Neutral Citation Number: [2023] EWFC 38

Case No: SD22C50024

IN THE FAMILY COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/03/2023

Before :

MRS JUSTICE JUDD

- -

Between :

WEST SUSSEX COUNTY COUNCIL	**Applicant**
- and -	
MM	**1st Respondent**
-and-	
FM	**2nd Respondent**
-and-	
GSM and BQM	**3rd and 4th Respondents**
-and-	
PGM	**Intervenor**

- -
- -

Martin Downs (instructed by **Orbis Public Law for West Sussex County Council Legal Services**) for the **Applicant**
Clare Ciborowska (instructed by Emma Taylor at **GoodLaw Solicitors**) for the **1st Respondent**
Aviva Le Prevost (instructed by Samantha Barker at **Brighton and Hove Law**) for the **2nd Respondent**
Ruth Webber (instructed by Claire Raitt at **Goodman Ray Solicitors**) for the **3rd and 4th Respondents**

Hearing dates: 6th – 10th, 13th – 17th March 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 23rd March 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE JUDD

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Judd :

1. This is a fact-finding hearing within proceedings concerning two children, a girl now aged 4 (GSM) and a boy (BQM) of 18 months.

The proceedings

2. These proceedings were commenced in February 2022 after the youngest child, BQM was taken to hospital by the parents unwell and suffering from Covid. He was examined, and later cannulated so that blood tests could be carried out. At some point after this procedure the mother informed doctors that his left leg was swollen and that he appeared to be in pain when it was touched. His leg was x-rayed and found to have been fractured. Then a skeletal survey was carried out and further fractures were found to his legs and ribs.

3. The parents were both arrested and interviewed. GSM was taken into foster care. When interviewed by the police, the father said that he believed that he might be responsible for the fractures to BQM's ribs and legs but could not account for the arms. He said he had been told he was somewhat heavy handed and could have squeezed BQM too tightly when changing or bathing him, or in play. He said that he had never lost his temper with him and had never meant to hurt him.

4. The paternal grandmother who lived with the family was also interviewed by police.

5. GSM was placed in foster care on 3rd February where she was joined by BQM on 9th February. They remained there until 10th March when they moved to the care of two sets of family member. They returned to live with their mother, supervised by the maternal grandparents on 10th December. The father and paternal grandmother have contact with the children but do not live with them currently. The children are the subject of an interim care order which was made on 10th February 2022 and remains in place to date. The parents and wider family have cooperated with the local authority at all times.

The background

6. The parents were married in 2014. They are both engineers. The father was born here and the mother in India. Both the parents are of Indian heritage, with the mother joining the father here after their marriage in 2015. At first, they lived with the father's family and then bought their own house nearby.

7. GSM was born in 2018 and BQM followed in 2021. Sadly, the paternal grandfather died in February 2020, just at the start of the pandemic. Following this, the parents and GSM moved to live in the grandmother's home to support her. She also helped the parents, by cooking for the family and helping with the children when needed.

8. The mother had a number of health problems in her second pregnancy, and it was also a difficult birth. She took some time to recover and, in that time, the father provided a lot of assistance with the care of both children. The mother said that BQM suffered from a lot of colic and sometimes cried for most of the evening between about 9pm and 1am. The parents would rock him, tap his back and do what they could to ease his discomfort. The mother said that he would finally get the wind out and then settle.

At the time she thought it was all caused by colic but now she knows about the injuries, wonders whether it was those which were causing him distress.

9. The parents shared their parental leave after BQM was born, so that they both had some time off after his birth until early December. The father then returned to work until 21st January when he started his next stage of parental leave. When the father was at home, the parents shared tasks. The grandmother helped to care for BQM for short periods, for example when the parents were having supper, or when GSM was taken to nursery or classes or there was shopping to be done.

10. On 11th November 2021 the mother saw a bruise on BQM's arm as she was changing him (it was mid-afternoon when the father was out picking up GSM from nursery). She took a photo of it and sent it to the father asking him if he knew how this had happened. He rang her straight back and said he did not know. He suggested it may have been caused during a photo shoot they had all attended on 9th November, when BQM had been changed into various different outfits.

11. On 18th January (Monday/Tuesday) GSM became poorly and tested positive for Covid. This meant she had to stay at home all day the following day (Wednesday) with the mother, grandmother and BQM. The same happened on Thursday. On the Friday GSM developed chicken pox as well. Then at the weekend the mother and grandmother tested positive for Covid. On Monday 24th it was the turn of BQM to test positive and then the father on Tuesday 25th.

12. BQM was not well over the weekend of 23rd/24th January and not drinking as much milk as normal. As the mother described it in her statement he would try and drink and then let go of the bottle and scream in pain. The parents consulted the GP and then were advised to take him to the local hospital. As the father had not yet tested positive for Covid he accompanied BQM who was seen and given a pain relief spray for his throat and some saline drops.

13. The family all remained at home together, isolating, for that week. The parents said that BQM improved. On Friday 28th the mother tested negative for Covid and so on Saturday 29th and Sunday 30th she and GSM went out for a few hours to get a change of scene and some fresh air. The father, BQM and the grandmother remained at home.

14. On Sunday 30th BQM's health appeared to deteriorate somewhat, according to the mother's statement. He took fewer feeds and had diarrhoea. On Monday 31st January GSM went back to nursery but BQM did not seem well so the mother contacted the GP again. They were advised to take BQM to the urgent treatment centre and from there they were advised to go to the local hospital. Both parents accompanied BQM but only the mother was allowed to go inside the hospital with him.

15. BQM was examined at the Urgent Treatment Centre at about 10.30. The doctor found his throat to be mildly red and the child 'mild, tired irritable, abdo soft but discomfort crying on pressing'. Treatment was said to be analgesia and the parents referred to the CAU.

16. At the CAU, BQM was seen by a nurse at about 13.10. The triage note is fairly short but there is a more detailed note timed at 13.20 on the following page. He was said to

be tachycardic (crying at the time) but all other observations within normal range. A nasogastric tube was inserted.

17. At 14.15 there is another note which is said to be the first doctor assessment which was carried out by the SHO, Dr. Kanendran. In her statement she said that she did inspect BQM's left leg and there was no swelling or bruising which she noted or recalled. She said that the mother did not mention any bruising to her. She completed a body map.

18. The examination is recorded on a proforma sheet, with headings for head/face/skin examination. I note in passing that there is no separate section for limbs other than by their physical appearance. It is recorded that no rash or bruise was seen. He was seen by Dr. Gurreebun (timed at 14.55 in the notes), who did the senior review, and recorded BQM to be "sleepy on mum but crying on examination". In her statement Dr. Gurreebun said that she did not strip BQM down or examine his legs, and that to her recollection no mention was made of any bruising or swelling of the leg by either the mother or the SHO, Dr. Kanendran.

