IN THE CARLISLE COUNTY COURT | Case No. CA09C00474

Courts of Justice
Earl Street
Carlisle

Thursday, 27th January 2011

Before:

THE HONOURABLE MR JUSTICE HEDLEY

In the matter of:

Re: R (A CHILD)

Counsel for the Applicant Local Authority:	MS J. CROSS, Q.C.
Counsel for the First Respondent:	MS S. GROCOTT, Q.C.
Counsel for the Second Respondent:	MS S. SINGLETON, Q.C.
Counsel for the Child:	MS F. JUDD, Q.C.

[Inquiries were made of the court, but no further information was available regarding representation of the parties.]

JUDGMENT APPROVED BY THE COURT

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APPROVED JUDGMENT

1. MR JUSTICE HEDLEY: I propose to give this judgment in open court, but in anonymised form, because it seems to me that the subject matter with which the court is concerned, and the outcome, are such as should be explained publicly. Of course, no reporting will be permitted which might reasonably lead to the identification of either the child or his family.

2. This case concerns a baby called R who was born on 12th April 2009. His parents were, and remain, in a stable relationship and the evidence indicates that there are no obvious risk factors within the social work history relevant to the family. It is perhaps convenient if, at the earliest stage in this judgment, I set out a short history so that the context and the issues to be resolved can be properly understood.

3. On 27th June 2009, when R was aged about 12 weeks, he was presented at a local hospital unwell. In due course a CT scan identified fluid collections around the brain and he was transferred to the regional specialist unit in Newcastle. There it was discovered that he had large and diffuse subdural haematomas. Because a potential cause of such matters is unexplained trauma, Social Services were alerted. A Section 47 investigation was undertaken and ultimately, on 24th July, a conclusion was reached that there was no evidence of non-accidental injury and, accordingly, no further action was required unless some new event developed.

4. During the time that R had been at Newcastle, he had been the subject of surgical intervention as to which I need to say more later. After a strategy meeting in July, R went home and lived with his parents, a state of affairs that continued until 25th October 2009. On that occasion R was again admitted to the local hospital. The parents indicated that he was irritable and had lost the use of his left leg. He was, in due course, x-rayed, but nothing suspicious was found and the paediatrician at the local hospital proposed to discharge R home to his parents for further observation. In fact, the parents sought to have R re-transferred to Newcastle. The reason for that was that they believed that there may be a blockage of his shunt which had been inserted during the course of the surgery in Newcastle on the first occasion – a blockage which could manifest itself in interference with limb function. There is no doubt that R's transfer was accepted by the specialist unit in Newcastle.

5. Whilst he was there, he was the subject, inevitably, of MRI scans, ultrasounds and skeletal surveys. On the last of the skeletal surveys there was seen some periosteal healing in relation to the mid-line of the left femur. When they went back to a previous x-ray, though not of course the x-ray in the local hospital, it was possible to discern a healing fracture. The result of that was that a Section 20 agreement was entered into and R left the care of his parents and was cared for within the family. That is the position which has been maintained to date, though, happily, there has been plentiful contact between R and his parents. It was as a result of all that, that care proceedings were instituted by the Local Authority. In due course, those proceedings were transferred to the County Court and, ultimately, approval was given for this part of the case to be taken by a Judge in the High Court and, hence, the hearing over the last two weeks.

6. There proved to be real difficulties in assembling the complete evidence in this case and I am not entirely persuaded that it was much before the first day of the hearing that everyone was finally confident that all the required evidence would be available to the court. In the event, all parties have expressed themselves satisfied that the court has

seen and heard all the evidence that was necessary for the purposes of determining this case. The hearing before me has been essentially devoted to an attempt to ascertain causation of the subdural haemorrhages found in July 2009 and the left femoral fracture found in November 2009.

7. Let me turn to the law that needs to be applied. For the court to consider the use of its powers to promote the welfare of a child through the means of compulsive intervention in family life under Part IV of the Children Act 1989, it is necessary that there be proved the factual threshold required by Section 31(2) of the Children Act 1989 which, so far as material, provides that:

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

In this case, a head injury and a femoral fracture are alleged. Either would, of course, amount to significant harm within the meaning of Part IV of the Act.

