Case No: **ZE20C00552**

IN THE EAST LONDON FAMILY COURT

11, Westferry Circus,
LONDON,
E14 4HD

Date: 28th June 2021

Before :

HER HONOUR JUDGE CAROL ATKINSON
(sitting as a Deputy High Court Judge)

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Between :

London Borough of Bromley	**Applicant**
- and -	
Mother	**Respondents**
Father	
JO & JS through their children's Guardian	

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Ms Kristina Hopper for the Local Authority
Mr Chris Mitropoulos for the Mother
Ms Gemma Farrington for the Father
Ms Julie Nix for the children through their children's Guardian

Hearing dates: 21st May 2021

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JUDGMENT

HER HONOUR JUDGE CAROL ATKINSON :

Introduction

1. JA (boy), JO (boy) and JS (girl) are triplets. In June 2020 when they were 14 months old, JA was found by his mother in his cot, unresponsive. She called an ambulance. Tragically JA died upon arrival at hospital. All attempts to resuscitate him were unsuccessful. JA had suffered a cardiac arrest after a period of diarrhoea and vomiting. He was subsequently discovered to have contracted an E-Coli related infection which in turn caused Haemolytic Uremic Syndrome.

2. As is routine, JA was subjected to a skeletal survey following his death. The films revealed what was believed to be a healing fracture of the clavicle (collar bone). The treating paediatric radiologist remarked that this was an injury not expected with normal handling. Thus, the suspicion of deliberately inflicted injury was raised. The expert view was that the time frame for the injury was probably 10-21 days before presentation at hospital.

3. Until that moment the family had been of no interest to the Local Authority (the LA). There has never been any suggestion that what was revealed on the skeletal survey was in any way connected with the child's death. The parents were unable to provide an explanation as to how JA might have fractured his collar bone. The one notable incident described by the mother occurred outside of the time frame and was not accompanied by the degree of pain and discomfort expected in a child who had fractured his clavicle. JA's siblings were subjected to full examination and no injuries were found.

4. Against that background the LA issued proceedings. The only crumb of comfort for these parents, already laid unimaginably low by the loss of one of their children, was that JO and JS were to remain in the maternal family and their mother with them, though subject to supervision by the maternal grandmother and/or aunt.

5. At a hearing last week, I indicated my approval of the LA's request that they should be permitted to withdraw these proceedings and step out of this family's life. In fact, the more proper course, as I shall explain, is for me to dismiss the application as the LA accepts that it is demonstrably unable to cross the necessary threshold. This Judgment explains briefly why, but more importantly tells a salutary tale of how difficult these issues are and how devastating the process is to the families who have no alternative but to suffer it. Whilst I am firmly of the view that the process is fair and as robust as we can design, it is still painful and sometimes far too slow and it is important that I acknowledge that in a case such as this it necessarily heaps more pain upon the family at its centre.

Essential background

6. JA, JO and JS are the first-born children of their mother, M. Their father, F, has older children from an earlier relationship. The triplets were born in early 2019. By the spring of 2020 their parents' relationship was encountering difficulties. I do not know why. Nor does it even matter. Suffice to say that the parents separated over Easter 2020 when the F moved out of the family home.

7. On 19th May 2020 police were called to the family home amid allegations of shouting between the parents. There were no complaints made to the police by either of the parents and no action followed.

8. On 21st June 2020, Father's Day, F came to visit. He cared for the children alone for around 30 minutes whilst M went to tend to her horses at the stables. By some accounts he called M frequently during that time reporting that JA was unsettled and crying. By the time M arrived home, she reported that JA appeared to have settled.

9. On 22nd June 2020 JA fell ill. M immediately took him to the GP. His throat and chest were clear and he appeared alert and co-operative. M reported that he had been unwell and vomited 3 times; he was taking little fluid and food. Nothing was found and advice was given regarding hydration.

10. On 29th June 2020, JA was seen at the surgery again due a suspected viral illness and vomiting. Two small bruises below his knees were noticed which were reported to most likely be due to crawling. Nothing untoward was found in the examination; his heart and chest were listened to, but no bones were examined. The following day, 30th June 2020, M found JA in his cot in a state of collapse. As I have already recounted, JA tragically passed away upon arrival at hospital by ambulance.