19. Dr. Kanendran carried out the cannulation. There is no recording of this in the notes. It is a very routine procedure. Dr. Kanendran said that she asked the mother to hold BQM. She looked for somewhere to cannulate him on his arm but was unable to find a suitable vein so she decided to do it on the dorsum of his foot. She said that the amount of force she used was gentle and BQM was not struggling. In her oral evidence she said that he was crying at all times but she did not see any 'extra crying'. She agreed that she would have noted it if she had seen a bruise on the leg or if there was obvious pain on movement. She said that she used her left hand to hold the foot around the toes and the right hand to cannulate. She did not hold his leg at all, or twist or bend the foot or leg. She said that she was not looking at the mother so did not know how strongly she was holding BQM's leg.

20. The mother's account of this was that the doctor tried for a long time to take the blood but said she was having difficulty because he was a chubby baby. She said that after multiple times she inserted a cannula into his leg. She said she held BQM's leg but looked away because she cannot stand seeing blood and that BQM was crying a lot when the cannula was inserted and 'seemed very unhappy'. The mother said that she was holding BQM on her knee when he was cannulated, which was disputed by Dr. Kanendran who said BQM was on the bed.

21. At 5pm, Dr Gurreebun saw BQM again. Nothing is recorded about the leg at this point. At 8.45pm the mother notified the nurse (Nurse Innocent) that his leg was swollen and appeared to be causing him pain. The nurse looked at the leg and said it was very swollen. She removed the cannula from his foot, and also noted that when he moved it (which he was doing less than his right leg) he cried.

22. In her statement the mother said that she noticed the swelling and reduced movement about two hours after the cannulation. The swelling was also noted by clinicians overnight and the consultant the following morning, 1st February. The mark on the shin was also noted and queried as a bruise. There were other bruises queried as being present on the nasal bridge and above the left eyebrow. The mother is recorded as saying in the note that the bruise on the leg might have occurred by BQM banging himself on the rocking chair. On 2nd February the leg was x-rayed and two fractures

found. On 3rd February there was a skeletal survey which revealed more fractures and led to the parents' arrest.

The local authority case

23. In the final threshold document dated 14th March the local authority pleads that BQM suffered the following injuries, namely:-

    a) Unexplained bruise aged 13 days old [HOa];

    b) Metaphyseal fracture of the distal left femur which is in the region of 2 - 6 weeks of age on 02/02/2022 [E45]:

    c) Metaphyseal fracture of the proximal left tibia which is in the region of 2 - 6 weeks of age on 02/02/2022 [E45]:

    d) Metadiaphyseal fracture of the distal left tibia which is no older than 11 days of age on 02/02/2022 [E44];

    e) Spiral fracture of the mid-shaft of the left tibia which is no older than 11 days of age on 02/02/2022 [E44];

    f) Metaphyseal fracture of the distal right tibia which is in the region of 1 - 3 weeks of age on 03/02/2022 [E44];

    g) Fractures of the lateral right 3rd, 4th, 5th and 6th ribs which are in the region of 2 - 7 weeks of age on 03/02/2022 [E44]; and

    h) Fractures of the lateral left 4th and 5th ribs which are in the region of 2 - 7 weeks of age on 03/02/2022 [E44];

24. The local authority pleads that the injuries above are non-accidental, sustained on at least two separate periods of time by at least four separate applications of excessive force [E46, E107].

25. It is submitted that the bruise sustained by BQM as set out paragraph (a) above was caused by BQM's father by a deliberate act which amounted to at least negligence and likely reckless care of BQM.

26. It is submitted that the fractures set out at paragraphs (b) – (h) above, were caused by:

    a) BQM's father, FM, by his deliberate act/s which amounted to at least negligence and likely reckless care of BQM; and/or

    b) BQM's paternal grandmother, MGM, in her care of BQM which was negligent as to whether it was likely to cause injury to him.

27. The local authority further pleads that BQM's mother failed to protect BQM from significant harm.

28. As a consequence, the local authority case is that BQM has suffered significant harm within the meaning of section 31 Children Act 1989 and that GSM is at risk of

significant physical harm. Although it is not specifically pleaded the local authority also contends that BQM is at risk of suffering significant harm in the future too.

The case on behalf of the mother

29. On behalf of the mother, Ms MacLynn KC and Mr Paisley submit that the tibial shaft fractures are more likely than not to have been caused by the cannulation procedure in hospital on 31st January 2022 and that this in turn provides strong evidence that there is a predisposition to fracture at play in this case. In turn too this means that his earlier fractures must be seen in an entirely different light as must the mother's disinclination to make a fuss about the father and grandmother's handling of BQM. Ms. MacLynn KC and Mr. Paisley also caution against too much weight being placed on the bruise to the arm and emphasise that the burden of proof must not be reversed – it is not for the parents to prove how the injuries were caused or that he has a genetic susceptibility to fractures.

30. Their written submissions contain a detailed analysis of the expert evidence, and the evidence surrounding the admission to hospital on 31st January 2022. It is submitted, on the mother's behalf, that the father's suggestion to the police that the parents had noted a reduction in movement of the left leg the night before the admission to hospital, was likely to have been said by mistake at a time when the significance of this was not realised, and that the mother's text message comment about the cannula being put into the sore leg was a reference solely to the bruise.

31. It is submitted that the absence of any further fractures does not assist the court at all in this case, as metaphyseal fractures are hard to detect and there have been no x-rays.

32. It is also submitted on behalf of the mother that the local authority has not made good its case that she failed to protect BQM.

The case on behalf of the father

33. The father's case is that the threshold criteria are not met. First it is submitted that tibial shaft fractures found on x-ray on 1st February were caused by the cannulation in hospital on 31st January. There is a detailed analysis of the evidence surrounding this in the written closing submissions prepared by Mr Sampson KC and Mr Bergin. I should add that I also found their opening note extremely helpful. Following the point made by both Dr. Saggar and Dr. Cartlidge, Mr. Sampson submits that this demonstrates that BQM has fragile bones, stating 'the clinical scenario indicates a far greater level of bone fragility than might at first have been thought'. In those circumstances, the metaphyseal fractures are likely to have been caused during the massages and it is submitted that as such the father cannot be considered to have been either reckless or negligent. As to the rib fractures, they could have been caused either by the father when handling BQM somewhat heavily in the bath or, in the event recounted by the mother, when BQM was taken out of his bouncer by GSM.

34. Finally, it is submitted on behalf of the father that in order to establish negligent handling the local authority must establish that it was reasonably foreseeable for the father, with the information he held or ought reasonably to have held to know that BQM would be hurt by his actions.