8. The burden of proving attributability in respect of both allegations lies firmly on the Local Authority. The standard of proof has been the subject of much judicial reflection, but is now authoritatively stated by the House of Lords in *Re: B (Care Proceedings – Standard of Proof) [2008] 2 FLR 141*. It is perhaps worth reflecting briefly on the judicial task as described by Baroness Hale of Richmond at paragraphs 31 and 32 of her speech where she says this:

> "My Lords, if the judiciary in this country regularly found themselves in this state of mind, our civil and family justice systems would rapidly grind to a halt. In this country we do not require documentary proof. We rely heavily on oral evidence, especially from those who were present when the alleged events took place. Day after day, up and down the country, on issues large and small, judges are making up their minds whom to believe. They are guided by many things, including the inherent probabilities, any contemporaneous documentation or records, any circumstantial evidence tending to support one account rather than the other and their overall impression of the characters and motivation of the witnesses. The task is a difficult one. It must be performed without prejudice and pre-conceived ideas, but it is a task which we are paid to perform to the best of our ability. In our legal system, if a judge finds it more likely than not that something did take place then it is treated as having taken place. If he finds it more likely than not that it did not take place then it is treated as not having taken place. He is not allowed to sit on the fence. He has to find for one side or the other. Sometimes the burden of proof will come to his rescue. The party with the burden of showing that something took place will not have satisfied him that it did but, generally speaking, a judge is able to make up his mind where the truth lies, without needing to rely upon the burden of proof."

Judges are clearly being encouraged to make specific findings without recourse to the burden of proof.

9. Baroness Hale goes on to make a more detailed analysis of the requisite standard of proof and, in paragraphs 70 and 71 of her speech, she says this:

> "My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish a threshold under Section 31(2) or the welfare considerations in Section 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies. As to the seriousness of the consequences, they are serious either way. A child may find her relationship with her family seriously disrupted or she may find herself still at risk of suffering serious harm. The parent may find his relationship with his child seriously disrupted or he may find himself still at liberty to maltreat this or other children in the future."

In short, each issue is to be determined on the balance of probabilities and, thus, the questions in this case may be posed as follows:

> (1) Is it more probable than not that the subdural haemorrhages were as a result of trauma inflicted by the parents, or either of them; and
>
> (2) Is it more probable than not that the femoral fracture was as a result of trauma inflicted by the parents or either of them?

Those seem to be the central controversial questions in this case. Thus, it can be seen that at the heart of the case lies the question of causation of the subdural haematomas and the femoral fracture. These cases occupy substantial amounts of the time expended in exercising the jurisdiction under Part IV of the Act. These issues, however, are not confined to this jurisdiction. They occupy much time of judge and jury in the Crown Court. There too these issues cause great anxiety and difficulty. In the case of *Henderson & Ors [2010] EWCA Crim 1269* (fully reported) the Court of Appeal Criminal Division sought to address these matters. Conspicuous effort was made to ensure that the experience of the Family Court was fed into that court's consideration. It is of course desirable, where possible, that the law applied in the two jurisdictions should be as consistent as the substantive law permits. There is, of course, a fundamental difference between the two systems in relation to the differing standards of proof that prevail. Nevertheless, it may be worth reflecting on the words of Lord Justice Moses which introduce the judgment of the court in that case. He says this:

> "There are few types of case which arouse greater anxiety and controversy than those in which it is alleged that a baby has died as a result of being shaken. It is of note that, when the Attorney General undertook a review of 297 cases over a 10-year period following the case of *Cannings*, 97 were cases of what is known as 'shaken baby syndrome'. The controversy to which such cases give rise should come as no surprise. A young baby dies whilst under the sole care of a parent or child-minder. That child can give no clue to clinicians as to what has happened. Experts, prosecuting authorities and juries must reconstruct, as best they can, what has happened. There remains a temptation to believe that it is always possible to identify the cause of injury to a child. 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."

