Neutral Citation Number: [2023] EWFC 47

IN THE FAMILY COURT

Royal Courts of Justice

Strand, London, WC2A 2LL

Date: 29/03/2023

Before :

MRS JUSTICE JUDD

- -

Between :

A COUNCIL **App**

- and -

H

-and- **1st Respo**

B **2nd Respo**

-and- **3rd Respo**

I **4th a**

-and- **Respo**

B and S

(Minors, by their Children's Guardian)

- -

- -

Sarah Philimore (instructed by **the Council)** for the **Applicant**

John Vater KC and **Jonathan Wilkinson** (instructed by **Pardoes**) for the **1st Respondent**

Galina Labworth (instructed by **The Family Law Company**) for the **2nd Respondent**

Gemma Chapman and **Nichola Bayliss** (instructed by **KSFLP**) for the **3rd Respondent**

Aidan Vine KC and **Ryan Morgan** (instructed by **Daniells Family Law Company**) for the **4th and 5th Respondent**

Hearing dates: 27th March 2023

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Approved Judgment

This judgment was given at 10.30am on 29th March 2023 and later circulated to the parties or their representatives by e-mail.

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MRS JUSTICE JUDD

This judgment was delivered in private.

Mrs Justice Judd :

Introduction

1.
These are care proceedings relating to two children, a baby (S) who is eight months old and an older child (B) who is five. The baby is the child of the first and second respondents who I will call the mother and father for the purposes of this judgment which relates to the threshold only, following a short fact-finding hearing. B has a different father, Mr B.

Background

2.
The background to this case is a very sad one. In October 2020 S's older brother, O, aged just five weeks, died in the night from unknown causes, otherwise known as a Sudden Unexplained Death in Infancy (SUDI). There is a possibility of overlaying, but this would not be anything other than a tragic accident.

3.
A post mortem examination revealed that O had metaphyseal fractures to the medial and lateral aspect of the left distal tibia. At first it was thought that these could have been caused either post mortem or during the delivery. There was an investigation which concluded that, subject to the results of the forensic post mortem, there were no suspicious circumstances surrounding O's death.

4.
The full results of the post mortem took a very long time to be obtained (this is undoubtedly the result of a shortage of experts which has been the subject of comment by other judges including the President of the Family Division). No cause of death was found, but Professor Mangham, Consultant Osteoarticular Pathologist confirmed the presence of the metaphyseal fractures. He dated them, however, as having occurred between 2 and 5 days before O died which meant that they could not have occurred during the birth or after he had died. This meant that they occurred in the care of the parents (or one of them).

5.
Once the dating of the fractures was identified the parents were interviewed by the police. This was in March 2022, eighteen months after O had died. As a consequence these proceedings were commenced at S's birth.

The proceedings

6.
Proceedings would not have been brought in this case were it not for the dating of the fractures as identified by Professor Mangham. At first the local authority and Guardian considered whether the proceedings should include an investigation as to whether O's death had been caused by one other of his parents. After careful assessment of the post mortem, the outcome of the hospital investigation and other evidence they concluded that it should not, a stance approved by the court.

7.
Dr. Rylance, Consultant Paediatrician was appointed to provide a report as to the aetiology and mechanism of the fractures, and O's likely response. The parents have filed statements.

The local authority schedule of findings sought

8.

The local authority seeks findings that O suffered the fractures as found by Professor Mangham, and that they were caused by the use of force considerably in excess of normal handling. It is alleged that this would have been recognised as being unreasonable by a carer, and as highly likely to cause distress and injury to a baby.

9.
The parents are the only possible perpetrators and the local authority does not suggest it is possible to identify either of them as the perpetrator on the balance of probabilities. It does not seek findings (nor would such be justified on the evidence) that there has been any failure to protect by the non-perpetrator or any failure to seek medical attention for O.

10.
The local authority's case is that it would intend to work with the family whatever the outcome of this exercise, and to start to stand down the level of supervision of this family. Currently there are social workers in the family home supervising the care of B and S 24 hours a day.

The parents

11.
Both parents deny using excessive force in their care of O, or apart from one incident recounted by the mother, of being aware of any incident in which this could have happened. In her written evidence the mother recalled an incident when she put O into his chair swing and, as she described it, his leg 'caught the metal bar' and his leg flopped under him. She said that he cried after this but was soothed quickly.

The Guardian

12.
The Guardian adopted a neutral stance. There was some criticism of the approach she had taken during these proceedings, criticism I do not share. The guardian's job is different to that of the social workers and for my part I think it important that the Guardian scrutinises the way in which the local authority frames the case, as well as having an independent oversight of welfare matters.