The case on behalf of the paternal grandmother

35. Ms Watson and Ms Hughes on behalf of the paternal grandmother submit that she is not responsible for any of the injuries suffered by BQM. Further, they argue that the tibial shaft fractures were caused by the cannulation and that BQM has fragile bones. Their written submissions contain a detailed analysis of the medical and other evidence which I will not repeat here, but for which I am very grateful.

The Guardian

36. On behalf of the Guardian, Ms Webber submits that the tibial shaft fractures were not caused by cannulation. The Guardian agreed with the local authority decision at the end of the evidence to remove the mother as a possible perpetrator of any of the injuries but disagreed with the finding sought that the mother had failed to protect BQM.

37. The Guardian agreed with the local authority submission of their being 'a real possibility' that the father caused the fractures to BQM in the context of heavy handedness, coupled with the type of massages the father performed on him. It is submitted that the father did so unknowingly, unintentionally and with no malice.

38. Upon my pressing Ms Webber she stated that the Guardian's case was that the threshold criteria were met on the grounds that the care 3? that had been given to BQM was not what it would be reasonable for a parent to give.

39. The Guardian also raised some concerns about the paternal grandmother's behaviour in stretching BQM's legs, but not that there was any malice or intention to injure involved.

The law

40. I have been provided with a detailed agreed document setting out the core legal principles to be applied in cases such as this, for which I am very grateful to counsel, and which I have read carefully. I will not set out that document in full here.

41. The core principles are summarised by Baker J (as he then was) in *Re JS* [2012] EWHC 1370 (Fam) and approved in many cases since.

> "36. In determining the issues at this fact finding hearing I apply the following principles. First, the burden of proof lies with the local authority. It is the local authority that brings these proceedings and identifies the findings they invite the court to make. Therefore, the burden of proving the allegations rests with the local authority.
>
> 37. Secondly, the standard of proof is the balance of probabilities (*Re B* [2008] UKHL 35). If the local authority proves on the balance of probabilities that J has sustained non-accidental injuries inflicted by one of his parents, this court will treat that fact as established and all future decisions concerning his future will be based on that finding. Equally, if the local authority fails to prove that J was injured by one of his parents,

the court will disregard the allegation completely. As Lord Hoffmann observed in *Re B*:

> "If a legal rule requires the facts to be proved (a 'fact in issue') a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1."

38. Third, findings of fact in these cases must be based on evidence. As Munby LJ, as he then was, observed in *Re A (A Child) (Fact-finding hearing: Speculation*) [2011] EWCA Civ 12:

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

39. Fourthly, when considering cases of suspected child abuse the court must take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss P observed in *Re T* [2004] EWCA Civ 558, [2004] 2 FLR 838 at 33:

> "Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."

40. Fifthly, amongst the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental head injury, is expert medical evidence from a variety of specialists. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. The roles of the court and the expert are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence (see *A County Council & K, D, &L* [2005] EWHC 144 (Fam); [2005] 1 FLR 851 per Charles J). Thus, there may be cases, if the medical opinion evidence is that there is nothing diagnostic of non-accidental injury, where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts.

41. Sixth, in assessing the expert evidence I bear in mind that cases involving an allegation of shaking involve a multi-

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

42. Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them (see *Re W and another (Non-accidental injury)* [2003] FCR 346).

43. Eighth, it is common for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (***see*** *R v Lucas* [1981] QB 720).

44. Ninth, as observed by Hedley J in *Re R (Care Proceedings: Causation)* [2011] EWHC 1715 Fam:

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

The court must resist the temptation identified by the Court of Appeal in *R v Henderson and Others* [2010] EWCA Crim 1219 to believe that it is always possible to identify the cause of injury to the child.

45. Finally, when seeking to identify the perpetrators of non-accidental injuries the test of whether a particular person is in the pool of possible perpetrators is whether there is a likelihood or a real possibility that he or she was the perpetrator (see *North Yorkshire County Council v SA* [2003] 2 FLR 849. In order to make a finding that a particular person was the perpetrator of non-accidental injury the court must be satisfied on a balance of probabilities. It is always desirable, where possible, for the perpetrator of non-accidental injury to be identified both in the public interest and in the interest of the child, although where it is impossible for a judge to find on the balance of probabilities, for example that Parent A rather than

> Parent B caused the injury, then neither can be excluded from the pool and the judge should not strain to do so (see *Re D (Children)* [2009] 2 FLR 668, *Re SB (Children)* [2010] 1 FLR 1161)."

42. In *Lancashire County Council v C, M and F (Children; Fact Finding Hearing)* [2014] EWFC 3, Jackson J, after citing Baker J above, added this:

> "To these matters, I would only add that in cases 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 of course 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 repeated 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 that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith".

43. In *Re A (Children) (Pool of Perpetrators)* [2022] EWCA Civ 1348, King LJ re-emphasised that judges should apply the simple balance of probability standard when determining whether it is possible to identify a perpetrator from a list of those who could be responsible. In coming to a conclusion each person should be considered individually by reference to all of the evidence. Glosses such as 'straining' to identify a perpetrator should be avoided.

44. In *Re A (A Child)* [2020] EWCA Civ 1230, the limitation of oral evidence was once again highlighted and the courts warned to assess all the evidence in a manner suited to the case before it, and not to inappropriately elevate one kind of evidence over another.

45. In *Re H-C (Children)* [2016] EWCA Civ 136 the Court of Appeal reminded judges in family cases of the proper approach to witnesses who tell lies as originally set out in *R v Lucas* [1981] QB 720. There are many reasons for this which do not denote guilt, for example, fear, shame, loyalty, panic and distress. An innocent person may lie to bolster their case. A lie should never be considered as direct proof of guilt. In criminal proceedings, to be capable of amounting to corroboration a lie must be deliberate, relate to a material issue and be motivated by a realisation of guilt and a fear of the truth. The same principle applies here. This point was emphasized again in *Re A, B and C (Children)* [2021] EWCA Civ 451.