10. The 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 disputed etiology 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. In the event, this case provides a vivid illustration of that very process. The medical evidence of the subdural haematomas and the fracture is discrete and must be considered as such. However, once that is done, an overall view will need to be taken to see if there is a unifying medical hypothesis. The medical evidence in respect of the subdural haematomas and the head falls into three parts. First, there is the evidence of the neuro-surgeons: Mr Mitchell, the treating surgeon and Mr Richards, the court-appointed expert. Secondly, there is the evidence of the neuro-radiologist, Dr Jaspan, instructed as an expert; and thirdly, the overview evidence of a consultant paediatrician, Dr Mecrow, also instructed as an expert.

11. I start with a look at the neuro-radiological evidence in this case. That undoubtedly shows a large collection of subdural haematomas likely to have become chronic. In Dr Jaspan's view, that was due to malabsorption within the brain itself, but there is also evidence of a chronic hydrocephalus. He can find no evidence, either of subdural haematomas or hydrocephalus in utero, nor can he find any evidence of aqueduct stenosis by which these conditions can be explained as having a natural or non-traumatic origin. On the other hand, it is also uncommon to see subdural haematomas of the sort found in this case. Most particularly was this so in relation to the hydrocephalus, for when subdural haematomas are drained, the ventricles of the brain usually expand to fill the space, but in this case the space was filled by fluid, giving rise to a frank hydrocephalus which required intervention in terms of a shunt.

12. The difficulty, so far as Dr Jaspan was concerned, with looking at this as an event that might have surrounded, preceded or immediately followed birth – that is to say, a perinatal event – is that there is no evidence of concern about the mother's pregnancy, about the birth itself, about the immediate aftermath of the birth or the condition of R. In those circumstances, Dr Jaspan, expressing himself with some degree of care, favoured as an explanation some unidentified event occurring between the six-week check-up which R undoubtedly had and his hospital admission. In his view, that event was most likely to be traumatic in origin, if only because most subdural haematomas found in the first year of life are known to have been caused by trauma, but by the same token he recognises that two aspects of the so-called triad (namely, retinal haemorrhages and encephalopathy) are markedly absent in this case. Moreover, there is nothing in the radiological evidence which suggests that this is as a result of an impact injury. He finds, at the end of the day, the cerebral presentation to be highly unusual. He expressed himself agnostic as to causation and said this: "There are many aspects of this case that I do not understand."

13. One then goes to the paediatric evidence of Dr Mecrow. Dr Mecrow recognised that this case may be complicated by R having a number of other conditions, in particular a connective tissue disorder or hypermobility and, as it happens, he has a very unusual skin texture. However, Dr Mecrow was satisfied, on the evidence that he had, that R did not suffer from a syndrome known as EDS, nor from osteogenesis imperfecta, and he was of a view, therefore, that there was nothing in his condition that would predispose him unusually to other children either to subdural haematomas or to fracture. He considered as a possible explanation some perinatal event. He thought such an event was unlikely for the same reasons as had been expressed by Dr Jaspan and he also said that, in his experience, birth subdural haematomas, which can certainly exist, do not lie dormant and then suddenly flair up weeks later. On the other hand, Dr Mecrow also recognised that there were certain contra-indications of trauma. There was no evidence of retinal haemorrhages, encephalopathy or contusion. What is more, he recognised that what was found at operation by Mr Mitchell was very unusual if one was dealing with traumatic chronic subdural haematomas. He recognised that a sudden development of subdural haematomas in this case had not been, and could not, apparently, be explained. Nevertheless, he asked himself what could have caused these. A birth event was one, but he rejected that for the reasons that I have indicated. Accidental trauma was another but, as he pointed out correctly, there was nothing that would satisfactorily explain accidental trauma in the evidence available from the parents. That must leave, in his view, non-accidental injury, although he recognised that he must factor into that a "don't know". He said this in the course of his evidence:

> "I am not sure that I can account for this head condition. Jumping one way or the other may mislead the court as this is balanced at fifty-fifty."

