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[2023] EWFC 57 (B)

IN THE FAMILY COURT SITTING IN COVENTRY
In THE MATTER OF THE CHILDREN ACT 1989
IN THE MATTER OF B

Date: 18/04/2023

Before :

HHJ WALKER

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Between :

COVENTRY CITY COUNCIL **Applicant**

- and -

A (1)
C (2)
B (By her Children's Guardian) (3)

Respondent

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Miss Sparrow (instructed by **Coventry City Council**) for the **Applicant**
Mr Kingerley KC and Miss Eveleigh-Winstone (instructed by **Askews LLP**) for the **First Respondent**
Mr Nuvoloni KC and Miss Gallacher (instructed by **Alsters Kelley Solicitors**) for the **Second Respondent**
Miss Mettam (instructed by **Jackson West**) for the **Third Respondent**

Hearing dates: 22nd, 24th, 28th, 29th March, 3rd, 4th, 5th, 18th April 2023

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JUDGMENT

HHJ Walker :

1. For the purpose of this judgment, I will refer to the child as B, her mother as A and her father as C. B was born on the 6th May 2022. These are care proceedings brought by the local authority and I am charged with the task of determining whether the threshold criteria for the making of public law orders is satisfied, as pleaded by the local authority in a document dated the 1st March 2023. B is represented in these proceedings through her Children's Guardian, Sian Harrison.

2. The parents met in July 2021, after A had arrived in this country from India in the April of that year. C had been married before to a woman called TT, and they had had a child together, ST. C has not had contact with ST since he separated from TT. The relationship between the parents progressed quickly, and they entered into an Islamic marriage in October.

3. B was born at 36+5 weeks by caesarean section and was kept in the neonatal intensive care unit for a period of three days. She and her mother were discharged home on the 9th May 2022. During the first weeks of her life, there were on-going concerns about her failure to put on weight. On the 20th May 2022, she was taken to A&E and advice was given. In fact, it took B until 22nd June 2022 to return to her birth weight.

4. Just after midnight on the 1st July 2022, the mother presented B to UHCW with a bruise to her right jaw. B was admitted, and subsequent investigations revealed 'multiple rib fractures of different ages'. The parents were arrested and interviewed, and that investigation is on-going. These proceedings began and B has been in the care of the authority since the 4th July. She is placed in a foster placement. Contact has been disrupted as a result of this hearing, which has been very hard for both parents, particularly the mother.

5. The findings sought by the local authority in relation to those injuries are set out under the heading of 'physical harm' within the threshold document. It is asserted that B presented with the following injuries-

   (1) On or before the 30th June, B sustained a bruise to her right jaw measuring 1.5cm x 0.5cm

(2) A non-displaced but complete fracture of the left 4th rib towards the side in the region of her left armpit, which was between 2 weeks and 4 weeks old at the time of admission.

(3) Non-displaced fractures of the left 5th and 6th rib at the interface between the bone and cartilage at the front of the rib cage, which were up to two weeks old at the time of admission.

6. The local authority contends that all those injuries were inflicted by either the mother or the father. Findings are also sought in relation to the father's poor handling of B as seen in various videos obtained from the mobile 'phone analysis. It is also asserted that the parents failed to take advice in relation to safe sleeping and that they failed to adhere to feeding advice leading to B's failure to thrive.

7. The mother and the father remain in a relationship, and they deny that either of them has ever harmed their child. The existence of the injuries is accepted, but both parents believe that there is an underlying cause for B's presentation. Neither of them accepts that there was poor handling of B (save for that observed in one video, a topic which I will return to in due course). They do not accept that they failed to take advice.

The Law

8. The starting point is, of course, s.31 Children Act 1989 ('CA') which sets the 'threshold':

(1) On the application of any local authority, the court may make an order—(a) placing the child with respect to whom the application is made in the care of a local authority; or (b) putting him under the supervision of [one]…

(2) A court may only make a care order or supervision order if it is satisfied—(a) 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 to expect a parent to give to him…

(9)…."harm" means ill-treatment or the impairment of health or development including, impairment suffered from seeing or hearing the ill-treatment of another; "development" means physical, intellectual, emotional, social or behavioural

development; “health” means physical or mental health; and “ill-treatment” includes sexual abuse and…ill-treatment which [is] not physical…”.

9. In respect of the task of determining whether the 'facts' have been proven the following points must be borne in mind as referred to in the guidance given by Baker J in *Re L and M (Children)* *[2013] EWHC 1569 (Fam)*.

10. The burden of proof is on the local authority. It is for the local authority to satisfy the court, on the balance of probabilities, that it has made out its case in relation to disputed facts. The parents have to prove nothing and the court must be careful to ensure that it does not reverse the burden of proof.

11. The standard to which the local authority must satisfy the court is the simple balance of probabilities. There is no room for a finding by the court that something might have happened.

12. Findings of fact must be based on evidence, and the inferences that can properly be drawn from the evidence, and not on speculation or suspicion. The decision about whether the facts in issue have been proved to the requisite standard must be based on all of the available evidence and the court should have regard to all of the evidence.

13. The opinions of medical experts need to be considered in the context of all of the other evidence. The roles of the court and the expert are distinct and it is the court that is in the position to weigh up the expert evidence against its findings on the other evidence. It is the judge who makes the final decision.

14. The evidence of the parents 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 *(Re W and Another (Non-Accidental Injury) [2003] FCR 346).*

15. 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 at all times that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear, and distress. The fact that a witness has lied about some matters does not mean that he or she has lied about everything *(R v Lucas [1981] QB 720).* In *Re A, B and C [2021] EWCA*

Civ 451, at §55, Macur LJ advised the use by Family Court of this 'Crown Court Compendium' guidance:

"1. A defendant's lie, whether made before the trial or in the course of evidence or both, may be probative of guilt. A lie is only capable of supporting other evidence against D if the jury are sure that: (1) it is shown, by other evidence in the case, to be a deliberate untruth; i.e. it did not arise from confusion or mistake; (2) it relates to a significant issue; (3) it was not told for a reason advanced by or on behalf of D, or for some other reason arising from the evidence, which does not point to D's guilt.