46. In *Re L-W (Children)* [2019] EWCA Civ 159 the Court of Appeal overturned a finding of failure to protect, where it had not been shown that on the particular facts

of that case, the mother should have identified a risk to the child. Lady Justice King stated:-

> "62. Failure to protect comes in innumerable guises. It often relates to a mother who has covered up for a partner who has physically or sexually abused her child or, one who has failed to get medical help for her child in order to protect a partner, sometimes with tragic results. It is also a finding made in cases where continuing to live with a person (often in a toxic atmosphere, frequently marked with domestic violence) is having a serious and obvious deleterious effect on the children in the household. The harm, emotional rather than physical, can be equally significant and damaging to a child.
>
> 63. Such findings where made in respect of a carer, often the mother, are of the utmost importance when it comes to assessments and future welfare considerations. A finding of failing to protect can lead a Court to conclude that the children's best interests will not be served by remaining with, or returning to, the care of that parent, even though that parent may have been wholly exonerated from having caused any physical injuries.
>
> 64. Any Court conducting a Finding of Fact Hearing should be alert to the danger of such a serious finding becoming 'a bolt on' to the central issue of perpetration or of falling into the trap of assuming too easily that, if a person was living in the same household as the perpetrator, such a finding is almost inevitable. As Aikens LJ observed in Re J, "nearly all parents will be imperfect in some way or another". Many households operate under considerable stress and men go to prison for serious crimes, including crimes of violence, and are allowed to return home by their long-suffering partners upon their release. That does not mean that for that reason alone, that parent has failed to protect her children in allowing her errant partner home, unless, by reason of one of the facts connected with his offending, or some other relevant behaviour on his part, those children are put at risk of suffering significant harm.
>
> This professional and realistic approach allowed the Court to focus on what was, in reality, the only live issue, namely; was GL's history of violence sufficient to lead to a finding of failure to protect upon the mother's part?"

47. Similar points were made in *G-L-T (Children)* [2019] EWCA Civ 717.

The medical evidence

48. Expert medical evidence was provided to the court from Dr. Johnson, Consultant Paediatric Radiologist, Dr Irving Consultant in Clinical Genetics at Guy's and St Thomas' NHS Trust with a specific expertise in skeletal dysplasia conditions, Dr.

Saggar, Consultant in Clinical Genetics at the Harley Street Diagnostic Centre, and Dr. Patrick Cartlidge, Consultant Paediatrician.

49. I heard oral evidence from all the experts save for Dr. Johnson. It is accepted by all parties that the fractures seen by Dr. Johnson on the scans are present, and there is no challenge to the dating.

Dr Irving

50. Dr. Irving gave evidence in a number of written reports (four in all) and orally to the court. She also took part in the experts meeting, of which I have a transcript.

51. In her oral evidence, in essence, Dr. Irving did not accept there were any genetic factors which played a part in the fractures sustained by BQM. She did not accept that there was evidence of any bony fragility, albeit she stated that there would always be a variation in bone strength within a normal range. Genetic factors are permanent so that a tendency to easy fracture would be expected to remain apparent as a child grows up. She stated that the variation in the LRP5 gene is now being regarded as more common than it once was (referencing a discussion she had had with another expert) and that there was no known association between this and increased tendency to fracture.

52. Dr. Irving maintained her firm stance throughout questioning by Ms MacLynn KC for the mother. She discounted any suggestion that the mother's hypermobility was linked to an increased propensity to fracture, or that this might have been passed in any way to BQM. When asked in particular about the history from the mother that she suffered a hairline fracture when a teenager from standing in an awkward position, she said first of all 'I do not put that in the bracket of a significant fracture' and then that 'to my mind that does not constitute a sound clinical history'.

53. Some research papers (which had been relied upon by Dr. Saggar in his report) were put to Dr. Irving, for example what was described as the *Korvala* paper, which suggested that in one case of a child who had the same gene variant as BQM (LRP5), there was evidence of a 24% reduction in function. This led Dr. Saggar to conclude that he could not exclude an effect of the variant being reduced bone integrity and strength (independent of any risk of inheriting Hypermobile Spectrum Disorder). Dr. Irving stated that it was risky to come to conclusions based on only one individual and also stated that the research papers, being published in 2017 and 2015 were old, and a lot had happened since they were written. She said she had contacted the authors to see whether there was any update and they told her – in the context of osteoporosis – that the variant was more common without an uptick in the number of cases of osteoporosis in young people.

54. All in all, it was Dr. Irving's view that there was more evidence now to show that the variant was benign.

55. Whilst Dr. Irving is plainly an eminent expert, I felt that her response to the questions was somewhat narrow. She was not really willing to consider any possibility that BQM could have had any bony fragility and tended to find reasons to discount evidence which might go the other way. At one point she used the phrase 'I cannot say it is absolutely conclusive' to explain why she discounted the relevance of the

child with the same gene variant as BQM in the *Korvala* paper. In my experience, experts have a variety of approaches to cases in which they advise. I thought Dr. Irving's approach was to discount the relevance of any particular piece of medical or research evidence unless it was positively proved to be reliable and relevant. Some other experts such as Dr. Saggar and Dr. Cartlidge in this case tend to look at the issue from a different angle. I do not say that Dr. Irving is wrong to look at it from her perspective but it is something that I bear in mind. It is one of the reasons why it is important to remember that in cases such as this, experts advise and judges decide.

Dr. Saggar

56. Dr. Saggar's evidence, both written and oral included a great deal of detail about genetic variants, dominant and recessive genes, the variable effects of these as between individuals, and research material. I will not set all this out in detail as it would add a great deal to the length of this judgment. In summary Dr Saggar was clear that BQM does not have what he described as a 'major susceptibility' gene that would cause fractures with normal handling. In this he was in agreement with Dr. Irving. Unlike her, however, he believed that the existence of the gene variant was something (and I believe from his perspective, something important) for the court to consider. The LRP5 gene in which the variant existed, and which was inherited from his father, is known to be relevant for bone metabolism. There are reports in the literature of children with this variant suffering fractures although when descending to the detail some of the reported children had other variants too, and some also had vertebral fractures. A recent article (2021) shows identification of LRP5 variants in some adult males with osteoporosis. Whilst Dr Irving considered that the differences between the cohort of individuals who were the subjects of the research and BQM were such as to render the research of very little (if any) relevance to this case, Dr. Saggar did not agree. To him, they demonstrate the association of the LRP5 variant with reduced bone mineralisation albeit it is difficult to understand how and why, and which individuals are affected.

57. Added to this, Dr Saggar agreed that there are other features of the family history in this case, for example the mother's HDS (formerly known as EDS type 3) and history of fracturing which could have also had an effect, something that he agreed could, potentially, make for a 'perfect storm' of factors affecting the strength of BQM's bones.

58. Ultimately, Dr Saggar was saying that the features of BQM's genetic makeup and family history were something that should be considered by the court. Even if BQM did have weaker bones, however, the fractures still needed an explanation and a mechanism. Like Dr Cartlidge he said that, if I was to find that BQM's leg had been fractured by the process of cannulation in hospital on 31st January that strongly suggested that his bones were susceptible to fracture with lesser force than normal, but the lack of any fractures since that date was also relevant. When considering the mechanism required for all the fractures, he deferred to Dr. Cartlidge and stated that individuals who are more susceptible to suffering fractures still suffer the same amount of pain as anyone else.

59. Dr. Saggar's evidence differed from that of Dr Irving in that he did not exclude the possibility that BQM's bones were of less than normal strength, causing his to suffer

fractures with a lower level of force than a so-called 'normal' child, whereas, in her oral evidence at least, she discounted it.

