well known indicator of a household in which abusive parenting is more likely to take place.

52. I have carefully considered the well known paediatric guidance in relation to areas of bruising on young children. R was 17 months old, and he was able to roll and move himself around on the floor, he was also able to kneel, however he could not stand or weight bear on his legs. His capacity to fall from a height was therefore limited; he could not fall from standing as he could not stand, but he could fall from an object (such as the toy car) and could fall against hard objects / surfaces (such as the cot bars and the outside doorstep). I am aware that abusive injuries to young children are usually located on the ears, the jawline, fleshy parts of the cheeks and the eyelids. I am also conscious that bruising in clusters on the head and face are often cause by abusive parenting and circular bruises are suggestive of a face being gripped and held by force. Bruises to the front and back of the ear helix are difficult to sustain by accident as the ear would need to be trapped between front and rear forces; such bruising patterns are consistent with the child's ear being pinched between two adult fingers.

53. In assessing R's injuries and the cause thereof, I have analysed the injuries both individually and collectively. I have carefully considered the fact that R had a bony injury, as well as multiple areas of bruising to his face and body. I have factored this into my decision as to whether I am satisifed that the s.31 threshold is made out by findings relating to a lack of supervision resulting in accidental injuries or whether, in addition, I am satisfied that F inflicted traumatic injuries on R by way of pinching, pulling grabbing

and/or forceful holding.

54. I caution myself that where the evidence remains unclear about events it is not my role to speculate or fill in the evidential gaps to try and provide a clear picture. Sometimes at the end of a fact finding hearing enough of the jigsaw puzzle is available to clearly see what happened to a child, but sometimes, as in this case, there remain significant gaps in the evidence and clarity about events remains frustratingly unavailable.

Findings

55. I find that F sustained the following injuries whilst being cared for by his father:
(i) multiple areas of bruising to his face, head and left ear
(ii) bruising to his shins, back and left forearm
(iii) a bony injury to his right femur

56. I have scrutinised the evidence in relation to the bruising to F's left ear. Within her oral evidence Dr Greenshaw commented that R had bruises on both sides of his ear *parallel to each other front and back*. I have carefully considered this, as I am conscious that such bruising would be highly indicative of a pinch and would indicate that R was being subjected to abusive parenting. However, I am not satisfied that there was bruising to the front and rear of his left ear. This was not seen in the CP medical on 22 March. When Dr X reviewed the photos taken by Dr Y on 23 March she concluded that there were *2 purple bruises and some yellowish discoloration on the posterolateral aspect of his left ear pinna.*

57. I am satisifed that there was a serious accident on 16 March 2024 involving R falling from the toy car and landing outside the side door and sustaining injuries. I accept that F's evidence has not been consistent about this accident, however I am not satisfied that any lies he told were deliberate or designed to hide the truth of what happened. Having had the opportunity to scrutinise the photographs of the side door area it is apparent that there are multiple different hard surfaces that could cause blunt force trauma resulting in bruising, were a child to fall onto those surfaces. I include in this the lip of the door frame, the raised edge of the door frame, the drop onto the bricks, the uneven nature of the bricks and mortar, the angle of

the step, the drop to the concrete path and the gravel on the path.

58. Dr Greenshaw speculates that R would have been able to extend his arms and use his hands to soften the impact and protect his body. I accept R had this ability but he was known to hold the wheel and press the buttons when sitting on the car and I cannot accept, with certainty, that R would have used his hands to soften a fall. I also note there were no abrasions or redness seen to his hands, which one might expect if he did indeed put out his hands or arms as speculated.

59. I am satisfied that there was an earlier accident involving the toy car, on or around 11 March, which resulted in R banging his head and falling off the car. Whilst there is no clarity as to where exactly R hurt himself, in my judgment it is possible that some of the bruises seen on 23 March were caused in this accident the previous week. I note the local authority submission that there are photos of R taken on 15 March and the morning of 16 March which show no facial bruises and therefore the bruises must have been sustained thereafter. However, the photos provided are not good quality and the lighting is such that I am not confident to concluded that R had no visible bruises before lunchtime on 16 March.

