Neutral Citation No [2013] NICty 6

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Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

Delivered: **04/09/2013**

In the Family Care Centre sitting at Belfast

In the matter of H

<u>Her Honour Judge P Smyth</u>

1. Nothing should be published which would identify the child, or any member of her extended Family.

<u>Introduction</u>

2. This is an application for a care order in respect of H, now aged 2 years and 5 months. On the 18th July 2012, H was admitted to hospital with the following injuries:

    - Acute spiral fracture of the left lower humerus (upper arm)
    - Healing fractures of the lower left ulna and radius (forearm)
    - Swelling to the left arm

    In addition, the child had bruising over the anterior aspect of her left arm which when examined on the 19th July included:

    - 5x3cm bruise which was tender, yellow, and brown in colour over the anterior aspect of her lower arm, just above the upper elbow.
    - 2x2cm yellow/brown bruise, non tender, over the anterior aspect of the arm, just below the elbow
    - 0.7x0.5cm yellow/brown bruise, non tender, over the anterior aspect of the forearm
    - 0.6x1cm yellow/brown bruise, over the elbow, non tender

3. The issues to be determined are:

    (1) Whether the injuries, or any of them, are accidental or non-accidental

    (2) If non accidental, the time frame within which the injuries, or any of them, are likely to have been inflicted

    (3) The perpetrator or pool of possible perpetrators

<u>The Medical Evidence</u>

4. The court heard medical evidence from Dr Evans and Dr Mackin, Consultant Paediatricians, Dr Sprigg, Consultant Paediatric radiologist, and Mr Cosgrove, Consultant Paediatric Orthopaedic Surgeon.

5. When x-ray examination revealed the fractures on the 28th July 2012, three members of staff independently took a history from the mother. Whilst she could not explain how the injuries had been caused, she gave a history of the child having fallen during contact with her father on the 15th July. The parents were separated and the mother was involved in a new relationship with Mr X. In addition, she suggested that a road traffic accident, in which she and the child had been involved on the 28th May 2012, may have been the cause.

6. The following day, Dr Mackin examined the child and spoke with the mother. He recorded, that the mother '*took H to hospital yesterday, because she was not using arm as much as normal. She says this dates back to last Sunday (8/7/12). She reported that H was with her father for a few hours that afternoon. When he returned her, he told Mum that H had had a minor fall. Mum thinks this was on a wooden floor. Mum said that when child was put into car seat on that day (8/7/12) she seemed a little upset, but nothing much. Over the next few days, she did not move her arm as much and winced a little when being changed, but mum did not think it was very much, and did not seek medical attention. Mum says she noticed bruises on L arm, three to four days after documented fall. She says these are now fading.*'

7. Dr Mackin gave evidence that he had checked the record from the previous evening with the nurse who confirmed that the mother had stated that contact with the father had occurred '4/7' 4 days ago, which was the 15th July. Dr Mackin was concerned about the inconsistency in the dates and said that in a case of suspected non-accidental injury, alarm bells began to ring. In evidence the mother insisted that she had always stated that the fall occurred on the 8th July and that the information recorded by other members of staff was

inaccurate. Dr Mackin said that his initial view was that such a minor fall as described by the mother would not afford an adequate explanation for the serious fracture of the humerus or the fractures to the ulna and radius.

8. The x-rays taken on the 18th July revealed no evidence of healing of the humerus, although there was clear evidence of healing of the ulna and radius. Dr Mackin concluded that the injuries were sustained on different occasions.

9. Dr Mackin described the fracture to the humerus as 'spiral in nature' and said that it is an unusual and very serious injury. The likely mechanism is 'twisting' of the arm with the application of considerable force. At the time of examination the child's arm had already been placed in plaster, and he removed it in order to observe the bruising which had been recorded in the admission notes. Dr Mackin observed bruising above and below the elbow in a pattern which he said fitted the fingers on his hand. He was questioned about the possibility of the bruising being related to the fracture itself which is known as 'tracking bruising'. In his view, tracking bruising would most likely be seen at the actual fracture site. He considered that the bruising was most likely caused by fingers which suggested a twisting of the elbow. He agreed that bruising is very difficult to date. Dr Mackin said that he had not been given an explanation that justified a conclusion that these injuries were caused accidentally.