60. Dr Saggar was an impressive witness. He is clearly very eminent in his field, which is fast developing and complicated. His enthusiasm for his subject was apparent throughout. He was confident without being dogmatic, willing to consider propositions put to him in an open-minded way but did not allow himself to led along any particular evidential paths that he did not agree with or to step outside his field of expertise. Whilst not wishing to criticise Dr Irving in any way, I preferred Dr Saggar's approach. There are a lot of 'known unknowns' in this case and I must bear in mind that BQM has a genetic variant associated with bone density even if it is becoming apparent that this gene may be more common than once thought and the number of reports of fractures in the population of those who have it limited. His mother has somewhat grey sclerae and HDS, which BQM has a 50% chance of inheriting.

Dr Cartlidge

61. Dr. Cartlidge provided five reports and some written answers to questions. He also took part in the experts' meeting with Drs Irving and Saggar. In his first report and before receiving the evidence of Dr. Saggar he concluded that the fractures must have all been caused by an excess of force, inflicted by an adult. As to radiological timing, he deferred to Dr. Johnson.

62. Looking at the metaphyseal fractures, he considered that they would have been immediately painful upon infliction for about five minutes. He might have had some reduced movement of the joint adjacent to each fracture but in an infant, this might be easily overlooked. Any tenderness might also not be noticed in such a young baby because they cry so frequently. He did not consider non-recognition of such a fracture to be surprising. Like Dr. Johnson he believed the mechanism would be yanking, twisting or bending force applied to the joint adjacent to each fracture.

63. As to the rib fractures, Dr. Cartlidge thought that they would be initially painful, typically for about 10 minutes. The pain would have lessened thereafter but BQM might have been more fractious than usual for a few days. Again, this might be difficult to identify because babies cry so frequently. Lateral rib fractures are caused by compression on the chest (this can be from one side, unlike posterior rib fractures) or occasionally by direct impact.

64. The mid shaft and metadiaphyseal fractures of the left tibia would be initially painful, for about 10 minutes. He would have been in obvious pain immediately after the fractures were inflicted and demonstrated lessened movement of the left leg. The spiral fracture would have been caused by a twisting force (although he clarified in evidence that not very significant twisting would be needed) and the metadiaphyseal fracture would have been caused by a bending force, typically be the leg being grasped by the ankle and bent. Such fractures can also be caused by an impact.

65. Dr. Cartlidge considered that any person witnessing the causal event for the tibial shaft and metadiaphyseal fractures would have known BQM had been hurt, as they would for the rib and metaphyseal fractures. A person not present may well not notice the latter fractures had happened but so far as the former were concerned, they

would notice that the left knee or ankle was painful when moved and that there was reduced movement.

66. During the course of the experts meeting and upon listening to the views of the geneticists, Dr. Cartlidge summarised that they both believed that BQM did not have a degree of bone fragility which would cause fractures with normal gentle handling of a baby, but that nevertheless he might have a degree of bone fragility that wouldn't normally cause fractures unless the child was roughly handled. He suggested that neither of the geneticists appeared to be excluding the possibility that BQM had a mild degree of bone fragility but they did exclude his having this to a marked degree. This was a proposition with which, during the course of the meeting, both agreed. On further reflection after the meeting Dr. Irving somewhat drew back from it, stating that she did not believe that BQM's bone strength was outside the normal range.

67. There is another passage of Dr. Cartlidge's evidence in the meeting which I thought to be particularly important, on E239n to E239o from lines 16 to 33 and then over the page to line 8. In this he explains that he was taken aback by the vigour with which the Indian massage was being done on the recordings sent to him and that, whilst this was unlikely to cause injury to a child with normal bones, it could cause metaphyseal fractures in a child with some bony fragility. He made clear this did not relate to the shaft of the tibia and he could not see a mechanism for the rib fractures during massage.

68. During the meeting, the experts all confirmed that a child with fragile bones would have the same pain reaction as any other child.

69. Dr. Cartlidge also considered the question of BQM's left leg during the course of the meeting. He said that most doctors would not choose to cannulate a leg if they perceived there to be a problem with it. That evidence, he thought pointed to an absence of any obvious injury to the left leg during cannulation. This was a theme that he returned to in the course of his oral evidence, stating, like Dr. Saggar, that if I concluded that BQM's leg had been fractured during the course of the cannulation then this would be very important evidence so far as the fragility of his bones was concerned. In the meeting he said that you would not really expect to put a twisting force onto the tibia but in his oral evidence he clarified that, to say that he did not think much twisting force would be necessary at all and he would be uncomfortable about excluding cannulation as a mechanism for the fracture on those grounds.

70. I am conscious that what doctors say during the course of the experts' meeting is somewhat different to the process of preparing a written report or giving evidence to a court. It is altogether less formal. Nonetheless, so far as both Dr. Cartlidge and Dr. Saggar are concerned, their subsequent written and oral evidence very much supported what they said during the meeting.

71. Dr. Cartlidge also gave evidence about the bruise(s). He said that the so-called bruise on the left shin was clearly not a bruise at all as it remains to this day. As to the bruise on the arm which the mother saw and photographed on 11.11.21, he said it was unusual for a child of this age to sustain a bruise. He said he would feel more comfortable with an accidental explanation if there were poppers on BQM's clothing on the arm and somebody had caught the skin in between.

72. Dr. Cartlidge was a very measured, careful and open-minded witness. He has a very great deal of experience as a paediatrician and in giving evidence in cases such as this. It seemed to me that throughout his evidence he was bearing in mind the fact that a number of things in medicine still remain unknown and unlikely things happen. He was willing to accept that BQM might have weaker than normal bones, and certainly took the view that, should the court conclude that the shaft fracture have happened during cannulation, this was firm evidence of bony fragility. He was also willing to accept that Indian massage of a type demonstrated in the videos could provide a mechanism for the metaphyseal fractures, but not the fractures to the ribs. He would have expected a doctor carrying out a cannulation procedure to have noticed and avoided a sore leg. Nonetheless, he would have expected BQM to respond to pain like any other baby and for anyone present when the fractures occurred to have realised that something was wrong. He did not believe a shaft fracture would have gone undetected for more than a day or so and would expect a primary carer to be aware of it even if not responsible for what had happened.

73. He also said that once a child becomes mobile one might expect to see more fractures if there was bony fragility albeit children with this condition will fracture more easily at some times than others for reasons that are not known. It is possible for parents to be careful up to a point, but a child will only be restrained so far.

74. At more than one point in his evidence Dr. Cartlidge said that he wondered whether there was someone in the family who handled BQM much more vigorously than they should, including when carrying out Indian massage, and had injured him albeit without intending to do so.

The mother

75. I have set out some of the mother's evidence in the chronology of events leading up to the discovery of the shaft fracture on 31st January and will not repeat it here. She gave evidence in numerous statements for the court, in her police interview and in the witness box over the course of a day.