11. Following JA's admission, JO and JS were also admitted to hospital. Concerns were raised regarding JO's health; he was reported to be pale and showing evidence of renal impairment and significant anaemia. JO was treated with intravenous fluids remaining an inpatient until 5th July. JS was clinically asymptomatic with no evidence of renal impairment or anaemia and was discharged on 2nd July. However, she is under the ongoing care of the Neonatal team and has developmental issues. JS's blood tests at the time gave rise to a concern that there may be an immunodeficiency disorder within the family that could compromise the siblings and may have contributed to JA's death.

12. On 8th July 2020, in line with departmental protocol, a pre post-mortem skeletal survey was performed on JA by a Consultant Paediatric Radiologist, Dr S. Dr S identified what he considered to be *'a healing fracture of the left Mid-distal clavicle with mild apical angulation and periosteal reaction evident'*. He noted that this was an injury not usually seen with normal handling of a child but advised that the fracture would have been caused by direct impact to the bone and that it *"could be accidental, with appropriate history, mechanism and timing, or inflicted"*. However, it was Dr

S's view that rarely were clavicular fractures seen in isolation from a simple fall unless they occurred from a significant height (e.g. a tree or a trip down the stairs – depending on how many stairs and the landing). Further, he would have expected JA to have been in pain and unable to move his arm for several days after the trauma. He considered that the fracture to JA's clavicle was likely to have occurred between 10-21 days prior to his death.

13. In response to the question of how this might have happened, M provided an account of how JA suffered a fall whilst climbing out of his bouncer, landing on his chest on a hard floor. She reported that she was caring for the triplets by herself at the time of this incident. She could not remember the exact date but recalled that immediately after the incident she bought the triplets high chairs to avoid it happening again. This dated the incident to some 2 months before the hospital admission and outside of the 10-21-day window given by Dr S.

14. The police completed a home visit on 11 July 2020 and saw the bouncer. M informed the police that there were no signs of injury or bruising, although JA had winced slightly when she lifted him in and out of the cot and cried. At the time she considered that he may have injured his ribs, as he moved in a way to avoid pain on his side. F reported that he had also checked JA when he returned home but had not found any injuries or anything to be concerned about. The police considered that the explanation was sufficient. The LA, however, was concerned that the explanation did not fit with the parameters set by the treating doctors.

15. Meanwhile, on 16th July, JO and JS underwent Child Protection medicals and skeletal surveys. Both children's body maps were clear, and no evidence of fractures, bruising or injuries were found. Nevertheless, JO and JS were made subject to a Child Protection Plan under the category of neglect on 30th July 2020.

16. JA was subjected to a post mortem. The Pathologist who completed the post mortem felt that she could feel a deformity in the clavicle when it was examined and sought for it to be sent to Prof M, an expert in bone pathology, a Consultant Histopathologist, for his examination and opinion. Prof M is an expert of some note and indeed if not the only expert, one of very few, it would seem, in this field. As a result, the waiting time for Professor M's report, the parties were told, was approximately 9 months.

17. On 12th Oct the LA issued proceedings. I made an interim care order on 16.10.2020 on the basis that the children remain living with the mother, at the maternal grandparents' home, with the maternal grandparents and maternal aunt supervising. At the hearing on 25th November 2020, experts were instructed to provide reports. A consultant paediatric radiologist and a consultant paediatrician.

18. I will return to the evidence of the experts in a little more detail in due course but suffice to say at this stage that by early 2021 the expert evidence could be summarised as follows. The paediatric radiologist agreed that there was evidence on the films of a healing fracture. He considered that the fall described by the mother was capable of causing such a fracture. However, he also agreed with the treating radiologist as to the time frame for the injury. The fall was outside of that time frame. The paediatrician likewise opined that the witnessed accident could have caused the fracture but expressed concern that the limited discomfort described by the mother as accompanying the fall did not fit with the nature of the injury.

19. In addition to the expert evidence, on 25 November 2020, the Court directed a forensic analysis of M's mobile telephone, in an effort to retrieve the messages sent to M by F on Father's Day 2020 (21 June 2020) when he was caring for the triplets alone and in what had been described by M as stressful circumstances. A number of the message exchanges between 20th and 22nd June 2020 had been deleted and ultimately were unable to be retrieved. A lengthy exchange, however, between M and her friend on the evening of 21 June 2020 revealed that the parents had argued that day before the M left F in charge of the triplets and that *"…by the time I got to yard he was ringing/messaging me to come back and get them…."*. She also expressed concerns about F's ability to 'cope with the children' and stated that she considered that his contact with the children would have to be 'supervised' in the future.