10. Dr Mackin also described the child's demeanour. Whilst she was calm initially, she became very distressed once the plaster was removed. He explained that this is because the immobilisation of the fracture by way of cast acts as an analgesic. The fracture would have caused this child extreme pain. She would have held her arm in close to the body to protect it because any movement would have intensified the pain. Such an injury would easily be noticed by a parent caring for a child.

11. In terms of the timing of the fracture of the humerus Dr Mackin concluded from the absence of any evidence of healing on the x-ray, that the injury had occurred less than 7-10 days earlier. However, the extensive swelling that was observed upon admission suggested that the injury was in fact more recent than that. He dated the humeral fracture as having occurred no more than a few days before admission to hospital.

12. In respect of the fractures to the ulna and the radius, Dr Mackin explained that this is a more common type of injury. However, it is not common in children of H's age. This is because the injury is typically caused by putting ones hands out to break a fall, but children of H's stage of development do

not do so. It is more usual for children of this age to land on their head or bottom.

13. It was clear from the x-ray, that these fractures were in a very advanced stage of healing and he dated those fractures as having occurred within the previous 2-4 weeks. In his view, the fracture of the ulna and radius would also have caused pain, although, to a lesser extent than the humeral fracture. There may have been some bruising and swelling and a carer should have noticed that something was wrong, even if a fracture wasn't suspected. Whilst a child could be momentarily distracted if such a fracture occurred, there would be on going pain which would have been exacerbated by movement.

14. Since the mother suggested that the injuries could have been caused by a road traffic accident that had occurred in May, Dr Mackin checked the clinical notes from that attendance at hospital. He said there was no indication of a significant degree of trauma or significant injury recorded. In any event, he considered that the x-rays on 18th July were not consistent with a humeral fracture that had occurred two months previously. Taking into account the lack of healing evidence from the x-rays, the extensive swelling and general presentation at hospital, Dr Mackin concluded that the injury had occurred no more than a few days before admission. This was outside the timeframe in which the father last had contact with H, which it is accepted was 8th July and not 15th July.

15. Dr Evans, retired Consultant Paediatrician confirmed Dr Mackin's evidence. He agreed that the nature of the humeral fracture, along with the child's clinical presentation and lack of adequate explanation, suggested a non-accidental injury. He described the significant force required to fracture the humeral bone in a child of this age, and the twisting mechanism which he considered to be the most likely cause of the injury.

16. Dr Evans was shown a photograph of the child sitting happily on a swing which was taken on the 12th July. He confirmed that the child certainly did not have a fractured humerus at that time judging by her demeanour and the presentation of both arms. He discounted any suggestion that the child could have had such a fracture without her carer being aware of it. Any movement of the arm would have caused intense pain and distress.

17. It was put to Dr Evans that the maternal grandmother had cared for the child on the 14th July, overnight until the 15th July. She had described how the child had played with beads, lifting them over her head. Dr Evans confirmed that a child with a fractured humerus could not have moved her arms in that

way. Judging from the child's clinical presentation and in particular the extensive swelling that was noted, in his view the injury was sustained not more than a few days prior to admission to hospital.

18. In relation to the fractures of the ulna and radius, Dr Evans agreed with Dr Mackin that while this is a more common type of injury, it is not common in children of H's age for the developmental reasons he had stated. Whilst he could not rule out an accidental cause for this injury, he considered that even without the fractured humerus, the fractured ulna and radius was suspicious of a non-accidental injury, because the child's carer ought to have noticed that she was in discomfort. Movement of the arm during washing or dressing would cause sufficient distress to justify medical evidence being sought.

19. Mr Cosgrove, Consultant Paediatric Orthopaedic Surgeon, agreed with Dr Mackin and Dr Evans, that the road traffic accident on the 28th May could not be related to any of the fractures because they would have healed within that period. Mr Cosgrove described the humeral fracture as an 'oblique fracture' rather than 'spiral'. He agreed that undue force would be necessary and that if it was not caused by a person, the required mechanism would involve a history of the arm becoming trapped in some way, and the child's body weight being placed upon it. He noted that no such explanation had been given in this case. Mr Cosgrove confirmed that it was not until the 25th July that any evidence of healing of the humerus could be seen on the x-rays, and by the 9th August the fractures were healing quite well. He agreed with Dr Mackin and Dr Evans that the humeral fracture most likely occurred within a few days preceding the child's admission to hospital. He described as 'unlikely' any suggestion by the mother that bruising on the 11th July was attributable to the humeral fracture.