76. She was adamant that the first time she had noticed any swelling or reduced movement in BQM's leg was in hospital and after the cannulation procedure. She timed this at between about 4 and 5pm. This was the case even though he had diarrhoea that day and she had to change a lot of nappies. She was challenged about some of the WhatsApp messages sent by her to the father on that day, including for instance 'poor boy's leg is already hurting where she took blood' but said that she was saying she believed he had a sore leg because of the bruise (which turned out not to be a bruise), and not because she had specifically noticed BQM showing any other leg symptoms beforehand.

77. She was asked to explain what she thought about the father's 'heavy handedness' or roughness as described by him. She said that he was rough with things and broke them more often than she did. He had bruised her when giving her a play pinch and had also hurt her once on another occasion in their former home (she was not specific about the details of this). She also said in answer to questions from Ms Webber for the Guardian that her husband carried out massages on her at times and that these were hard – so that it would have worried her if he had used that much pressure on BQM. She had seen him massage BQM and whilst he was less gentle than her, she

did not believe BQM was being hurt. She was not always there during those massages. She agreed when it was suggested to her that the father did not know his own strength and said there were times when she had pointed this out to him and told him to be more gentle.

78. She was absolutely clear that she had never seen the father behave in an aggressive fashion or be angry with either of the children. She said that she had asked herself how she had missed the fractures, and that it had never crossed her mind that BQM was injured.

79. I thought the mother was doing her best to give an honest account to the court. She clearly loves her children very much, and it is obvious that they are the centre of her life (indeed that was true for the father and grandmother as well). Within this, I also thought that she found it very difficult to believe that BQM had suffered so many fractures in the home and that the repercussions of this remain hard for her to take in. This in turn affected her evidence. Her acceptance that the November 2021 bruise could have been caused at the photoshoot was uncritical and somewhat at odds with her immediate reaction when she saw it which was to ask the father how it had happened. I also considered that her evidence as to whether BQM had a sore leg before the admission to hospital to be inconsistent with the contemporaneous messages. My view was that this was motivated by wishful thinking and rationalisation after the event rather than deliberate dishonesty.

The father

80. The father also gave evidence through numerous written statements, his police interview and in the witness box. Of central importance was what he said to the police before his interview, repeated when he gave oral evidence, namely that he is, as he describes 'heavy handed'. When he heard about all the fractures, he said that he thought it might be his handling which caused the problem. Indeed, he said that he had first been informed by his wife about all the fractures, shortly before his arrest. He had suggested to her that it could be his handling which was responsible but she had said that this did not make sense.

81. He accepted throughout his oral evidence that he could be heavy handed and did not always know his own strength but repeated that he had handled his daughter in just the same way as he had BQM without any adverse effects. The same was true of his nephew. He said that BQM had cried when being massaged and did not enjoy it but that he had never cried for hours and hours, as he would expect if he had broken a bone.

82. He was asked by Ms Webber whether, on reflection, he saw a link between his heavy handedness, massaging BQM's legs and the fractures, and said that on reflection he did. He said that it may have been subconscious but his legs were chunkier and so he could have thought he could 'go deeper'.

83. It is important also to record that the father said that if he had caused any of the fractures that this was never intentional. He had never lost his temper with either child. He denied causing the early bruise and said that his reference to himself and the mother discussing BQM moving his left leg less before the admission to hospital on 31st January was because he became confused in what was a very difficult situation.

He had discovered that his son had suffered from a number of fractures and he had been arrested in front of his daughter. His mental state was, as he described it, 'all over the place'.

84. The father was emotional at times in his evidence but answered all the questions put to him even when they were difficult. He was courteous throughout. He was very willing to acknowledge he might have caused at least some injury although he was extremely clear that this was never intentional.

The paternal grandmother

85. The paternal grandmother gave evidence last. She lived with the family throughout BQM's life until his admission to hospital on 31st January. She has always denied being responsible for causing any injury to BQM or being aware at any stage that he had been injured. She said that she had been very shocked when she found out. In her oral evidence she said she had never seen the early bruise, nor was the possibility of it being caused at the photo shoot (at which she was present) discussed with her at the time.

86. Much of her oral evidence was taken with discussing Indian massage. She said that she did massage BQM but mostly on the legs and after she had changed his nappy. This did not happen very often. She acknowledged stretching his legs to straighten them but said that she did not do this roughly and would let go if he cried.

87. She said that her son, the father would massage her at times, and she had thought he did it very hard. He was also heavy handed in other ways – for example when he pulled the handbrake on the car.

88. When asked questions on behalf of the mother by Ms MacLynn KC about the incident when GSM had been left alone with BQM and picked him up out of the bouncer, she said that the mother had taken GSM into the kitchen to calm her down, leaving her to look after BQM. The implication of this was that it was GSM that was the more distressed of the two.

89. There was nothing to suggest to me that the grandmother was being dishonest in any way in her evidence, nor was this suggested to her.

90. I also heard evidence from Dr. Kanendran about the cannulation process and her earlier examination of BQM. Her evidence was very much along the lines of the medical notes and her statement. She had not noticed anything untoward about BQM, nor was anything pointed out to her. BQM was crying throughout, saying that they had felt he was a bit irritable compared to a normal child.

Analysis

91. It is very clear from all the evidence I have heard and read that this is a close and loving family. Both the children with whom I am concerned are much loved by their parents and the wider family. Leaving aside the injuries, they are very well cared for. There is nothing adverse known about any of them at all. There are lots of text messages between the parents which show affection and cooperation between them.

92. I have read the contact notes, the foster carer notes and the parenting assessment. I have read the written submissions with care, particularly those prepared on behalf of the mother which refers to the case of *Re BR (Proof of Facts)* [2015] EWFC 41 in which risk and protective factors are set out from material produced by the NSPCC, Common Assessment Framework and the Patient UK Guidance for Health Professionals. There is a complete absence of risk factors and a full presence of protective factors. They all demonstrate the bond between the parents and children. When GSM was in foster care it was obvious how much she missed her mother and her father too, which confirms the quality of her upbringing to date.

93. She did tell the foster carer that her father had hit BQM on the leg and pushed a bottle into his mouth. These remarks appeared to be quite spontaneous although there is no record of GSM exhibiting distress at the time.

94. It is against this backdrop that I must consider BQM's injuries. Given the central importance of the shaft fractures to the left leg and whether or not they were caused by cannulation, I will consider this first. I make it clear that although I have to start somewhere, I am considering each piece of evidence in the light of all the other evidence, looking at it individually and then standing back to look at it as part of the whole.