20. In addition, on 25 November 2021, I directed the Local Authority should obtain and file Witness Statements prepared on behalf of the Maternal Grandmother and Maternal Aunt, addressing their care of JA in June 2020, their observation of his behaviour and presentation and the detail of any incidents they may have witnessed, which may have provided an explanation for his injury. In her statement filed on 19 January 2021, the Maternal Grandmother described an incident where JA had tipped out of a rocking dinosaur toy sometime in June 2020. The MGM described how JA had *"..managed to tip the horse over whilst still strapped into it and land on his left side. I was sitting very close to him so after undoing the strap, I checked him for any sign of a bump thinking that he had possibly hit his head on the carpeted floor. Once he had been picked up and comforted, he stopped crying and resumed his normal behaviour……I cannot say when this occurred, but I am guessing it must have been sometime in June before he became ill on 21st June 2020."*

21. Investigations into F's past relationship revealed that following separation from his former wife there had been proceedings in another county court followed by enforcement proceedings in the crown court after an alleged breach. No breach was found, but the court did make a 5-year Restraining Order against F. For the sake of completeness, M reported that following the disclosure of these current investigations to F's former wife, his former partner harassed the maternal family causing them to have to report matters to the police.

22. Finally, it is important to record that there were no other recorded concerns regarding the triplets or the care given to them by either of their parents prior to these events. Nor since. Indeed, M's care of the children and her preparedness to work with the LA has been exemplary.

23. Against that factual background, the LA was invited by me to reconsider the single injury against the broader evidential canvass. To focus their thoughts, I listed a hearing to consider the evidence on threshold. However, over the weekend of 24th/25th April 2021, JS was taken to hospital with a fracture to her foot. Initially, it was not clear how JS sustained this fracture other than it was a fall when she was walking. After admission to hospital the treating medics were content that this injury was an unfortunate accident. However, this incident caused a further delay the hearing to consider the evidence on threshold.

24. Nevertheless, after a short period of reflection, in what the LA described as a 'very finely balanced' situation, the LA decided to seek permission to withdraw.

25. Just prior to the hearing, unexpectedly, came Prof M's report. Essentially, Prof M described that on examination of the bone he found no fracture to the clavicle. In short, the healing reaction identified by the radiologists on the film was not a reaction, it would seem to a fracture but rather to a trauma. In his view the time frame could now be lengthened permitting the mother's described incident to provide a complete explanation for the injury.

The Law

26. The LA applied for care orders with respect to these children. The statutory framework within which the LA's application is made is contained within Part IV of the Children Act 1989. Put shortly, I am only able to make a care order in circumstances in which I am satisfied that the statutory threshold is crossed and if it is, with the welfare of these children separately as my paramount consideration, if I am satisfied that the interference with their right to family life is necessary in order to protect them and proportionate to the risks identified. It is the LA that brings the case and it is for the LA to satisfy me on the balance of probabilities that it has proven it's case at each stage. If the threshold is not crossed then there is no basis for the LA to pursue any orders.

27. The statutory threshold requires me to be satisfied that it is more likely than not that, at the relevant date, the children were each suffering or likely to suffer significant harm and that harm is attributable to the care given to them if the order is not made "not being what it would be reasonable to expect a parent to give". In this case the LA relied upon the unexplained fracture to JA's clavicle identified by the radiologists. It argued that this raised a risk of harm to JO and JS.

28. At the interim stage the LA does not need to prove the injury but simply persuade the court that there are reasonable grounds to believe that the threshold is crossed. What that means is that there is a sound evidential basis, if accepted, to support that assertion.

29. The LA now seeks to withdraw its application. I have considered two important authorities on the approach to be taken in such an application. The decision of Hedley J in *Redbridge London Borough Council v B C & A* [2011] 2 FLR 117 and the decision of Cobb J in *J, A, M and X* [2014] EWHC 4648. The principles can be distilled as follows:
    a. Leave is required before an application can be withdrawn: see *rule 29.4 FPR 2010.*
    b. Where the LA cannot prove the threshold criteria, then the application to withdraw must succeed. Where the threshold can be proven then *"the application would really depend upon the court concluding under s 1(5) of the Children Act 1989 that no order was necessary; that is to say on the basis that withdrawal was consistent with the welfare needs of A.*"
    Per Hedley J in *Redbridge London Borough Council v B C & A* [2011] 2 FLR 117 (at para.9 of the judgment).
    c. Of course, applications to withdraw generally come at a stage at which there has been no evaluation of the evidence in support of the threshold. In the case of *J, A, M, and X* (supra), Cobb J considered that the circumstances envisaged by Hedley J in Redbridge (supra) were circumstances in which the inability of the local authority to cross threshold was 'obvious'. So, where it was arguable that threshold might be crossed, depending on the court's construction of the evidence, the court must carry out a fuller evaluation and remind itself that the factors pertaining to threshold may also be relevant to the welfare of the children.
    d. In the case of *A County Council v DP, RS, BS (By The Children's Guardian)* [2005] EWHC 1593 (Fam); [2005] 2 FLR 1031 McFarlane J (as he then was) set out the factors that should form part of this evaluation. These were:
        i. the interests of the child (relevant not paramount);
        ii. the time the investigation would take;
        iii. the likely cost to public funds;
        iv. the evidential result;
        v. the necessity of the investigation;
        vi. the relevance of the potential result to the future care plans for the child;
        vii. the impact of any fact finding process upon the other parties;
        viii. the prospects of a fair trial on the issue;
        ix. the justice of the case.