2. The direction should be tailored to the circumstances of the case, but the jury must be directed that only if they are sure these criteria are satisfied can D's lie be used as some support for the prosecution case, but the lie itself cannot prove guilt.

16. The judge in care proceedings must never forget that today's medical certainty may be discarded by the next generation of experts or the scientific research would throw a light into corners that are at present dark. Particularly, recent case law has emphasised the importance of taking into account the possibility of an unknown cause. The possibility was articulated by Moses J in *R v Henderson-Butler and Oyediran [2010] EWCA Crim 126* when he said,

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

17. In *B (Children: Uncertain Perpetrator)* [2019] EWCA Civ 575, Jackson LJ clarified the test for identifying the pool of perpetrators. Jackson LJ set his analysis at paragraphs 46 to 49 as follows:

"*Drawing matters together, it can be seen that the concept of a pool of perpetrators seeks to strike a fair balance between the rights of the individual, including those of the child, and the importance of child protection. It is a means of satisfying the attributable threshold condition that only arises where the court is satisfied that there*

has been significant harm arising from (in shorthand) ill-treatment and where the only 'unknown' is which of a number of persons is responsible. So, to state the obvious, the concept of the pool does not arise at all in the normal run of cases where the relevant allegation can be proved to the civil standard against an individual or individuals in the normal way. Nor does it arise where only one person could possibly be responsible. In that event, the allegation is either proved or it is not. There is no room for a finding of fact on the basis of 'real possibility', still less on the basis of suspicion. There is no such thing as a pool of one.

The concept of the pool of perpetrators should therefore, as was said in Lancashire, encroach only to the minimum extent necessary upon the general principles underpinning s.31(2). Centrally, it does not alter the general rule on the burden of proof. Where there are a number of people who might have caused the harm, it is for the local authority to show that in relation to each of them there is a real possibility that they did. No one can be placed into the pool unless that has been shown. This is why it is always misleading to refer to 'exclusion from the pool': see Re S-B at [43]. Approaching matters in that way risks, as Baroness Hale said, reversing the burden of proof.

To guard against that risk, I would suggest that a change of language may be helpful. The court should first consider whether there is a 'list' of people who had the opportunity to cause the injury. It should then consider whether it can identify the actual perpetrator on the balance of probability and should seek, but not strain, to do so: Re D (Children) [2009] EWCA Civ 472 at [12]. Only if it cannot identify the perpetrator to the civil standard of proof should it go on to ask in respect of those on the list: "Is there a likelihood or real possibility that A or B or C was the perpetrator or a perpetrator of the inflicted injuries?" Only if there is should A or B or C be placed into the 'pool'".

18. I have also reminded myself of the recent decision in *Re A (Children) (Pool of Perpetrators)* [2022] EWCA Civ 1348 and in particular the judgment of Lady Justice King. Having considered the use of the word 'strain' by Lord Justice Jackson, Her Ladyship, at paragraph 34 concludes:

"I suggest, therefore, that in future cases judges should no longer direct themselves on the necessity of avoiding "straining to identify a perpetrator". The unvarnished

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

This hearing

19. I have read and considered all the papers in the court bundle, which is 2687 pages long. I have also been provided with a separate bundle of medical research. I have also watched a number of videos and looked at a series of photographs. This hearing has been conducted on a 'hybrid' basis, with all of the professional witnesses appearing remotely, along with the parties. However, both the mother and the father attended in person to give their evidence.

20. The court approved the instruction of four experts. I intend to deal with their written evidence in summary first before considering the totality of the evidence, including their oral evidence, within my analysis and conclusions.

21. Dr Oystein E. Olsen is a Paediatric Radiologist based at Great Ormond Street Hospital and he provided his first report on the 5th September 2022. His executive summary reads as follows;

"1.1 As an experienced paediatric radiologist I have reviewed the available radiological examinations of B from the period 30 June 2022 to 17 July 2022. I have not assessed the brain.

1. *In my view, there is no radiological evidence of any underlying abnormality, including rickets.*

2. *It is my opinion that three fractures are present, on the balance of probabilities:*

1.3.1 Left 4th rib—about 2 weeks to a month old on 30.06.2022; and

1.3.2 Left 5th and 6th ribs—up to about 2 weeks old on 30.06.2022.

1.4 It is my opinion that the fractures resulted from at least two separate applications of excessive force by external agency, and that no fracture has been satisfactorily explained."

22. Dr Olsen lists the imaging results that he was provided with in order to complete his report at para 4.1. Dr Olsen also notes that the treating clinicians, including Dr. J (whose second opinion had been sought), had reached slightly different conclusions as to the presence of possible fractures.

23. Dr J opined that there were 'possible' fractures of the 7th and 8th left ribs. Dr Olsen disagrees and considers that that which can be observed demonstrates 'bulbous front ends.' He goes on,

"I therefore believe the alternative explanation is more likely, namely that infantile ribs display great variability at their metabolically active front ends. I am less certain in respect of the right 5th–7th ribs where the focal expansion is rather striking; but were there fractures, the fractures would have been fairly recent, so I emphasised the absence of healing-signs when concluding there is no fracture on the balance of probabilities. I cannot say where Dr Johnson's 'possible' sits relative to the Court's standard of proof, but I am certain that some expert radiologists would disagree with my conclusion."

24. Dr J also described an 'irregularity' in the right 6th- 8th ribs. However, Dr Olsen formed the view that, although there is a slight variation in the density of those ribs close to their articulation with the spine, no discontinuity is seen, no displacement, no callus, associated soft tissue swelling or hearing. On that basis, he concludes that there are no fractures to those ribs.