95. The mother and father are adamant that they did not notice any limitation of movement or pain reaction in BQM's left leg before the cannulation on 31st January. The mother – who I did not find to be intentionally dishonest or unhelpful – told me she noticed nothing wrong until teatime despite changing numerous nappies that day. Dr. Cartlidge was clear that he would expect a primary carer to become aware, and he thought it unlikely that nothing would have picked up by Dr. Kanendran when she carried out an examination of BQM (including filling out a body map) or when she moved the leg to cannulate it.

96. The lack of any sign of injury before the canulation is in stark contrast to what was seen later that evening and the following day when obvious swelling and restricted movement were seen not only by the mother but by numerous medical professionals.

97. On the other hand, there is evidence to suggest there was something wrong with the leg before BQM's admission to hospital. The father told the police that they had noticed at home, probably the night before, that BQM was moving his left leg less than the other one. He suggested to them that they had intended to mention this when he was taken to the doctor. This piece of evidence fits with the WhatsApp message from the mother to the father on 31st in the evening that the doctors had taken blood from 'that sore leg' to suggest that that BQM's leg symptoms predated his admission to hospital and the cannulation. There is no record anywhere of the mother pointing out that mark or bruise to the doctors on admission to the CAU or at the urgent treatment centre although she said she did. Whilst medical records can be inaccurate, I think that if she had pointed it out it would have appeared somewhere in the notes at that time. It would be a potentially significant finding in a baby of this age.

98. As well as expressing the views that I have set out above, Dr. Cartlidge also said that in the light of the history given by the parents on presentation on 31st January it was not surprising that some of the doctors at least would not have focussed on examining the legs. None of them noticed the mark to the leg until much later. If a child is

crying anyway, then it may be harder to notice a specific area of pain. Dr. Cartlidge stated that the appearance of swelling following a fracture was very variable as to timing, in that it could appear up to 24 hours afterwards. Further, he said that it was possible the movement of the leg caused by cannulation could have caused or exacerbated it.

99. If it had not been for the possibility of the cannulation causing a fracture, none of the experts believed that from a medical perspective that BQM was likely to suffer from more than a mild degree of bony fragility as a result of the genetic variant, either by itself or in combination with HDS. Whilst individuals with conditions such as osteogenesis imperfecta or osteopenia do not fracture at a predictable and regular rate throughout their lives these conditions do not disappear and so, had BQM suffered from a fracture from the relatively gentle process of cannulation, it is surprising that he has not suffered anything like that since even though he is now mobile and walking. It is true he has not had any x-rays but there is no account of his appearing to suffer any injury in circumstances where his mother would now be very vigilant. There is some research evidence of cannulation causing a fracture in an infant with acknowledged bony fragility but it is extremely rare.

100. Dr. Kanendran remembered this family because the mother was Indian and they chatted together. She also clearly recalled that BQM was crying all the time and said in her oral evidence that she thought he was more irritable than would have been expected.

101. This is a very difficult area of the evidence. I am very conscious that the burden of proof is on the local authority to show that the shaft fractures were caused by the parents and it is not for the parents to prove that they were caused by the doctors. I am also very conscious indeed that the mother is loving and attentive, and she was intimately involved in BQM's care that day. If anyone would have noticed something wrong with BQM's leg it would have been her.

102. On a balance of probabilities, I have come to the conclusion that the shaft fractures were caused before BQM was brought to hospital that day and not during the cannulation procedure. I do not think the father was confused or mistaken when he said what he did to the police, and I do not think that the mother was referring to BQM having a sore leg in the text messages only because she thought he had a bruise. BQM was very unwell that day, with symptoms of covid, poor feeding, and diarrhoea. I believe that concern over those took priority over his leg, and those symptoms were likely to have masked it somewhat, not just to the treating doctors and nurses but the mother too, especially when she would have had no reason to think that BQM could have been seriously injured. Also, when listening to her evidence I found her to be reluctant to accept or believe that BQM could have been injured by the father without her picking this up, and that this had clouded her recollection. She does not want to believe the father caused the fractures and therefore has focussed her mind on factors which point away from his being responsible. I did not find her evidence about these matters to be reliable.

103. In my judgment the mother knew that BQM had a sore leg that day but did not become aware of how bad it was until later on when it began to swell. I appreciate that in making this finding that it is surprising that Dr. Kanendran (or any of the professionals) did not notice anything wrong with BQM's leg either when she

examined or cannulated him but it seems to me that she either missed BQM having a sore leg before or during the cannulation or that she and the mother failed to notice she had broken his leg in doing it. The cannulation did not involve the use of very much force, and I do not accept that this was the cause of the tibial fractures.

104. I have balanced all these factors in coming to this conclusion.

105. I will then turn to the bruise on BQM's arm as seen on 11th November. Although there is only a small photograph from the mother's phone it is clear that this was a significant bruise in a tiny baby not yet two weeks old. I do not accept that this bruise was caused at the photoshoot. It was two days before the mother saw the bruise and it seems unlikely that she would have noticed nothing in the intervening 48 hours. Additionally, nobody noticed anything untoward at the photoshoot itself. Even if there had been times when the mother and father were not there, the grandmother noticed nothing and the bruise was not discussed with her. I do not think the mother was responsible because upon noticing it she immediately sent a photograph to the father asking him if he knew what had happened. Rather than wait until he arrived home with GSM, he telephoned her immediately.

106. I accept the evidence of both parents that the grandmother could not have been responsible for the bruising. On the balance of probabilities, I find that it was not caused by the mother or at the photoshoot but by the father at an undisclosed time. The injury was likely to have been painful. The existence of this bruise is relevant because it shows that the father was capable of being rough although I do not know whether he was aware he caused a bruise at the time. It does show that the mother, against her better judgment, accepted the father's explanation.

The metaphyseal fractures and the ribs

107. I have noted above that the father's initial reaction, which he voiced to the police, was that he was responsible for the fractures to BQM's legs and ribs. He is an intelligent man who was fully able to appreciate the significance of what he was saying in such a context, in an interview that was being recorded. There was no sense that his statements to the police were led in any way. Whilst I accept the submission of Mr. Sampson on his behalf that a lay person would not be expected to know how much force is required to cause rib fractures, I believe that most people, this father included, are aware that fractures to the limbs do not happen easily. I do not think he would have made such admissions to the police without good reason. He repeated these admissions in his oral evidence, particularly in response to questions from Ms Webber on behalf of the Guardian. At one point he said 'I don't know if this is a subconscious thing but his legs were chunkier – I was gentle on the arms because they are thinner. His legs were chunkier so I thought I could go a bit deeper'. When asked if he saw a link between his heavy handedness and the fractures and he said that on reflection he did. He also said that he could have caused the rib fractures by pressing his ribs when he was face down on his knee. He also agreed that it was possible that the machine they used to soothe BQM (with white noise) could have masked the pain. In other parts of his evidence, it is true to say that the father said other things, for example that he did not think he had caused the fractures and certainly he maintained throughout that he had not seen anything like the pain reaction described by Dr. Cartlidge.