14. He did have, and expressed, views about the leg fracture. He took the view that it was traumatic in origin. There was no satisfactory explanation of it forthcoming from the parents and, therefore, it could be and should be concluded that this amounted to an inflicted, non-accidental injury. In those circumstances he went on to say that, therefore, one should read that conclusion back into the consideration of the head injury and that would tip the balance in favour of a conclusion that that was a non-accidental head injury.

15. I add only at this stage that I did not attach significance to the evidence about head circumferencing. As a general rule, in my view, three measurements will not produce reliable evidence of a trend and I have decided to take no further account of that part of the evidence.

16. And so one comes to the neuro-surgeons' evidence. Although there had been little discussion between Mr Mitchell and Mr Richards, and only limited information in Mr Mitchell's notes that were seen by Mr Richards, there was, in fact, substantial accord in their views and evidence which I, as it were, express jointly. They were of the view that the findings at operation were very unusual for trauma. On the face of it, it looked more like a lengthy process. There were, in their view, three options that had to be considered as to the causation of what was found. The first was a perinatal event; the second was trauma; and the third was a recognition that it was unknown. There were, in their view, a number of unusual features about this case. There were the findings at operation, to which I have referred, but there was no explanation for any spontaneous bleeding. There was no obvious identification of process. There might have been infection. It was simply not possible to tell.

17. The hydrocephalus, following on the drainage surgically, was, in the view of each of them, something that they had simply never seen before and yet, beyond a doubt, that is precisely what occurred. Mr Richards did not want to exclude aqueduct stenosis. He recognised that the aqueduct itself may appear perfectly normal on radiology, but opined that the flow of liquid may have been too great at the crucial moment for the aqueduct to accommodate. Be that as it may, Mr Richards, in particular, was of the view that, in the absence of a perinatal event or an explained accident, the usual conclusion would be a non-accidental head injury. However, in this case there were a number of difficulties with it: partly, there were, as has been already said, no retinal haemorrhages or encephalopathy or evidence of impact; secondly, there was simply no evidence of an acute event; and thirdly, so acute and dramatic was the hydrocephalus that neither felt able to explain it exclusively by the evacuation of the subdural haematomas.
Mr Richards' view was that, if anything, he preferred the happening of a perinatal event as the most likely explanation. He said: "I think it unlikely to be an inflicted head injury," and he said this at another part of his evidence: "I still do not understand what has happened to R so far as his head injury is concerned." Mr Mitchell's evidence does not go beyond this, but it is worth observing, that he regarded the findings at operation as "highly atypical", as he described it. He favoured also a perinatal event as the most likely explanation, but he said this: "My first impression was that this did not raise a child protection issue…" and then he added, "…and I was keen to say so."

18. Upon careful reflection, it is apparent to me that there are three realistic options on the evidence as to the causation of the subdural haematomas: first, the perinatal event which has been brewing and has now flared up; secondly, the non-accidental, inflicted head injury; and thirdly, an etiology which is neither known nor understood. There are, it has to be said, significant difficulties with all three options. First, it would be very unusual to have a perinatal event where the subdural haematomas remained dormant and subsequently flare up. Nobody can say that is impossible, but it is not within anybody's clinical experience. Secondly, there would have been expected some event in pregnancy, birth, thereafter or in the condition of the infant to show that something was wrong and there was not. Thirdly, when one comes to the possibility of non-accidental head injury, one has to confront the findings at surgery which contradict an acute event and support a chronic subdural collection and one has to recognise the absence of retinal haemorrhages, encephalopathy and contusions. If one turns to the possibility of an unknown etiology, it has obvious objections of its own as a conclusion to be reached in a fact-finding hearing on the balance of probabilities. I have to say that I found the neurological evidence compelling and that would, in effect, make a finding of non-accidental head injury, on any standard of proof, impossible. Moreover, Dr Jaspan and Dr Mecrow, while in the end perhaps just favouring non-accidental head injury, in the one case declared himself agnostic and in the other that to jump one way or the other could prove misleading. I therefore reject non-accidental head injury as causative of these subdural haematomas.