25. It is unfortunate that a CT scan was not undertaken of B's chest, as this would have clarified the equivocal appearances of the left and right ribs. But is now too late, and Dr Olsen has rightly considered the questions put to him on the basis of the evidence available.

26. Dr Olsen does not consider that the radiological imaging indicates any signs of bone fragility, but also rightly reminds the court that there is no unequivocal radiological evidence of rickets. He considered whether the bulbous rib ends might represent rachitic abnormality but concludes that he is not able to do so, based on the x-rays of the ribs alone, given that rickets is a disease which affects the whole skeleton. But he cannot exclude early rickets as being present. As commonly accepted by radiological experts, Dr Olsen also concedes that bones may be abnormally fragile without any radiological signs being present.

27. The advance state of healing seen in the 4th rib leads Dr Olsen to conclude that fracture is two weeks older than the others. None of the fractures date back to the birth in his view. The precise degree of force required to cause rib fractures is unknown, but such fractures do not occur spontaneously, and they are not self-inflicted. It is accepted that rib fractures are caused by the compression of the chest or a direct impact. It is generally accepted that the force required must go beyond that used by a reasonable carer in normal handling.

28. Professor Stephen Greene is a Consultant Paediatric Diabetologist and Endocrinologist. He has over forty years' experience in clinical medicine and paediatrics. His first report is also dated the 5th September 2022. He notes that by the time that B was seven weeks of age, her weight had dropped from the 25th centile to below the 0.4th. A bone metabolism screen conducted on the 30th June also showed that B had a Vitamin D deficiency with compensated hyperparathyroidism. Because of this, the mother was also tested and she was also found to be deficient, with a level of 24 nmol/L.

29. Professor Greene concludes that there was not specific cause for B's failure to thrive and is most likely to have been related to poor nutritional intake. He summarises the current view of the Royal College of Paediatrics in relation to fractures in children,

- *Abusive fractures are more common in children less than 18 months of age than in those older than 18 months*
- *Rib fractures in the absence of major trauma, birth injury or underlying bone disease have a high predictive value for abuse*
- *Multiple rib fractures are more commonly abusive than non-abusive*
- *Children with radiographically confirmed rickets have an increased risk of fracture, whereas children with simple Vitamin D deficiency are not at increased risk of fracture*
- *Vitamin D insufficiency is common in young children with fractures but was not more common than in previously studied healthy children. Vitamin D insufficiency was not associated with multiple fractures or diagnosis of child abuse*

In summary, NAI in infants, especially if non-mobile, is a common cause of fractures. In such cases, the significance of abnormal measurement of bone biochemistry markers has been questioned for decades medically and legally. The weight of evidence currently supports the view that occult rib fractures in the absence of specific signs of clinical bone deformity and/or abnormal bone development, as seen classically in rickets, are most likely caused by inappropriate physical force.

30. Overall, Professor Greene concluded in his first report that;

"There are no symptoms or signs of any hormone or metabolic disturbance, other than the Vitamin D insufficiency, which I believe to be secondary to maternal Vitamin D deficiency and poor feeding intake in the neonatal period.

There is no suggestion of any other syndrome or genetic disorder to account for the clinical picture of FTT (failure to thrive) and unexplained fractures."

31. In his conclusion, Professor Greene said,

"On the basis of the radiology reports before me, there is no evidence of clinical rickets as defined by radiological examination. She does have Vitamin D insufficiency with secondary hyperparathyroidism, but normal phosphate and calcium. The radiological reports do not suggest abnormalities in bone density, but there is no measure of the 'bone strength' available in these circumstances. I believe it would be correct to say that, secondary to the low Vitamin D levels in mother and baby, homeostatic measures controlling bone architecture, with likely sub-optimal bone structure. There is no evidence in the literature to suggest that such bones fracture spontaneously, and a force is still required to cause such fractures." However, he went on to say that he was unable to assist the court as to the degree of force required to produce such fractures, either in a healthy baby or a baby who was insufficient in Vitamin D.

32. Professor Greene was asked a number of supplemental questions, which he answered in an addendum report dated the 28th November. Within that report, he considered the conclusions of Dr Ward (of which, more in a moment) and the medical literature to which she had referred. It is fair to say that Professor Greene did not disagree with any of the additional material, but he did comment,

"While only a very small number of cases presenting with fracture in infancy appear to have abnormal bones, it is difficult, however, to non-invasively assess bone strength and fragility. Contributors to bone fragility include abnormal bone architecture, low bone mass, abnormal collagen matrix and altered degree of bone mineralisation; too much mineral and the bone becomes brittle as in osteogenesis imperfecta; too little and the bone is insufficiently stiff to resist bending or compressive forces as in rickets. Conventional x-rays can capture gross architecture - bone size and shape - but are relatively insensitive in assessing bone mass, often regarded as a surrogate for bone strength."

33. However, after consideration of the totality of the evidence, Professor Greene said that, on the balance of probabilities, despite the evidence in B of Vitamin D insufficiency secondary to dietary deficiency, there was no substantial evidence of abnormal bone structure that fits a recognised pattern of disease associated with occult fractures, without the application of inappropriate and unfitting force.

34. When asked about the degree of pain and distress that a child who sustained a rib fracture would be likely to experience, Professor Greene was clear that this can be variable and difficult for a parent to recognise, even with an 'experienced eye.'

35. Dr Ward is a Consultant Paediatrician of many years' experience. She has, as would be expected, undertaken a comprehensive review of the evidence, including the medical records. Of note, are the following entries

- A told Dr. T upon admission to hospital on the1st July that she had first seen a dark patch to the right side of B's jaw at 23.00hrs.
- In a subsequent conversation with Dr H, A said that she had noticed a black circle on B's right jaw and had called 111 for advice. They advised to take B to hospital.
- Dr M, Consultant, reviewed B. She observed an ill defined green area over the right law line measuring 1.5cm by 0.6cm. It was long and did not appear to be circular. A subsequent review with Dr HL confirmed the presence of the bruise.