20. Dr Sprigg, Consultant Paediatric Radiologist prepared a report in which he suggested a much wider time frame for the humeral fracture than either Dr Mackin or Dr Evans. He based his timings on the follow up x-rays taken on the 25th July, 7 days post presentation. He described early healing bone formation at the fracture site which he considered was consistent with dating at least 10 days old. He opined that 'the callus formation was more mature than 10 days and [was] about 2-3 weeks old.' The significance of this time frame is that it would include the 8th July, the last date the father had contact with the child.

21. However, in the course of an expert's meeting with Mr Cosgrove, Dr Sprigg revised his opinion. In evidence he explained that the x-rays taken on the 18th July revealed no healing reaction. Therefore, based on the child's age,

he would date the humeral fraction as having occurred sometime within the previous 10-14 days. Dr Sprigg said that as a radiologist his timings were based on the x-rays alone. However, he agreed that it was also relevant to take into account the clinical history, the accounts given by the parents etc. in order to make a proper determination. Having considered the photograph of the child taken on the 12th July and the maternal grandmother's evidence that the child exhibited no sign of injury on the 14th/15th July, Dr Sprigg agreed that if a humeral fracture had been present at that time, he would expect an independent observer to see that the child was in pain, even if she was receiving doses of Calpol to relieve symptoms of teething.

Evidence of the Parents

22. At the conclusion of the medical evidence, the trust submitted threshold facts could not be established against the father. In those circumstances the father was not called to give evidence. The mother gave evidence that she was unsure how the injuries had been caused. She described a history of the child having fallen whilst having contact with her father on a number of occasions including the 8th July when contact last took place. The father agreed that the child had a minor fall from a toy car on that date. She also raised the possibility of the road traffic accident which had occurred on the 28th May. She said she had asked her sister to take H to hospital for a check-up after the collision. Whilst no injury was detected, she said the child appeared to have a sore left arm and leg for a few days. In her statement of evidence, the mother pointed out that H had not been x-rayed on that occasion. She also said that a number of extended family members had been caring for the child during the relevant period.

23. The mother denied that her partner Mr X, with whom she has been in a relationship since March 2012 was ever left unattended with H, or that he took any part in her daily care.

24. The mother described in detail the events of the 8th July when the father returned H to her after contact. She said H was crying and 'stiffened' when she placed her into the car seat which was unusual. She said the father told her that H had had a 'wee fall'. She said H was 'tired and cranky, almost drooping in nature and lacking energy'. She said H was reluctant to go to bed which was unusual.

25. The mother said that on the 9th July H's face 'slightly winced' when her left arm was being put into her t-shirt, as though she was uncomfortable. She

said she was concerned and attributed this to the fall the previous day. The child was receiving regular doses of Calpol at this time because she was teething. When this account was put to Dr Evans, he observed that if H had had a fractured humerus, she would not have 'winced' - she would have 'screamed'.

26. On 10th July, the mother described the child as being in good form. On 11th July, the mother said she first noticed some bruising on H's arm but she was using it normally. This pattern continued until 17th July, when the mother began to notice "a slight deterioration" in H's arm movements. She occasionally rested her arm and "held her left hand in her right and at times began fiddling with it". She was, however, using her arm normally and was not upset or distressed in any way.

27. The mother said that throughout the course of the 18th July, she noticed a 'definite deterioration in H's arm movements, although she was not upset or crying.' She decided to 'get her checked out' to put her mind at rest.

28. It was put to the mother that she has a history of telling lies and concealing the truth. The mother agreed that she had initially told the father that he was H's biological parent, but later told him that she was mistaken and deliberately falsified evidence of DNA results to prove the point. The mother described in detail to the court how she had altered the document which revealed H's true parentage. The mother had been cohabiting with another man when H was conceived. She had informed him that he was H's father and had put his name on H's birth certificate although she knew this was untrue. When the mother subsequently decided that she wished to have a relationship with H's father, new DNA tests were carried out which confirmed the position.

29. The court also heard evidence from the maternal grandmother and the mother's partner Mr X. The maternal grandmother confirmed that while she observed bruising on the child on the evening of the 14th July when she was caring for her, she observed no sign of injury. She also described the child playing with beads and raising her hands above her head.

30. Mr X's account was that he had first noticed that the child was injured on the 9th July, when the mother said that H had a very sore arm. He said she was holding her arm, although he had not examined it. On the 13th July, he said that bruises appeared on her arm and the arm did not appear to be getting any better. On the 18th July, the mother said that she was taking the child to the hospital because the arm was 'getting no better'. He denied

causing the child's injuries and maintained that the problem started on the 8th July when the father last had contact.