19. That said, I found the arguments against this being a perinatal event also persuasive, particularly the absence of what might ordinarily be expected to be found. In these circumstances, I am unable to find that the subdural haematomas are attributable to a perinatal event, whilst recognising the possibility that they may be. I have been impressed over the years by the willingness of the best paediatricians and those who practise in the specialities of paediatric medicine to recognise how much we do not know about the growth patterns and what goes wrong in them, particularly in infants. Since they grow at a remarkable speed and cannot themselves give any clue as to what is

happening inside them, and since research using control samples is self-evidently impossible in many areas, perhaps we should not be surprised. In my judgment, a conclusion of unknown etiology in respect of an infant represents neither professional nor forensic failure. It simply recognises that we still have much to learn and it also recognises that it is dangerous and wrong to infer non-accidental injury merely from the absence of any other understood mechanism. Maybe it simply represents a general acknowledgement that we are fearfully and wonderfully made.

20. I am satisfied, upon my consideration of this evidence, that I can make a finding on the balance of probability. In so doing, I have not adverted to the evidence of the parents. That is only because they had, in the end, no direct evidence to give which could throw further light on the mechanism of the condition of their child's head. I am satisfied that the cause of this child's head condition was one of an unknown etiology. Perhaps the next generation will come to understand it. This one does not. I regard both non-accidental head injury and a perinatal event as each less than probable. In those circumstances, I have not factored in Dr Mecrow's view that the conclusion on causation can be affected by a conclusion on causation as to the leg. I am not saying that it never could be. Where a parent seeks to advance only a marginally plausible explanation of accident, it might still remain highly relevant that non-accidental injury is proved in respect of another incident. In circumstances such as these, however, where actual causation is not understood and non-accidental head injury is less than probable, such a factoring-in would be fraught with danger. Moreover, there are risks of circularity on the traditional chicken and egg dilemma. For these reasons I have formed my conclusion on the head condition on the evidence specific to that alone and am satisfied that, in this case, there is no unifying medical hypothesis.

21. Thus, one comes to the evidence of the femoral fracture of the left leg. Before considering the details of that evidence, there are a number of matters that can be dealt with quite shortly: first, this child undoubtedly suffered a fracture; secondly, the cause of that fracture was undoubtedly traumatic; thirdly, that that event occurred on the evening of 25th October 2009 whilst the child was in the care of his parents and no-one else; and fourthly, if this is an inflicted injury, it could not have been inflicted by anyone except the parents or one of them. None of these matters is any longer in real dispute. The question is: What happened to the child whilst in the care of his parents that caused him to have a hairline, undisplaced, oblique fracture within one-third of the left femur? In those circumstances, all those who were joined as potential intervenors were discharged before the trial began, save in respect of Mrs B who was discharged at the end of the evidence.

22. I turn then to the medical evidence in respect of the femoral fracture. Whilst Dr Mecrow undoubtedly expressed some views on this, they were substantially dependent on, and effectively in accord with, those expressed by the consultant radiologists, Dr Wilson and Dr Sprigg. As they too were in effective agreement, I propose to address the radiological evidence on the leg as one, save where there are specific differences to be mentioned. Although the radiological evidence recognises Professor Goodship's tentative diagnosis of a connective tissue disorder or hypermobility, they do not believe that such a condition is associated with the risk of fracture, at least so far as infants are concerned, even though it could pre-dispose to dislocations. Whilst they recognise that the periosteal healing came later than usual, the fracture would indeed explain the symptoms that were described by the parents and, thus, they locate the occurrence of the fracture in the events so described. Dr Wilson was perhaps more surprised than

Dr Sprigg by the lateness of the identification of the fracture, but in the event I think nothing turns on this because I accept the evidence that the happening of the fracture is to be found in the events described by the parents. It was the view of the radiologists that a stress fracture in a non-mobile infant was not known to them and was profoundly unlikely. What was required to cause a fracture of this sort must have been a degree of force which included a twisting component, perhaps with some compression. One of them described it as the "torque effect" which depends on speed and direction of force. Dr Sprigg was particularly willing to recognise that these fractures can happen accidentally, but in his view the carer will always know of the event that caused it and it is the absence of that explanation that troubles him most in this case.