36. Dr Ward notes that it is common for infants to lose some weight in the early stages of life, but that it normally stops after about three or four days and most infants will have

returned to their birth weight by three weeks of age. B's weight fell well below the 0.4th centile and in doing so, it crossed more than two centiles.

37. The term *"faltering weight"* is now favoured to failure to thrive, in part to avoid parents of those children feeling at fault or criticised. Dr Ward is of the view that B's faltering weight was most likely to be related to the mechanics of breastfeeding and inadequate intake of breast milk. She goes on,

"Maternal vitamin D deficiency, faltering growth likely due to inadequate breast milk intake, exclusive breastfeeding and dark skin were all factors likely to contribute to low vitamin D levels, which in her case were on the threshold between vitamin D insufficiency and vitamin D deficiency."

38. Rickets refers to a failure of mineralisation of growing bone and cartilage and is the principal manifestation of vitamin D deficiency in infants and young people. Depending on the severity, the child may be asymptomatic or have varying degrees of pain and irritability, motor delays and poor growth. Quite properly, Dr Ward defers to Dr Olsen in terms of the radiological signs of rickets.

39. Dr Ward says,

"Although there has been much debate on the issue of vitamin D sufficiency/insufficiency, there is no documented evidence on the force required to cause fractures in children with vitamin D sufficiency/insufficiency. There appears to be no increased risk of fracture unless there are changes of rickets on plain radiographs. It is highly unlikely that rib fractures would occur spontaneously and without force over and above that considered to be reasonable in a child of this age (see below)."

40. B was of an age where one would not expect to see bruise as a result of accidental trauma. Bruising to the face is unusual. Dr Ward cannot identify any underlying medical explanation and concludes that it is most likely that the bruise to B's cheek was caused by squeezing for forceful grasping of the cheek with the thumb on one side and the fingers on the other. One would not necessarily see bruising to both sides of the face in this scenario.

41. Rib fractures are painful at the time of injury, but that upset will resolve relatively quickly, making such fractures difficult to detect clinically. Dr Ward defers to the

radiological evidence that B showed no signs of rickets. In an addendum report, Dr Ward considered that the most likely mechanism for fractures in infants of this age is usually compression, although a forceful impact may occasionally cause a rib fracture.

42. Mr Peter Revington is a Consultant Oral and Maxillofacial Surgeon. The issue to which his evidence relates is the presence of a soft tissue lesion that was observed on the gingiva of the right lower jaw on the 27th July 2022 (after B's removal to foster care). When seen by treating doctors at the time, a provisional diagnosis was reached that the lesion was an Epstein's Pearl, which are common in neo-nates and are caused by collections of keratin beneath the mucosal surface. However, that diagnosis could not be related in any way to the facial bruise that had been observed a month before.

43. The mother has filed three statements and was interviewed by the police once on the 2nd July. She is adamant that she has never harmed her baby, intentionally or otherwise. She loves her daughter and the parenting assessment undertaken of her demonstrates that she is well able to meet all her needs. Despite being a relatively new relationship, A is clear that B was a wanted baby, and that A and C were and are entirely committed to each other.

44. A says that 29th June was an entirely normal day. C left for work at about 11pm, and when she went to feed B, A noticed a dark mark to her cheek that had not been there when she had had her 8pm feed. She 'phoned C, who advised that she call A&E. In fact, A called 111, but she got disconnected, and so she arranged for an uncle to take her and B to hospital. A has wondered whether the bruise might have been caused by the strap on the car seat that B used, but she cannot think of any other incident in which B's face might have been bruised. A is equally clear that she has never injured B's ribs. Nor is she directly aware of any incident in which B might have been accidentally injured.

45. The father was interviewed on the 1st July 2022 and has filed three statements. I note that he was not provided with the assistance of an interpreter for the police interview, whereas he has had an interpreter for these proceedings. The father has said that over the weekend that included the Queen's Jubilee celebrations, the mother had gone to bed early as she was not feeling well. B was in her cot, but the parents had taken one side off, so that the cot could be placed directly next to the bed without impediment.

A was in the other room sleeping when, whilst C was getting something from another room, he heard a noise from the main bedroom and B had rolled onto the carpeted floor. He picked her up immediately. He didn't tell his wife what had happened until after his police interview. He can also recall one occasion when he rolled over onto B's head when he was sleeping. He bathed B before he went to work on the 29th June, and he saw no mark to her.

My assessment of the parents

46. As I have already noted, B was a much loved and wanted baby. A, having arrived from India having suffered the loss of both of her parents within a very short period of time, was somewhat isolated in the UK, although she did have some family on C's side and a few friends. At the time that B was born, C was working two jobs, as a delivery driver at night and then daytimes at a local supermarket. She accepts that this meant that she was on her own with her baby for long periods of time. A also told me that she had some relapse in her C-section pain, and was also spending lots of time trying to encourage her baby to feed. The family did have some days out at the weekend, but life was hard and very tiring.

47. A told me that she had told her close family about her marriage and her pregnancy, but she also accepted that she had told a friend that she had 'mixed emotions' about having a baby, feelings that it is not hard to understand if the circumstances were that A had lost her parents so recently. A also told me that there were complexities related to the fact that she as a Hindu Indian woman was having a baby before marriage to a Pakistani man that led her to be more cautious about who she told her news to.

48. A is a Doctor of Pharmacy. She has two degrees. It is apparent that she might also be classed as a 'worrier' in that her internet searches demonstrate her searching for any number of medical complaints related to both herself and her baby which were highly improbable. It was also apparent from her evidence that she had a very close relationship with her parents, and their absence from her life was something that she continues to feel daily. I think that I am entitled to infer that, had her mother still been alive when B was born, a lot of the advice that she sought from the internet and from friends might have been provided by her own mother.