Applied to this case

30. In this case, just prior to the receipt of Prof M's report, the LA sought to withdraw on the basis that there was nevertheless an arguable case that the threshold was crossed - one which they might have pursued but for welfare reasons decided not to. With the receipt of Prof M's report, however, the LA had to concede that it had become 'obvious' that the threshold was not crossed. With that I wholeheartedly agree but I think it important to set out a little more detail.

The evidence on threshold

The experts in the case

31. I have set out in summary the findings of the treating radiologist and his views as to mechanism and timing. I turn now to the expert paediatric radiologist instructed in the case. I start with the excellent summary given by the expert of what it is such an expert sees on a film and what he is looking for to evidence a fracture:

'In general, fractures heal by periosteal new bone formation (callus) which only becomes visible after 1 week in the majority of cases (the accepted range is a minimum of 5 days and a maximum of 11 days before periosteal reaction is visible).....Prior to this, fractures can be identified radiographically due to a visible lucent 2 fracture line which can be difficult to visualise when undisplaced, or by focal angulation in the cortex (edge) of the bone if the fracture does not pass across the whole diameter of the bone (an incomplete or greenstick fracture). Non-visualisation of the acute fracture line is common in rib fractures where the fracture line routinely cannot be radiographically identified until healing by new bone formation has commenced. Skull fractures do not heal by the above process. Metaphyseal fractures do not always heal by the above process.'

'Bone healing progresses through early and late phases ('soft' and 'hard' callus); the late phase becoming apparent at 4 weeks approximately. During this time, the focal periosteal new bone formation becomes initially progressively more prominent, then gradually less prominent. The fracture is then gradually incorporated and remodelled into the involved bone over time.'

'Radiographically fractures usually heal completely in 3-6 months. The rate at which these stages are visible radiographically is variable and becomes more variable the older the fractures appear radiographically at presentation. It is therefore not possible to date accurately fractures that are in an advanced state of healing.'

32. In this case the expert considered that there was evidenced on the films of a left clavicular fracture. He identified *'established callus formation and some remodelling.'* Based on the radiographic appearances only, he estimated that this fracture was between 2 and 6 weeks old on the date of JA's death. He opined that the

'morphology of the fracture is transverse and is slightly angulated.' The mechanism for this type of fracture, he said, is usually *'direct blunt trauma to the clavicle or less frequently the result of sudden traction or a transmitted force along the arm from a pull or fall.'*

33. It was the instructed expert's view that clavicular fractures are commonly the result of simple falls in mobilising children and in his view required lesser force than that described by the treating radiologist. He described how *'clavicular fractures are common in mobile children following falls onto the shoulder or arm whilst standing or running, or falls from short heights or bicycles, horses, trees etc but require an adequate explanation in non-mobile children.'* JA was mobilising at the time. He was able stand, jump and climb.

34. On the mother's account of the fall from the bouncer, Dr W said that:

'This incident describes a blow or impact to the upper chest which could provide a mechanism for the fracture. It is possible that the amount of force described could have resulted in a fracture if he landed on his shoulder.'

He likewise considered that the later account, given by the MGM, concerning the fall from the rocking horse would also provide a mechanism.

35. As to presentation he confirmed that:

'In this case, the fracture is not significantly distracted and shows no gross angulation. I would therefore expect there to be a variable degree of loss of function of the limb following the occurrence of the fracture, ongoing until the fracture healed. This would be less than a distracted or markedly angulated fracture.'

However, he also commented that as a radiologist that this was outside of his area of expertise and deferred to the paediatrician on this issue.