The Law

31. In accordance with Article 50 of the Children (NI) Order 1995, it is open to the court to make a care order only if satisfied of two matters. The first is that H is suffering, or is likely to suffer significant harm. The second is that the harm, or likelihood of harm, is attributable to the care given to the child, or likely to be given, if the order were not made, such care not being what it would be reasonable to expect a parent to give to the child. This constitutes the statutory threshold for intervention by the court. This must be considered in the context of the "threshold criteria" in this particular case. If satisfied that the statutory threshold is met, the court will then consider whether it is appropriate to make an order, giving effect to the welfare and non-intervention principles enshrined in Article 3 of the 1995 Order. In making its determination, the court must be alert to its duty as a public authority under section 6 of the Human Rights Act 1998 and, in this context, the right to family life, guaranteed by Article 8 ECHR. At the heart of the legislation is a determination of what is in the child's best interests, which must be the court's paramount consideration.

32. I have taken into account the following authorities relating to medical evidence in non-accidental injury cases; Re M (children) (fact finding hearing: injuries to skull) [2012] EWCA Civ 1710 and Re R (a child) [2011] EWHC 1715 (Fam). These cases are, however, fact-specific and merely serve to emphasise the importance of correctly analysing the expert medical evidence before reaching findings of fact. I have also taken into account the observation of Dame Elizabeth Butler-Sloss in Re T [2004] EWCA Civ 558 that "*evidence cannot be evaluated and assessed in separate compartments. A Judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the*

conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof ".

33. I have also taken into account Re J (Children) [2012] EWCA Civ 380 which concerned the approach to be taken to "possible perpetrators". At paragraph 18 LJ McFarlane said:

> "18. *Where a court is in the position…..of finding that significant harm has been occasioned to a child, but being unable to identify on the balance of probabilities which of a number of individuals perpetrated the harm, the most the court can do is to identify a pool of possible perpetrators. As will be seen, the case law establishes that an individual will be considered as a "possible perpetrator" where the evidence establishes that there is "a real possibility" that that is indeed the case. As the concept of the "pool of possible perpetrators "only arises where the evidence is insufficient to identify one or other possible perpetrator as being "the" perpetrator on the balance of probabilities, a name goes into the pool of possible perpetrators only where the evidence falls short of the balance of probabilities but is sufficient to establish "a real possibility " that a particular individual caused a particular injury."*

34. LJ McFarlane also referred to the judgment of the Supreme Court in Re S-B (Children) (care Proceedings: Standard of Proof) [2009] UKSC 17; [2010]1 AC 678 which confirmed that the simple balance of probability test, following the House of Lords decision in RE B (Children) (Care Proceedings: Standard of Proof) [2008] UKHL 35 should be applied in finding that a person was the perpetrator of an injury. The Supreme Court also confirmed in Re S-B that where the evidence falls short of that standard, an individual will be found to be *a possible* perpetrator if the evidence establishes "a real possibility" that they caused the injury.

35. Baroness Hale, giving the judgment of the Court in Re S-B identified the case as being:

> "…about the proper approach to deciding who has been responsible for harming a child in proceedings taken to protect that child, and others in the family, from harm. It raises profound issues: on the one hand, children need to be protected from harm; but on the other hand, both they and their families need to be protected from the injustice and potential damage to their whole futures done by removing children

from a parent who is not, in fact, responsible for causing any harm at all." (paragraph 2)

Conclusion

36*. Were the injuries, or any of them accidental or non-accidental?*

I am satisfied on a balance of probabilities that the fracture of the humerus and the fractures of the ulna and radius were non-accidental. All of the medical evidence confirms that the humeral fracture was a serious and unusual injury which was oblique or spiral in nature, and is likely to have been caused either by a person applying significant force or by the arm becoming trapped in some way, and the child's body weight being placed upon it. No such explanation has been provided.

37. I am also satisfied that the mother gave conflicting accounts to medical professionals regarding the date on which the child had fallen whilst in the care of her father. It is highly unlikely that three members of staff who independently took a history from the mother after the fractures were identified, would all make the same alleged error. The significance of the change in date is that the father was identified as a possible perpetrator when the medical evidence confirms that the child could not have sustained this injury on the date he last had care of the child.