49. One of the issues that concerned A was that she continued to experience considerable pain in the area of her C-section operation, such that she was thinking about seeking

emergency medical advice in the days before B was admitted.

50. C has been married before, and his ex-wife has made allegations against him that he was abusive towards her and his daughter. In particular, it has been alleged that he slapped his child. Those allegations have never been determined by a court, and they are wholly denied by C. It is not unusual for two adult parties to a relationship to have very different accounts of their relationship, and sometimes serious allegations are made by one against the other, which are not true. I am not persuaded that these were matters to which A should have been more 'interested' or which should have alerted her to potential risk. She has only ever known C to be a caring, thoughtful and hard-working partner.

Analysis

Inappropriate handing

51. The police's investigation of the parents' mobile 'phones has led to the discovery of a number of videos and photos, all of which I have viewed. The majority show B looking like a happy, well-cared for and loved baby, often with A being the person who is both videoing and touching and coo-ing to her baby with obvious affection. But there are a few that are not so endearing.

52. In one particular video, C can be seen behind the wheel of his car, without his seatbelt on (this factor being observable, but also you can hear the warning light continually beeping), with B lain across his lap, completely unrestrained. A is taking the video, and she can be heard laughing and chatting with C. She told me that she had passed B to the father when he collected them from the bus stop, and I was left with no understanding of why she allowed C to drive off. During her evidence, she accepted that she was enjoying the moment with her husband but was critical after the event. Both parents now accept that this was completely unacceptable but there was an air of defensiveness from both of them when making that admission, such that I was left with the impression that they both still struggled to understand why professionals have been so concerned at their behaviour. A said that, in India, where she grew up, this would not be considered to be unusual.

53. As I indicated to A during her evidence, at a point at which she appeared to become irritated at the questioning, this incident demonstrates, at the very least, incredibly

poor decision making by both adults, who preferred to have a 'special moment' for themselves, rather than consider the physical safety of their child. A momentary lapse in C's concentration, even at a relatively slow speed, may have been fatal for so small a baby. This incident placed B at risk of significant harm. It also tells me a great deal about the dynamic between the parents, and A's ability to protect her child.

54. In another video, B is shown lying on the back seat of the car, whilst the vehicle is clearly moving (despite both parents denying this), without any means of restraint, save that her mother is sitting next to her and has her hand on her chest. Again, this behaviour was irresponsible and dangerous. Both of these videos show handling that falls below that to be expected of a reasonable parent.

55. Reliance is also placed on some of the photographs that have been extracted. In three particular photos, C is shown holding A (who is tiny) up on the roof of the car (which is parked). He told me in evidence that he was very proud, not only of his daughter, but the fact that he had just purchased the car, and he is the first in his family ever to do this. I infer from his evidence that the photo was intended to show his pride in how far his life had come. I would note that although these photos have a slightly bizarre feel to them, I am not persuaded that they show C holding B in a way that was deliberately harmful or neglectful. There is also a photo in which the father is placing his thumbs in the middle of B's cheeks, in which he says that he is rubbing her cheeks. It doesn't look very comfortable. All of the 'concerning' photos relied upon by the local authority have an air of carelessness about them but I am not persuaded that they demonstrate parenting that falls below that expected of a reasonable parent. But they do tell me a little about the 'kind' of parent the father was.

56. On the night at about the time of the Queen's Jubilee (2/3/4/June), the father has said that he was responsible for caring for B, as A was feeling very unwell. A told me that she was really poorly, with the 'chills'. Despite the fact that she was breast-feeding her baby, she told me that she was so poorly that she took the decision to 'miss' a feed and allow C to offer expressed milk to B whilst she had a rest in the spare room. C told me that he went to bed and went to sleep.

57. A's written evidence was that she knew nothing at all about any incident having occurred that night until after they had both been interviewed by the police, when her husband told her that B had fallen from the bed whilst in his care. Her statement said,

"B slept in a cot next to our bed and there are no railings on one side of the cot so it could be attached to our bed. I was in a bed in the spare room asleep when this happened. I wasn't very well. I had chills and a fever and so C was completing the night feeds and bottle feeding B to help me rest and get better. C told me that B did not cry out when this happened and she didn't seem like she was in pain or hurt. It didn't wake me up and I think that it would have done if she had cried out, even though I was in a different room." In fact, she goes on to agree with her husband that, had she known about this incident at the time, she would have 'panicked.'

58. She was explicit in this statement that she did not even hear B cry out. However, during cross-examination, she told me that, in fact, she had heard B cry out, and was able to describe this as a 'normal' cry. She asked her husband what was going on and he said that there was nothing to be worried about. She continued to tell me that she knew nothing about B having fallen until later on. She seemed somewhat 'detached' when asked her feelings about having been misled by her husband.

59. The mother's oral account to me was more in keeping with the written evidence of the father. In his first statement, he says,

"7. I then went to my wife and tried to get her to eat something. The door to the room my wife is in is next to the door to the main bedroom where B was, at right angles to each other so if I stand facing the door to the room my wife was in, the door to the main bedroom is directly to my right. I heard a noise from the main bedroom and turned around and saw that B had rolled out of her cot and landed on the carpeted floor.

8. I immediately went to her and picked her up, comforted her and then put her back in the cot.

9. My wife asked "what is happening" but I just said B was hungry because I did not want her to worry as she was poorly and I could manage. B cried for a moment but settled when I picked her up and was not distressed or hurt, as far as I could see. I didn't tell my wife about this until about 1 or 2 days after the police interview."

60. However, in his oral evidence, there was a different account again from C. In fact, I found the father's oral evidence in relation to that evening almost incomprehensible, and the impression I formed was that he was 'making it up as he went along.'