23. In all these cases, highly controversial and difficult to ascertain is the degree of force that is required. The view expressed by Dr Wilson and Dr Sprigg is that it would require "a significantly forceful twist". The force required would be less than where there was an angulated or displaced fracture and it was recognised that, as fractures go, this was a fairly minor fracture, but they were insistent that the force required must have gone beyond what could properly be described as "ordinary handling".

24. So far as the mechanism of the baby-walker was concerned, their view was that it would be very rare for such a fracture to happen in a baby-walker with a non-mobile child. On the other hand, Dr Wilson in particular said it was unusual that a fracture of this sort was not visible, as indeed it was not, on the first x-ray, and so perhaps the radiological evidence comes to this: that these fractures can happen accidentally but, where there has been an accident, there will be an explanation of that accident made available. Where there is no evidence of predisposition to fracture - and they say there is none in this case - and where there is no accidental explanation, then the conclusion of inflicted non-accidental injury is one that is likely to follow. Unlike the head injury, these fractures are generally well understood within the medical profession. In essence, I am disposed to accept the evidence of the radiologists. I do not think there is any evidence that would entitle me to conclude that this child had a predisposition to fracture. I accept that, generally, these fractures are well understood, unlike, as I have said, the head injury in this case. I accept that the question of force (and by this one refers to type rather than amount) remains problematic, but the mechanism does involve a twisting component.

25. In that context one then turns to the parents' evidence. I do not propose to set out the evidence of the parents extensively, not least because most of it is uncontroversial and the conclusions to be drawn from it will be examined a little later in this judgment. It is sufficient at this point simply to set out the father's evidence on the events in their home of 25th October 2009. He had described that a baby-walker had been given to them very shortly before they went on holiday to Egypt. In the course of their holiday in Egypt with R, they discovered that he thoroughly enjoyed being in a rubber ring in a swimming pool and the freedom that that gave him. That predisposed them to think that he might enjoy the baby-walker when he got home. The father, who is an engineer by trade, had adjusted the seat in the baby-walker. He said it was done by clicks, so you could not be absolutely precise about it, but he tried to get it in such a position where the child's feet would be in contact with the floor, but not very firmly in contact with it.

26. He came to the evidence of 25th October. The mother had played football that day; the father had been off to watch football. They had left R with the paternal grandmother and R had had his tea at the paternal grandmother's. He had been collected from there by his parents and taken back to the maternal grandmother's house where the parents were

then living. It was said that it was about a five-minute journey in the car. He describes how they were all in the sitting room, of which I have a plan, and how this was at tea-time. The father says that he had eaten his tea and he thought, whilst he was lying on the sofa in the sitting room, opposite the television, with the child in the baby-walker between him and the television, that the mother was either in the kitchen or was re-entering the room. He described the child as facing away from him, towards the television, but he was playing with the child and the child was endlessly turning right the way round and giggling and being generally entertained, whilst at the same time amusing himself in the baby-walker. Then he describes that there was suddenly an acute cry. He said that it was a bit similar to when he had had the trouble with his head. Perhaps it was the mother who said it was worse than when he had had an injection. Clearly, both of them reacted immediately to the cry as something that was unusual and they took the view, and it appears that everybody accepts this, that the cry was a response to pain. The mother either came into the room, or was on her way into the room at the time, and took R out of the baby-walker. She cuddled him briefly and then gave him to the father to see if the father could calm him because he was still distressed. The father said that something that R always enjoyed was to be bounced on the father's stomach, with him being held under his arms and bounced up and down. The father tried that, though without obvious success on this occasion. In the light of what we know actually had happened to R, that is no surprise and the father, unsurprisingly, is rather upset about what he did on that occasion, although it was at the time a perfectly sensible thing to do. At all events, they tried to console R by distracting him and, in particular, by getting him to take a bottle. The bottle had the effect of calming him, but they were both aware that he was still in discomfort and it was at that stage that it was seen that he was holding his left leg rather oddly.