36. A consultant paediatrician was instructed. Dr IM opines:

'*There is a history of falling to the left off a rocking dinosaur having been strapped in. There would have been a significant force with the weight of the rocking dinosaur landing with him on to the carpeted floor. JA only cried for a short while and was back to his normal self. It would be unusual for a child with a fractured clavicle to not show any signs of distress thereafter on day to day handling involving his left upper limb. The time frame of the injury would be consistent with dating of the fracture. In my opinion this could be a likely cause of injury however I am cautious with the history of James being his normal self shortly after the injury.'*

37. In response to further questions as to loss of function where the fracture seemed to present with a small degree of angulation and no obvious distraction, Dr IM states in response to questions that *'....it would be reasonable to conclude that pain would be directly proportional to the degree of distraction and angulation of the fracture. The perception of pain in an adult or child is also variable. The same fracture would cause different responses in different people.'* Dr IM goes on to say that: '*It is not possible to comment on how long or severe the pain from a fracture would last for as there are many variables in this. However, I can say that any fracture is painful and a child would normally cry. This would alert a carer that a child is in pain after a fall but would not necessarily indicate at the time that fracture occurred.'*

The broader canvass

38. So, whilst the expert evidence in this case was united as to the existence of a fracture, it was also accepting of the mechanisms described by M and MGM. However, M's account did not quite fit with the timeframe and with what the medics expected in terms of presentation whilst the MGM's account was greeted with suspicion by the LA because of the late recollection and also the lack of associated pain reaction at the time.

39. It is nevertheless important to remind ourselves at this stage that expert opinion is not of itself determinative of these important issues. It must be examined together with all of the other evidence. As decision maker I must look at that expert opinion against the essential detail of events given by other, equally significant witnesses, as to context, character, circumstances and events; the so called 'broader canvass'.

40. There were no concerns about this family prior to these events. Following the death of JA, however, the LA has applied its magnifying glass to every aspect of this family's life in order to see whether there was anything of concern.

41. There was a generalised concern within the LA as to the parent's relationship, the possibility that there was domestic abuse between them and that they were seeking to conceal that. What though is the evidential basis for this? There was the call out in May, shortly after the parents' separation. It is clear from messages between the mother and her friend that the parents were arguing with one another. The mother's deletion of messages from her phone during the key period and the parents' inability to remember the detail of what they might have contained but nevertheless to remember other detail from before that time raised a concern that there was more to the situation than their admissions.

42. The father has had some issues with a former partner and he has suffered with his mental health but nothing stands out so far as I can see and nothing that necessarily points to him being abusive to any of the children. It is clear that when the father had the children in his sole care on Father's Day JA was unsettled and miserable.

However, that this was probably when he was already becoming unwell from the illness that later caused his death.

43. In terms of the parenting assessments, the assessment of the mother was positive and all observations of her with the children have been good and suggestive of her being a good and capable parent. Observations of father's contact likewise showed a loving relationship though there were questions for the LA regarding father's commitment to parenting which undermined the outcome of his parenting assessment. However, one has to remind oneself that this was a man (and a woman) who were also grieving the loss of a child.

44. Nevertheless, after close examination of that evidential picture the LA concluded that it should apply to withdraw:

"The Local Authority notes that the decision as to whether to apply to withdraw is a difficult and finely balanced decision. The Local Authority has carefully considered all of the evidence within the care proceedings and in particular the evidence of the expert medical professionals ..... who conclude that the explanation provided by the parents and the family of [JA] falling from a rocking toy, is a plausible explanation for the fracture to JA's clavicle and the dating of the incident provided by the family was accepted by the medical experts as a feasible timeframe for this injury. The Local Authority accepts the evidence of the experts that the fracture occurred, but JA did not die as a result of an inflicted injury. It is within this context, that the Local Authority requests to withdraw their application.

The Local Authority does not make Court applications lightly and is aware that applications are only made when there is enough evidence to support such an application and is in the best interests of the subject children'

The pathologist

45. The Police Witness Statement of Professor M, Consultant Histopathologist, is dated 10 May 2021. The report was not expected to be available for the hearing listed to consider permission to withdraw. It was not seen by the LA until after the decision to withdraw was taken. It is not simply confirmatory of that decision; this evidence could hardly be more significant.