61. I do accept that there is a video which appears to show that B was able to roll very early on in her development, and Dr Ward was happy to accept that it is possible for very young babies to develop this skill. So, there is no mechanical reason that the account of the fall could not be true. But I am sure that it is not.

62. As I have already said, the incident in which B lay on her father's lap was nothing short of dangerous. But they also provide me valuable information about the way in which these two adults related to each other and behave as parents. My impression of the mother is that she was willing to allow the father to handle B in a way that she may have known he should not, or at least, with hindsight can see he should not, because of her love for him and her desire for them to be the family that she has always wanted. She was pleased and proud that her partner was taking such 'pleasure' in their daughter. As a consequence, she has found it very difficult to be critical of him, and there continued to be an element of her evidence that struggled to accept that the father's behaviour was poor. For example, both of the parents tried to tell me that there was something about the mother's tone of voice during the 'car' video that indicated that she was disapproving, but that is not what the video shows. The mother is laughing and nothing about her tone is remotely critical. They have subsequently felt the need to say that they reflected on their actions, because that is what is expected of them. But it was not true at the time.

63. Equally, whilst the other photos and the videos may not demonstrate neglectful or harmful parenting in themselves, they do show that the father was careless with his daughter, and was capable of acting in ways that were focused on meeting his own needs (for a cuddle, to show off his car) without thinking through the consequences of his actions for B. The mother had done nothing to intervene. She was the photographer.

64. I am in no doubt at all that both parents are lying to me about the events of the Queen's Jubilee. A is an incredibly attentive mother, who was worried about her child's feeding, such that she told me that it was on her mind all of the time. She has been determined to be able to feed her herself. She is a worrier and she panics, that much is clearly true. A told me that her husband had never fed their daughter unsupervised (by her) before the night that she was poorly. In truth, B had barely had a bottle feed. Throughout her daughter's short life, the mother has always engaged well with medical professionals, and I have formed the view of her that she has been

honest when asked questions about her health and development. She was horrified when she was told that her baby had rib fractures by hospital staff. It is inconceivable to my mind that, once A was told about the injuries, and she had been aware that there had been an occasion that B had fallen off a bed, A would not have told the doctors about it immediately. But more than that, had she heard her baby cry out on the night in question, as she would have done had she fallen from a bed, this is a mother who would have jumped out of bed, no matter how ill she was feeling.

65. Equally unbelievable is the evidence of C, when he asks me to accept that, knowing that his daughter had fallen, and knowing that she had fractured ribs, he did not think to tell the staff at the hospital about it. The first time that this 'fall' is ever mentioned by anyone, is at the start of the father's police interview, in a pre-prepared statement in which he said,

"Some time after the Queen's Jubilee I understand that the baby had rolled from the cot and fell on the carpet in the bedroom. I immediately checked the baby and she seemed fine and calmed down. This is the only time she fell."

66. C made no mention of his wife being ill in this account. In the account given to the court which I set out above, he makes no reference to feeding his baby, despite accepting in oral evidence that it was a significant feed. He also told me in evidence that B had been somewhat 'troublesome' during that feed, trying to fall asleep, and 'fretting.' That much would be expected of a child who was so used to being fed at the breast by her mother.

67. I do not accept that A was aware of B suffering from a fall on a night around the time of the Queens Jubilee. She did not know that C was going to recount such an event in his police interview until after the interview had taken place. But she has subsequently presented her husband's account as being truthful when she knows that it is not. I am afraid that I have formed the view that whatever went on over the weekend of the Queen's Jubilee, both A and C are lying about it.

68. I must now go on to consider the relevance of that lie in terms of the central issue that I must determine.

69. Firstly, I must determine what relevance the fact that B was diagnosed as being Vitamin D insufficient has to the probable cause of her fracture, that her mother was

the same, and that A had also suffered with gestational diabetes. What might have been the effect on the structure of her bones, their strength and their propensity to fracture? These are complex questions that have been the subject of medical and legal debate for many years and in many cases. Dr Ward, Dr Olsen and Professor Greene provided me with a number of research studies in order to demonstrate the extent of the medico-legal debate. All of them sought to give me as much assistance as possible, but all acknowledged certain unknowns that underlie what conclusions they are able to reach.

70. No-one knows through experimentation the precise level of force it takes to break the rib of a six-week-old baby, for obvious ethical reasons. However, it is possible to extrapolate from the fact that rib fractures are not sustained through everyday activity and handling, something outwith the usual must have occurred. We do know that lots of those children have chest x-rays (for example in relation to breathing difficulties) and no fractures are seen.

71. However, Professor Greene also reminded me that there is no available data on the mechanical function of the bones of children who suffer from a Vitamin D deficiency or insufficiency. Professor Greene was prepared to accept that this uncertainty extends to whether, in respect of bones to which there is an underlying mechanism which may affect their viability, there was an associated greater risk of fracture. Again, what we do know is that there are vast numbers of children in the UK who are low in Vitamin D, and those children are not presenting with fractures, either through unknown cause or reduced levels of force having been applied. Professor Greene (having considered the research) told me that he did not consider that there is a proven relationship between an increased risk of fracture and vitamin D insufficiency/deficiency. That was the case even if one included the possible impact of A's gestational diabetes.

72. There is simply no data on the impact of low levels of Vitamin D on bone strength or the force required to break a bone. Professor Greene was prepared to say that there is an inevitable range as described in the arrow below (my creation).

73. At either end of the range, there is a greater degree of medical certainty. Children with entirely normal bone structure require a significant force to be applied to their chest in order to fracture a bone. Children with observable rickets on an x-ray can and do sustain fractures of their bones without a significant force having been applied.