38. Dr Mackin, who was the only doctor who observed the bruising on the child's arm, described the pattern as matching his hand, and concluded that the bruises were made by fingers. He did not consider that the bruising was likely to be "tracking" bruising from the fracture because of its position and pattern.

39. Clearly the fractures of the ulna and radius were sustained at a much earlier date than the humerus. While they could be accidental because they are a more common injury and are usually caused by putting one's hands out in the event of a fall, all of the medical experts agree that H was unlikely to be developmentally able to respond in this way. I am therefore not satisfied that the injury was sustained in a fall from a toy car. Furthermore, the medical evidence suggests that even if the fractures had been sustained in this way, there would have been sufficient evidence of ongoing discomfort and distress to justify a responsible parent seeking medical attention. I am satisfied that even if the child had been receiving Calpol to relieve teething problems it is likely that a carer would have noticed that something was wrong when the arm was moved during washing or dressing. There is evidence that the mother sought medical attention appropriately in the past. The failure to do

so in this instance is therefore significant and is a factor to be taken into account.

40. If one considers the fractures of the radius and ulna in isolation, I would not be satisfied on a balance of probabilities that this injury was non-accidental, although I would be highly suspicious. However, taking into account the unexplained fracture to the humerus which occurred within a matter of weeks, and which I am satisfied was non-accidental, I am satisfied to the requisite standard that both injuries were non-accidental.

41. *The timeframe within which the injuries or any of them are likely to have been inflicted*

It is clear from the substantial evidence of healing seen on x-rays taken on 18th July that the fractures of the ulna and radius were sustained between two and four weeks prior to admission to hospital. In respect of the humeral fracture, I am satisfied that it was sustained no more than a few days prior to admission. While Dr Sprigg initially suggested a longer timeframe, he revised that opinion in light of the views of the other experts, who based their opinion on the clinical presentation of the child on admission to hospital. The degree of swelling which was apparent is indicative of a recent injury and it is unlikely that the child could have had it for any significant length of time.

42. *The perpetrator or pool of possible perpetrators*

In the relevant period when the child suffered the fracture to the humerus, she was in the care of the maternal grandparents, the mother and her partner Mr X. Having considered the evidence, the court is not satisfied on a balance of probabilities that the grandparents were perpetrators, nor that there is a real possibility that they were perpetrators. All of the evidence suggests that the child was uninjured when she was returned to the care of the mother on 15th July. The description of H playing with beads and lifting them over head does not accord with a child who has a fractured humerus.

43. The court must therefore consider the evidence against the mother and her partner Mr X. The account given by the mother, which was corroborated by her partner, is completely at odds with the medical evidence. According to them, the problems with H's arm began after she last had contact with her father on 8th July. They give a history of the arm becoming progressively worse up until her admission to hospital on 18th July, when the medical evidence is clear that symptoms are most acute immediately after injury and reduce with the passage of time. The extensive swelling observed on admission does not support the history given.

44. However, there is no previous history of concern about the care afforded to H by her mother. Medical records confirm that she sought appropriate advice and treatment when required. Her relationship with Mr X commenced in or about February or March 2012 and the Trust submit that the recent involvement of Mr X is the only factor that had changed in this child's life. The court also has to take into account the fact that there is evidence that the mother is a devious and accomplished liar. Her falsification of evidence concerning H's parentage is indicative of the lengths to which she is prepared to go to get what she wants. I am also satisfied that the mother's inconsistent accounts of the date the child last had contact with her father were motivated by a desire to put the father "in the frame".

45. The court was provided with very little information about Mr X. The mother gave unchallenged evidence in her written statement that Mr X has contact with his own child. That may suggest that there is no previous history of violence towards children. H, of course, is not his child.

46. As already stated, I am satisfied that both fracture injuries were non-accidental although they were inflicted at different times. I am unable to determine on the balance of probabilities whether the mother or her partner is the perpetrator. The mother has stated that at no time was H left alone with her partner. I am satisfied that the mother and her partner are colluding with each other to hide the truth. If the mother did not cause these fractures then she knows that it was her partner who did so. The humeral fracture in particular was a very serious injury which would have caused intense pain and distress. The signs of injury would have been obvious to any carer. Either the mother is the perpetrator or she is protecting the perpetrator. In light of that finding, threshold facts have been proved against the mother. Both the mother and Mr X are possible perpetrators because there is a "real possibility" that they are each a perpetrator.