46. Professor M concludes that:

"There is an area of periosteal compact new bone formation just lateral to the midline of the clavicle. This is most likely to be a consequence of a periosteal haematoma due to direct impact injury. The periosteal new bone is compact and organized indicating that it has formed and remodelled over a period of several months. The overall appearance is

consistent with having occurred within the time frame given by the mother for the recalled and described event between 2 and 4 months prior to death. There is no evidence of an associated fracture (including no evidence of a healed fracture).
I am not convinced of an angular deformity of the clavicle. It may be that the periosteal new bone gave the impression of an increased angle to the reporting radiologists.
There is no evidence of an underlying bone disease."

47. Professor M's report was immediately sent to the experts in the case for comment. The paediatrician responded swiftly saying:-

'Professor M confirms that there is no fracture but evidence of a previous periosteal haematoma due to direct impact injury.
Professor M's findings support my opinion of the explanation of the injury, time scale and also supports the fact that JA did not show distress or have restriction of movement that would have been expected from a fracture."

The consultant radiologist was always clear that *'...the histological dating of fractures is more precise than that of radiological estimation'.* On the issue of the presence of a healing fracture he likewise deferred to histological examination of the bone.

Comment

48. With the arrival of the report from Prof M there is little for me to analyse. The evidence is now clear. The experts are unified. There was no fracture. The periosteal healing seen on the film by the paediatric radiologists was not a reaction to a fracture but rather a reaction to a trauma. Something that I have not come across before. The mother's explanation is a complete explanation for that trauma.

49. I am quite satisfied that the LA cannot prove the threshold facts. That much is now 'obvious'. The appropriate course, in my view, is that the application should be dismissed for that reason.

50. It is not necessary for me to conduct any further analysis in accordance with the authorities set out above though I am bound to say that had I done so my conclusions that the LA should step out of this family's life would have likely been the same.

51. In terms of a decision there has been little to record in this Judgment but I considered that this was a story that needed to be told. It is a story that shines a light upon many aspects of the family justice system in circumstances in which complaint is often made that there is little light and little transparency.

52. In the first place, this decision demonstrates very clearly, in my view, the difficult position that the LA and those charged with the safeguarding of children are in when faced with what appears to be incontrovertible evidence that a child has suffered an

unexpected and significant injury whilst in the care of a parent. Until the arrival of the report from Prof M there was little room for an argument that there was no fracture. I would suggest that this LA could not ignore that information and an investigation had to follow.

53. In the final analysis and after an intensive inquiry the LA carried out its own analysis of the broader canvass and concluded that it should step away. This is a brave but proper decision for a responsible LA to take. In the current climate and in particular following the recommendations of the Public Law Working Group, there might be an argument that such an investigation could have taken place in advance of the issue of proceedings. However, the fact is that such an investigation would have been unlikely to proceed without the protective arrangements being in place equivalent to those following my making of an Interim Care Order. No one has suggested to me, nor could they, on those facts, that the ICO was anything other than justified. The question then becomes about who should hold the risk.

54. The decision for me has been very much easier with the arrival of Prof M's definitive report and the acceptance of that position by the other experts. However, the second lesson from this story is as I have set out above. The opinions of experts are not determinative. It would have been my role in any contested hearing to listen to the parents, examine the history and determine whether I accepted the mother's account of this incident even though it did not fit with the medical view. The careful examination of the broader evidential canvass in this case would have been crucial. This was one injury to one of three children who otherwise showed no signs of physical injury and with whom the LA had not been previously concerned. Medical science is not infallible and those offering their opinion in cases seldom suggest that it is. It provides us with hypotheses about cause and effect but leaves us as fact finders to test those hypotheses and measure them against what else we know. Cases like this are an important reminder to us all of the care that must be taken in considering the entirety of the evidence in every case. case in which there is one single seemingly isolated incident .

55. As will be apparent from everything that I have said, I have faith in the system. It is far from perfect and it is all too often too slow, but I nevertheless have faith that it can balance the rights of parents, the right to respect for family life and the need to protect children from harm whilst coming to a fair and just conclusion. However, the third lesson from this case is one we must never lose sight of. That is the emotional cost to this family and other families through having to endure the process. I am truly sorry for that. They have borne this intrusion into their lives, during which they have on occasions been considered culpable, with astonishing dignity and fortitude. What these parents have suffered following the death of one of their children is revealed here and marked, I hope, as significant. I hope that by setting out the facts in this way, they can dispel the suspicion that has surrounded them and may yet rise again in the future in relation to these events. They can and must be applauded for their

stoicism and their ability to keep things as ‘normal’ as possible for the two children for whom they continue to care.