74. In the middle of that range, there will be children who have a Vitamin D deficiency, whose bone density cannot be observed by x-ray (Dr Olsen and Professor Greene both being in complete agreement that x-rays are not sensitive to changes in bone density until they become significant), but whose bone density is 'suboptimal,' who have a degree of poor bone growth that might have an impact on the degree of force, but that impact is wholly speculative. B's 'suboptimal bone structure' put her somewhere on that line, but it is not possible to say where she was, or to directly infer from that suboptimal bone structure that it there was a resulting impact upon her bone strength or her propensity to fracture. It would be right to conclude that the fact that her mother was similarly deficient, combined with her being breast fed, and her poor feeding up until her admission to hospital, are likely to indicate that she was becoming more insufficient as time went on.

75. Professor Greene left this valuable and detailed discussion with this conclusion. That, in his clear view, a force that one would not expect to see in normal handling is most likely to have been applied to B's ribs, even in the context of her Vitamin D insufficiency.

76. Dr Ward agreed with this analysis and reminded me that the group of children who appear in the middle of that arrow is very large indeed (where B is), and that very many children in the UK today will have insufficient Vitamin D, and yet rib fractures are still very rare. We simply do not know at what stage bones become more susceptible to fracture, save from the knowledge that we gain from our day to day experience. It is also accepted medical opinion that the bones of children have a degree of elasticity which is not present once a child is fully grown. Everyday accidental falls do not cause rib fractures. Serious RTAs can. And fractures in a child of this age are very rare, whatever the cause.

77. It will be apparent from this discussion that despite being asked extensive questions on the subject, none of the experts, in fact, diverted from their original conclusions, which Dr Ward set out with admirable clarity in her report as follows,

"Prof Greene referred to the limited evidence from studies and case reports and consensus from expert groups which lacks absolute clarity, though he referred to a global consensus on rickets in 2016 which concluded that fractures only occurred in those who were mobile and had severe radiographic evidence of rickets. They suggested that simple vitamin D deficiency without radiological or biochemical signs of rickets has not been associated with increased fracture risk in infants and children. The radiological opinion has not changed i.e. no radiological evidence of rickets, and biochemical changes of insufficient 25OH vitamin D with mild elevation of PTH and alkaline phosphatase was modest has not changed. I have not seen further opinion from Prof Greene. B was not mobile in terms of crawling, cruising or walking. The statement of Dr H simply repeats information from the records. Therefore I would not wish to change my opinion that although there was a potential risk of bone fragility associated with vitamin D insufficiency, there is no confirmed radiological evidence of rickets which would predispose to fractures. One cannot be more specific in relation to risk of fractures on the basis of current research."

78. I accept the opinion of all three experts that a force must have been applied to B's ribs in order for them to fracture, and I accept Dr Olsen's clear view that the appearance of the 4th rib (in terms of the stage of healing that could be observed) was different to that observed in relation to the 5th and 6th. Therefore, I am entitled to conclude that there have been two incidents during which inappropriate force has been applied to B's ribs. That force was sufficient to characterise it as being outside of normal handling (which does not cause rib fractures), and it would be obvious to an observer that the handing was inappropriate.

79. Dr Ward was equally clear in her view that the bruise seen to B's cheek was as a result of inappropriate handling, there being no evidence that B had a tendency to bruise. She did not consider that it was probable that the cheek being rubbed against the strap of the car seat was the cause. The presence of the small lump inside her mouth has no relevance at all to the causation of the bruise.

80. As I have already set out, everything that I have come to know about the parents from the evidence indicates that A is an attentive, warm and caring mother. She showed remarkable determination in her desire to feed B herself, and she dedicated herself to the care of her child, with very little else in her life at that time. I also accept her evidence that she first observed the bruise to B's face at about 11pm, when she fed B.

The bruise had not been visible to her before or immediately after C had bathed her that night. A immediately sought medical attention for her daughter, and I do not accept the father's evidence that she sought his consent before she did so. It is improbable in my view that A would have taken her child to hospital in the way that she did if she had any suspicion that the bruise had been deliberately inflicted or her child had previously sustained rib fractures.

81. The father's evidence was implausible. He answered every question put to him with complete confidence, but seemingly without any appreciation of the inconsistencies in his account. He spoke with a high degree of confidence and did not accept that any of his parenting could have been better, even when challenged about the car video. He is invested in this relationship, having already 'lost' his relationship with his older child. It is my clear determination that A did, indeed, go to bed because she was unwell on an evening around the Queens Jubilee. I consider that it is most probable that the father struggled to feed B and that he was too rough with her and broke her 4th rib. It is highly probable that he squeezed her chest too hard. I also find that there was another incident in which the father similarly broke B's 5th and 6th ribs in a similar way. I consider that it is most probable that C bruised B's face by a poke or a prod when he was bathing her on the night of the 29th June.

82. I am afraid that, despite all of the positive things that I have been able to say about the mother as a parent, she has lied about what she knows, in an effort to protect her husband and to conceal the truth about how B's ribs were broken. I accept that she would not have known about the bruise being caused, but she would have heard B cry out in an unusual and painful way on two occasions, when B was in the hands of her father, and she has concealed those from professionals and from the court. Whilst she has, quite properly, sought to explore whether B suffered from any underlying medical issues that were relevant to the causation of her fractures, by the time she gave her own evidence, she knew that this was unlikely, and she failed to tell the court the truth.

<u>Failure to take sleeping advice</u>

83. A told me that she and the father would always put B to sleep on her back, but she would prefer to roll slightly onto her side, with her arm above her head. She told me that she never put B to bed in any other way than on her back.

84. The local authority has sought to rely on an observation from a video which shows B being put to bed on her front, and not with her feet at the bottom of the bed. There are also videos of B in the middle of the cot rather than at the foot.

85. The parents assembled B's cot (which had four sides) in a way that left one side open, in the manner of a 'next to me' cot, although because not specifically designed, their cot did not have straps or any other means of attaching the cot to the parents' bed to avoid it becoming separated, posing the obvious risk of the child falling out. Of course, that is exactly what the father says happened on the night of the Jubilee, if that is a truthful account. But I accept the mother's evidence that, at all other times, she ensured that the cot was pushed up against her own bed whenever B was in it to go to sleep.