27. Father said that they had not at any stage changed the child because the paternal grandmother had indicated that she had changed the child, having fed him, and therefore there was no need to do so unless there was obvious evidence that he needed it and there was not. It is at this point, the father says, that he remembered advice from Newcastle that, if there was a blockage in the shunt, it might make itself apparent by interfering with the function of a limb or limbs. They decided on that basis that the child should be taken to hospital. The mother made one, or possibly two phone calls to her mother and, in due course, the family went to hospital and, in the circumstances which I have earlier mentioned, went on to Newcastle two or three days later.

28. That evidence was made the subject of a searching and effective, but entirely proper, cross-examination by Miss Jane Cross, QC on behalf of the Local Authority. Inevitably, some potential contradictions and oddities emerged, especially over the question of whether the child was changed. That could be important, for changing a baby too roughly is indeed one way in which this kind of fracture can be caused. Although it was the Local Authority's case that these parents, or either of them, have caused either or both of these injuries, certain specific acknowledgments are made: first, that the care of the child has otherwise been exemplary in all features; secondly, that the parents have shown throughout consistent levels of loving care; thirdly, that the parents have shown a high level of commitment throughout, from first referral at the hospital on 27th June 2009 and thereafter; and lastly, that if these events are culpable then they are, at worst, due to a momentary loss of self control. These are important concessions and, having now heard the evidence, in my judgment they are concessions correctly made. It is well recognised that the obverse of these features are often seen by the court as supporting of findings of abuse. The presence of these features cannot provide decisive evidence

against abuse, for the best of parents are at risk of a momentary loss of self control. At the very least, however, the conduct of the parents is all, and perhaps more, than would be looked for in wholly innocent parties.

29. When assessing the evidence of parents, the court can be left with a number of impressions. It might conclude that a particular parent is simply wholly unreliable. It might conclude – and perhaps this is the commonest position – that the particular parent is potentially credible and should be accepted, unless and until that evidence is plainly inconsistent with another established piece of evidence – for example, a clear medical diagnosis – or it may, and no doubt somewhat unusually, conclude that it is convinced by the evidence that it has heard from a particular parent. I have to say that that was my position, having heard the evidence of the father in this case. To say that is not to disparage the evidence of the mother, but merely to recognise that she struggled much more in her attempts, which I have no doubt were fundamentally honest, to recollect events. That conclusion is, of course, of fundamental importance in the judicial task described by Baroness Hale in *Re: B*, to which I referred at the beginning of this judgment. The problem comes when such a conclusion conflicts with clear, established medical evidence explaining what the parent cannot. How are these two very different aspects of the evidence to be fitted into what the late Mrs Justice Bracewell liked to describe as "the jigsaw puzzle"? It may be that the court must regard its conclusion on credibility, however strongly held, as nevertheless provisional. Certainly it must consider, as could be the case here, that it has been told 99.5% of the truth but a crucial two minutes have simply been omitted. At the end of the day, if the court is to make a finding, all the accepted evidence must be consistent with it. I found this case, for this reason amongst others, particularly difficult.

30. I am satisfied that this fracture was traumatic in origin and occurred whilst the child was in the care of his parents. An explanation has been offered which the radiologists think, at best, would be "extremely rare". Generally then the court would go on to draw an inference adverse to the parents on the basis of a momentary loss of control. However, there are three further features of this case that I need to consider before that inference is fairly available to me. The first is that no fracture showed up on the x-ray at the local hospital. As I say, Dr Wilson thought that unusual though Dr Sprigg thought it less so. Certainly, the parents were advised that the child could be discharged. That raises, of course, the possibility canvassed in the evidence that a number - perhaps a great number - of these comparatively minor fractures are missed. The relevance of that in this case is to raise the question as to whether such fractures can be caused by appreciable forces, but those which are not outside what might happen without carers realising it is dangerous. The second matter is that the parents insisted that the child be transferred to Newcastle because of concerns over blockage of the shunt. There is no doubt that they had reasonable concerns on that basis, having regard to the advice that they had been given at Newcastle, and that is confirmed by the readiness of Newcastle to accept the transfer. The relevance of the feature in this case is that it is an extraordinary stance for parents to take if, in fact, they know that the causation of the leg problem is as a result of something which they have done or known that the other has done. This feature, by itself, is not determinative. It is simply another odd feature in an odd case. The third aspect I have to take into account is the strongly favourable view that I formed of the father's own evidence.