60. I accept that neither Dr X, nor Dr Greenshaw, were satisifed by the explanations provided by F in relation to the falls from the car. Both raise concerns about the lack of detail and consistency provided by F which Dr Greenshaw refers to as a *red flag*. However, neither paediatrician had a proper understanding of the timetable of events or the challenges F presents with, which impact on his memory and ability to reliably recall events. I accept the hospital environment was stressful for F and would not have enabled him to calmly recall the events to Dr X. I am not surprised she found F’s account confusing and unclear. In relation to Dr Greenshaw, I cannot be confident that she properly reviewed all the relevant evidence before drawing balanced conclusions in relation to the range of potential explanations for R’s injuries.

61. In relation to the femur injury I agree with Dr Watt that, on the balance of probabilities, there was no fracture and this was a periosteal reaction to a traumatic grabbing and pulling injury. The local authority suggest this may have been caused by F grabbing R’s leg during a nappy change, noting that F did not like changing nappies and found this stressful. However, there is simply no evidence to support this suggestion. F accepts that on 16 March

he grabbed R's leg with force, when he picked him up off the floor and explains that this is the only time he ever applied force to R's leg and it was done in panic and not deliberately.

62. I am satisifed that this mechanism, with appropriate force, could explain the femur injury that R sustained. Medical literature supports findings of bony alterations and periosteal reactions in neo-nates delivered with difficulty from breech presentations. Medical research highlights that the forceful grabbing and pulling of the long bones (including the femur) during birth have resulted in bony injuries which present with periosteal reactions when scanned around 7 days later.

63. Within his written report Dr Watt ruled out the fall from the car as relevant to R's injury, as it was not within the appropriate time frame to show the healing seen on the scans. At the time he prepared his report he was basing the timeline on F's initial report that the fall from the car was *a few days before presentation.* He was not asked to consider a forceful grab of R's leg following a fall 6 days before the first skeletal survey.

64. In his oral evidence Dr Watt accepted that dating fractures is not exact; I took from his evidence that dating a bony injury from a periosteal reaction, where there is no fracture, is even less precise. Within his written report he advises that the accepted minimum period to see a periosteal reaction from a healing fracture is 5 days.

65. Considering all the evidence I am not persuaded that the femur injury was sustained by abusive parenting. In my judgment it is more likely that the injury was sustained when F grabbed and pulled R's leg when picking him up of the floor on 16 March 2024 following an accidental fall. The force used by F was excessive and inappropriate, however this was caused by his panic in response to the accident, rather than deliberate. In his first statement F described R being upset when he fell from the car and then having a *deeper cry* once he was picked up. I find it likely that R would have exhibited a pain response to his father forcefully grabbing his leg and this would have been clear to F. I accept, however, that he would not have known that he caused a bony injury and there is no evidence of swelling or loss of movement after the incident.

66. Looking at the totality of injuries found on R, I have carefully considered whether this fact makes it more likely that some, or all, of the injuries were

inflicted by force, rather than all sustained accidentally. Ultimately given the challenges with Dr Greenshaw's expert opinion, and the lack of probative factual evidence that F ever lost his temper with R or treated him abusively, I am not persuaded that any of the injuries were caused by abusive parenting. On the balance of probabilities, I find it more likely that the multiple bruises were caused by a combination of serious accidents that occurred when R was neglected and not properly supervised. Within this series of accidents I include: the crash into the hallway chest of drawers on or around 11 March, the fall from the step on 16 March, R banging his head on the cot bars and rail and R banging his head on the floor. I am conscious that the location and clusters of the facial bruises make an accidental explanation unlikely. However, I am satisifed that the unusual circumstances of the fall from the car onto the step and the varied and multi-surfaced areas onto which R fell, and the presence of gravel, provide a credible explanation for the injuries sustained.

67. In spite of my findings that R's injuries were accidental I do find the s.31 threshold met on the basis of the following matters:

(i) F neglected R's need for proper supervision at all times. This resulted in R falling off a toy car when left alone for an inappropriate period in an open doorway. This situation was obviously dangerous and the care provided by F was neglectful. R sustained significant bruising to his face, head and body.