86. I accept the mother's evidence that she had been advised about safe sleeping, and the risks of SIDS and that she applied it to the extent that she would put B to sleep on her back. I also accept that foot to feet is only significant in the event that a baby is sleeping underneath a blanket, which is tucked into the side of the cot, whereas B was being swaddled. I am not persuaded that there is evidence that the parents wilfully failed to accept sleeping advice.

87. I remind myself that society must accept diverse and varying standards of parenting. Some parents will read every book available to them in relation to the care of their child, seek professional support and advice on every issue and implement every bit. Some parents will never allow their child a sweet (or refined sugar), whilst others may not place strict limits. The parents would have been cautioned against using a cot without a side had the health visitor seen it, but it was not neglectful in and of itself, given the age of B and the way in which I accept that the mother arranged the room.

<u>Failure to take feeding advice</u>

88. On the 9th May 2022, B was being mixed fed by breast and bottle, as A told me that B was really struggling to latch on. By the next day, at the initial midwife visit, A reported that B was feeding well. By the 20th May, the midwife referred B to A&E due to the lack of weight gain. The parents attended a review with Ms. W, specialist feeding advisor. The notes read,

> Attended with both parents. Reported to be very difficult to latch onto the breast initially.

> Lots of pushing against the breast and getting upset, which mum said could be typical. Advice given on how to position and latch her correctly as parents were pushing B onto the breast from the back of her head, and not allowing for a backwards head tilt. Once she was fixed, she fed really well – all signs of active and effective feeding seen – chin deep in breast tissue, strong jaw movements, rhythmic suck/swallow patterns and content at the breast. No obvious problems seen. However, when discussing feeding patterns with parents, they reported that she could go up to four hours in the day without a feed and overnight they allowed her to sleep, and she could sleep up to five or more hours without a feed. Advised that the problem was not with the latch but with the fact that she was not being fed often enough – advised to feed three hourly as a minimum even if it meant waking her and encouraging more feeds at night due to prolactin levels. Explained that more frequent feeding would not only help with weight gain but also relieve mum's engorgement and, in turn, make latching on easier. Reassurance offered that she did not have to feed from both breasts but to always offer the second one just in case. A member of the midwife community team was to reweigh in 48 hours.

89. Unfortunately, the court was not able to hear directly from Ms W, due to her own personal circumstance meaning that she was unable to attend court to give evidence. Without doubt, she would have been able to offer valuable evidence in relation to the specific advice that the mother was being given, and her view as to the mother's willingness to accept that advice.

90. The mother accepted that she took from this meeting that she should try to cluster feed and at a minimum level of every three hours, so that she produced more milk. From that time onwards, A told me that she would breast feed B, would then offer the other breast. A then said that she would also offer her a 'top up' feed of expressed milk when she had produced using a breast pump. She kept a log for her own purposes. A was clear that her 'main intention' was always to fully breast feed her baby, and it was obvious from her evidence that she regarded this advice as 'temporary' whilst she got into a routine that suited her and B.

91. By the 25th May, B was slowly increasing in weight, but was still 9% below her birth weight. She was advised to continue to feed every two to three hours and to express

breast milk with which to top up.

92. During this time, the feeding team were messaging and video calling the mother in order to check on her progress. On the 30th May, Mother's friend called WP messaged the mother, and mother reported to be 'exclusive breastfeeding' and then went on to say that *"I have started feeding her properly from last Friday."*

93. A told me that between the appointment on the 25th May and the 20th June (B's six week check with the GP) she was expressing and offering top up milk. From the point of the GP consultation, she felt that her milk production was good enough and so she stopped expressing or topping up in any way.

94. A spoke to a friend via text message about being 'tortured' by midwives, but she explained to me that she felt overwhelmed by the different advice that she was receiving, including from her friends. She did not like using the breast pump, although she was very clear in her evidence that she had used it.

95. Dr Ward was asked the opinion about B's failure to thrive. It was clear that in the absence of an organic cause, the reality was that B was not intaking sufficient calories.

96. RY, health visitor told me that, from her perspective, there was nothing in the notes that would suggest that the mother was not receptive of, and accepting the feeding advice given. But the fact that B immediately put on weight once admitted to hospital might suggest that she was not. But of course, she was also switched to bottle feeding at that same point.

97. Dr Ward has years and years of experience behind her. My impression of her evidence was that she was sympathetic to the position of the mother, particularly, and that it was obvious that she was encouraged throughout those first few weeks to persevere with breastfeeding, despite the faltering growth. Dr Ward told me that advice given to parents can be conflicting

98. A has accepted that she scoured the internet for parenting advice but would also search for things about which she had no reason to believe were relevant to her baby. But those searches do indicate that A was incredibly concerned for B, was acutely aware that feeding was difficult, and that she wanted to do everything that she could to help her. A told me in evidence that the 'feeding issue' was always on her mind.

99. I entirely accept that there are emotional and physical complexities related to being a first-time mum, desperately wanting to breastfeed, and receiving conflicting advice as to the 'best' way to go about it. It was obvious from the mother's evidence that she did not want to use formula feed, which she believed increased the chances of B being sick, and that she was determined to breast feed. It was also apparent that she did not enjoy using the breast pump and stopped using it as soon as she could. By the time that she did that, B was gaining weight, although not very quickly. Lots of mothers persevere with breast feeding through thick and thin because they want to do the best that they can for their baby. Feeding a child must involve a degree of personal choice, and I am not persuaded that the care provided by the parents (and specifically the mother) fell below that of a reasonable parent. Had the medical professionals strongly advised bottle feeding, stopping breast-feeding or using formula at certain times, and the parents had objected, they may well have been criticised. But that was not the case in relation to B.

100. That is my judgment.