108. Dr. Saggar's evidence is that (absent the cannulation causing BQM's leg to fracture) the genetic findings are not of such a nature to suggest BQM would suffer fractures with normal gentle handling and that he would be expected to demonstrate the same pain reaction as any child. Dr Cartlidge agrees. These factors, together with the father's admissions lead me to conclude that he was responsible for causing the fractures by the use of excessive force.

I do not think the father has given a full explanation for the fractures, but do not find that particularly surprising. The descriptions of force are fairly limited and vague and I am sure he is genuinely concerned (as are all the family) that BQM might have a propensity to easy fracturing. I can appreciate that from an emotional point of view that this would be easier for all the family to accept.

The fractures to the shaft of the tibia

109. As stated above, I have come to the conclusion that the fractures were caused before the admission to hospital. The most likely time is at some point on the previous evening as the evidence of the father to the police suggests.

110. In my judgment the father's admissions relate to all the fractures. I bear in mind that it is possible for someone to believe they are responsible for causing an injury when they are not, but I do not find that is what has happened here.

111. The local authority does not now allege that the mother is a possible perpetrator but they submit that the grandmother could be. The description of the grandmother stretching out BQM's legs do not suggest the use of any significant force and I accept her evidence that she stopped if BQM cried. She did not massage him very much at all, and nobody has ever suggested that she is 'heavy handed'. I understand why the mother did not like the grandmother straightening BQM's legs – after all he was only tiny and babies' legs at this age are not held straight – but a desire that a young baby should grow up with strong limbs is common to all cultures. People develop different ideas about how to encourage this.

112. It is highly unlikely there were two separate perpetrators in the household so that both the father and grandmother caused injuries to BQM. The only circumstances in which this would have been at all likely here would be if BQM did have significantly fragile bones which would fracture with normal handling. I do not find that this is so.

Further findings

113. The local authority invites me to find that the fractures were caused by the father by deliberate acts which amounted, at least, to negligence and likely reckless care of BQM.

114. Section 31(2) Children Act 1989 provides as follows:-

> "(2) A court may only make a care order or a supervision order if it is satisfied –
>
> (a) that the child concerned is suffering, or is likely to suffer, significant harm; and

> (b) that the harm, or likelihood of harm, is attributable to –
>
> > (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable for a parent to give to him; or
> >
> > (ii) the child's being beyond parental control"

115. Here I am concerned particularly with s31(2)(b)(i) and in this case prefer to look at this wording rather than definitions of negligence or recklessness but forward in the parties' submissions.

116. In my judgement the father used excessive force at times when handling BQM, which was sufficient to cause fractures on at least two different occasions with four separate applications of force. There was a further occasion when he caused a bruise, albeit this is not as serious. In using excessive force, he caused BQM significant harm.

117. I am therefore satisfied that the care given to BQM, and likely to be given to BQM and GSM by the father is not what it would be reasonable for a parent to give. There is a risk of significant harm in the future. The threshold criteria are met.

118. The level of excessive force used by the father is difficult to quantify, especially as BQM was so young when all this happened and his genetic makeup may mean he has slightly more fragile bones than the average child. I also do not know whether the fractures were caused during the course of massaging his limbs or handling him when changing his nappies, feeding or winding him because the father has said different things at different times. He did say that he did not massage BQM when he was ill which suggests that the most recent tibial fractures were not caused in this way.

119. The videos of Indian massage do show that the handling of babies in this context is robust. Certainly Dr. Cartlidge had never seen this before and was surprised. Nonetheless this is a common practice and it would not be if babies were known to be seriously injured as a result. Some element of bony fragility might mean fractures are more likely in this context, especially if BQM's very young age is taken into account but massage does not explain the rib fractures. Nor, if the father is right about not giving BQM massage when he was ill, do they explain the shaft fractures.

120. Neither the mother or the grandmother have given any evidence that the father has a bad temper or that he has been aggressive with or in front of either of them or the children. Of course, they are both partisan witnesses, but from my assessment of the mother in particular I do not think she would have chosen to cover this up. There is no suggestion in the messages that pass between the parents that this is the case, or that the father does not love his son. Quite the contrary. In some cases, injuries such as we see here are caused by anger towards the child and a lack of self-control. That does not seem to be the position here.

121. The Guardian's case, put to the father in cross examination and in final submissions is that the injuries were caused by the father using excessive force, but not deliberately or with any malice. Certainly, this would fit with all the other evidence, including the father's handling of BQM on one occasion during the parenting assessment. This still remains a serious finding, however, because the injuries were very significant and

happened on several occasions. Also, the father does not seem to have been attuned to the pain BQM must have suffered. This is something that must be considered at the welfare stage of the case. It is to the father's credit that he accepted responsibility for the fractures; this fact means that it should be possible to work with him to reduce the level of risk in the future.

The mother - failure to protect

122. I have set out above that there are some points when I think that the mother's evidence to the court was not accurate and her difficulty in accepting the father could be responsible affected her perceptions.

123. None of these facts (or any others) however, lead me to a conclusion that the mother failed to protect BQM from the father in the sense that her care of him was 'not what it would be reasonable to expect a parent to give'. Dr. Cartlidge's clear evidence is that the rib and metaphyseal fractures would not have been obvious to a non-perpetrator. The only fractures which would have been so were the shaft fractures to the left tibia which happened very shortly before the admission to hospital. The parents were worried about BQM generally and sought treatment for him on 31st January. Even if the mother failed to point out the problem with the leg straight away, she drew attention to it when it became incontrovertible that something was seriously wrong, including asking that he have an x-ray. This mother is loving and attentive, and this is not a case where she has failed to seek medical attention for her children, colluded in any ill treatment or took an active decision to cover things up.

124. The mother's protective role (and that of the wider family) from now is very important, but that is a matter for the welfare stage. At the end of the Guardian's submissions Ms Webber stated that he hoped that matters could move forward quickly so that final decisions can be made as soon as possible. It was clear that in the light of the Guardian's view that the father's behaviour was not intentional or malicious that this was a reference to the family being reunited once again. I hope that the local authority will carry out some work with both parents, individually and together with a view to considering how this might be achieved. This will of course require an assessment of the future risk, and whether and how it can be ameliorated to keep the children safe.

125. I wish to extend my thanks to all the representatives in this case which was prepared impeccably by all concerned, solicitors, leading and junior counsel. Those who represented the intervenor did so without any funding. This was a very significant commitment, with Ms Watson and Ms Hughes being present every day of the hearing. For this paternal grandmother to have had no representation at the hearing would have been extremely difficult and worrying for her, and difficult for the court as well. I am very grateful indeed that this did not happen.