(ii) R also sustained multiple injuries including a cut to his mouth, bruising to his face and eyes, marks on his head, bruising to his shins, bruising to his left arm and bruising to his back as a consequence of not being properly supervised and supported by F.

(ii) Whilst caring for R when M was at work there were times when F failed to provide R with appropriate stimulation and supervision. This included leaving R for long periods awake in his cot and placing him in front of a screen for hours.

(iii) Both parents neglected R's need for medical attention following the fall from the car. It was known to both parents that R hit his head, was sick and fell asleep and it was incumbent on both of them to ensure R received medical attention.

(iv) It was also known to F that R had shown pain and distress after he picked him up by grabbing his leg and arm and whilst F may not have known he had seriously injured R's leg he should have sought medical attention.

(v) F neglected R's need for safe and supervised play by allowing him to play on the toy car, despite knowing this was unsafe and caused injuries to R.

(vi) Both parents used cannabis when R was in their care and neglected his need to have an available carer who was not under the influence of cannabis.

68. The local authority invite me to find that M failed to protect R from the harm caused by F. Having considered the parents' text messages, it is clear that M was worried about the number of injuries R was sustaining when she was at work. She challenged F about these and it is apparent that he became defensive and his responses were not always straightforward and honest. As I set out earlier this judgment, I was struck that M seemed very naïve in relation to F's presentation and the lies he told her, and this continued up to and including the fact finding hearing, despite having access to all the case papers and the mounting concerns. When they were together, I consider it likely that she was desperate for the relationship to work. Despite him being absent from her and R's lives for long periods, and failing to effectively take responsibility for being a parent, M welcomed him back and set up home together. I accept she tried hard to teach him how to care for R and had no choice but to return to work in February 2024.

69. I am satisfied that had M known the poor level of care that F was providing to R in February and March 2024 she would have stepped in to safeguard her son. I accept that some of the signs were there, including the injuries R was sustaining and the messages he sent her saying he was struggling. However, I accept M's evidence that she did not know the true extent of F's mental health difficulties or that he was, at times, prioritising his needs over R's. I accept M was genuine when she spoke of how sad she felt watching the police BWV and seeing the lack of interaction between F and R.

70. I am concerned that M made the decision to try and hide R's injuries during the Child in Need visit on 21 March. She accepted that it was a conscious decision by her and F to put a hat on R to try and hide his bruises to avoid difficult questions. M was also aware of other injuries sustained by R when she was at work and had received photos of injuries, marks and bruises to R. The decision to try and withhold this information was clearly

inappropriate, and in doing so M failed to prioritise R or seek appropriate support; she accepted this when asked during her oral evidence. In my judgment her decision making around this whole visit - asking to meet in the pub, trying to hide R's injuries, failing to raise other injuries sustained by R - was driven by her wish to placate F, and maintain their relationship, rather than what was best for R.

71. I am satisfied that M did not know the true extent of the neglectful parenting R was receiving from F and therefore I do not find she failed to protect R from his father's lack of care. However, I do consider it appropriate to make an additional threshold finding as follows:

    (vii) Neither parent was open and honest with social work professionals about the injuries sustained by R when in his father's care and sought to hide bruising to R by placing a hat on his head.

Next Steps

72. I have invited the local authority to urgently consider what steps should now be taken to reunite M and R. I am clear that she has not caused injuries to R and, whilst she may need ongoing support and guidance, there is no longer a proportionate or necessary reason to separate R from his mother.

73. In relation to F there remains uncertainty in relation to the ongoing police investigation and whether his behaviours are sexually motivated and whether these presents a risk of harm to R. I note the view of the expert psychiatrist that F's capacity to parent is impacted by his anxiety and depression and the recommendation that he engage with psychological treatment, including further CBT. I remain concerned about his poor and fluctuating mental health and his willingness to engage with appropriate services. Given the findings I have made, any contact between F and R must continue to be supervised and supported until F can demonstrate meaningful engagement with mental health services and a shift in his ability to engage openly with professionals and prioritise his son. I anticipate this will be a lengthy and complex process, which may be outside the timetable for these proceedings.

HHJ EARLEY