31. In all those circumstances, I am deeply unwilling to make a finding of culpable conduct against these parents, unless entirely compelled by the medical evidence to do so. In my

view, the court faces four options: first, that the child sustained the fracture whilst in the baby-walker, notwithstanding that explanation's innate unlikelihood; secondly, which emerged in the course of argument, that the child sustained the fracture when, having in some way hurt himself in the baby-walker, he was yanked from it by the mother in such a way as to cause a twisting injury, but in circumstances where she could not be expected to know that. That is a possible, if inherently implausible, mechanism. Thirdly, that this was an inflicted injury in a momentary loss of control, perhaps whilst changing the baby; and fourthly, that the cause of this fracture is simply unknown. It seems to me that the explanation has to be found in one of these options, but all four options pose serious difficulties. The first two are inherently unlikely, though of course not impossible. Inflicted injury raises the difficulties that I have already referred to. Moreover, there is simply no evidence from which the court could draw any inference of pressure, tiredness, frustration or bad temper at the relevant time in either of the parents, nor indeed have any such circumstances been suggested to them. An unknown cause is very unlikely in circumstances where, quite unlike the head injury, the mechanism and causation of these fractures are generally well understood. An unknown cause must, I think, be rejected in this case. I have given long and anxious consideration to this matter, deeply aware, as Baroness Hale has reminded us, that a mistake either way can have serious consequences. As she says, however: "It is a task which we are paid to perform to the best of our ability," and that is all that I seek to do.

32. In the end, I have concluded that the Local Authority has not satisfied me that this injury has come about as a result of the culpable conduct of the parties. In my judgment, the difficulties over force, the parents' insistence on Newcastle, the whole social picture in the case, the parents' conduct throughout and my assessment of the father's evidence raise, in combination, an insuperable obstacle to such a finding. It follows that, notwithstanding the inherent unlikelihood, I have come to the conclusion that this fracture was caused accidentally, in the home of the parents on the late afternoon of 25th October 2009. If I had further to identify the mechanism, I would prefer that of the child hurting himself somehow in the walker, but suffering the fracture in the course of being removed from it. One can sense the feeling of panic on hearing the cry described, of grabbing the child to comfort him from something that was essentially new to the family and, in that distress, simply not appreciating that the forces used could produce a fracture such as this. In so acting, the parents were not giving care which it would not be reasonable for a parent to give – quite the contrary.

33. In the light of my findings, it follows that the Local Authority has not proved the threshold findings as required by Section 31(2) of the Children Act 1989 and, accordingly, these proceedings must be dismissed. I would, however, like to add a general word. The Court of Appeal has in a recent case called *East Sussex County Council & A* drawn attention to the costs of our system of child protection. In that case the focus was principally on the importance of Local Authorities and the police using their wide-ranging and intrusive statutory powers of child protection carefully, lawfully and proportionately. That has unquestionably occurred in this case and no such complaint is made or even hinted at. Nevertheless, as in *East Sussex County Council & A*, a very high price has been paid by this family in terms of the right to family life and the state's disruption of that. It is a price which society accepts in order to have an effective child protection system, but it is nevertheless, in my view, right that such a price should be acknowledged and I should add that it has been borne by this family with a dignity and fortitude that compels admiration.

34. This judgment is, of course, a public document. I would ask the guardian's solicitors to see that it goes to every professional witness in the case. The court is indebted to all of them for their expert professional analysis of the material and their exposition of it. I would not wish to part from this case without also expressing my appreciation to all counsel for the preparation, management and conduct of the case before me. It has done much to render a potentially impossible task at least manageable. That is the judgment I propose to give.

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