The law

13.
I will not set out the law in detail in this short judgment. The burden of proof is on the local authority. The standard of proof is the balance of probabilities. I must have regard to the relevance of each piece of the evidence to the other evidence and to exercise an overview of the totality of what I have heard and read in order to come to a conclusion as to whether the case has been made out. The role of the court and the expert are distinct, and I must weigh up the expert evidence together with everything else. I must guard against a belief that it is always possible to identify the cause of an injury to a child. Some things remain unknown.

14.
When seeking to identify a perpetrator of a non-accidental injury I must consider the list of people who could be responsible and determine if it is possible to identify an individual on the balance of probabilities. If it is not, then I must ask myself whether there is a likelihood or real possibility of each of those individuals having been the perpetrator.

15.

I take all these propositions from well-known case law, the core principles which were summarised in Re JS [2012] EWHC 1370 (Fam) and in subsequent cases such as Re A (Pool of Perpetrators) [2022] EWCA Civ 1348,and Re A(A Child) [2020] EWCA Civ 1230, There is extensive case law too as to the approach that judges should take to lies told by witnesses and/or of changing accounts. These have not been a feature of this case, nor has the issue of failure to protect.

16.
A likelihood of significant harm does not mean that such is more likely than not but a real possibility that cannot sensibly be ignored; Re B (Children)(Care Proceedings: Standard of Proof)(CAFCASS intervening);[2008] UKHL 35. The assessment of likelihood must be based on fact, proven on the balance of probability.

The hearing

17.
I read all the statements, reports and other documents in the main bundles provided to me. I was also provided with extensive notes from Purple Elephant, the agency which provided the 24 hour supervision of the family for the last six months. I have not read those notes save as directed by the parties.

18.
I heard oral evidence from Dr. Rylance, the mother and the father.

The medical evidence

19.
Professor Mangham identified metaphyseal fractures of the distal left tibia. Although there are two fractures identified, one which is medial and one lateral, they would have been caused at the same time and can be considered as one. They were sustained no less than 2 days and no more than about 5 before O died.

20.
There is no evidence that O suffered from any medical condition that would have predisposed him to suffering fractures. According to Dr. Rylance only rare genetic causes, each of which could possibly have become apparent if O had lived longer and could not be excluded by the comprehensive investigation already undertaken remain as remote possibilities.

21.
Dr. Rylance stated that metaphyseal fractures of long bones in children of O's age do not occur in normal handling. Nor, in his view, do they occur with rough handling when that description applies to a carer who is appropriately concerned about the wellbeing of a baby. Evidence of this, he says is available by way of exclusion in that such fractures do not tend to be discovered incidentally in routine x rays of children who are screened for reasons other than suspected injury.

22.
Fractures do not seem to occur when doctors handle children confidently (sometimes interpreted by parents as more robust than they would be themselves), or when children get their legs or arms stuck through furniture such as cot bars.

23.

The mechanism for these sorts of fractures is a pull combined with a twist or torsion. Dr. Rylance said that a sudden jerking movement has been described to him by two perpetrators. He said that the perpetrator would be aware that the force they had used would be excessive, but not that they had caused a fracture.

24.
The child is likely to cry but the duration cannot be predicted. A non perpetrator would likely not have realised that anything had happened because babies behave as usual after such fractures – a baby of this age would cry so frequently anyway anything amiss would not necessarily be noticed.

The mother

25.
The mother filed three witness statements and gave very short evidence. She described S and B with obvious pleasure and love. She exhibited distress at some points when speaking of O, but was also able to collect herself and answer questions.

26.
She was adamant that she had not lost her temper or become frustrated and hurt O. She said that she had never felt that way about him, nor did she believe that the father had done so. She said that he would have been 'out the door' if she thought he had harmed her children.

The father

27.
The father's filed one witness statement. His oral evidence was, if anything, even shorter than the mother's. He became very distressed when discussing O, and (I thought) found the whole process of giving evidence hard, which is not surprising. He said that he had nor injured O, and nor had the mother. He had not asked her whether she had done so because, he said, 'we are not animals'.

Wider canvass

28.
After O's tragic death there was an investigation (A Child Death Review) which culminated in a meeting on 3rd November 2020 which included the Consultant Paediatrician, Health Visitor, Names nurse for Public Health Safeguarding, the Team Manager of the First Response Team and Children's Services and a Detective Sergeant from Avon and Somerset Police. Information about the family and medical background from further sources such as the family GP was also presented to the meeting. The mother gave a statement to the police shortly after O had died, setting out events in the days and hours beforehand. The metaphyseal fracture had been discovered and so a decision was made that there should be a forensic post mortem. There were no other concerns about the family.

29.
It was not until May 2022, some eighteen months after O died that the post mortem report was received, with the dating of the fractures. By that time the mother was pregnant with S, who was born in August 2022. In the intervening time the social worker reported that there had been no concerns about the care being given to B by the mother or by the father (who is of course her stepfather).

30.
A parenting assessment was commissioned, with a report being filed in February 2023. This is a carefully written and thorough document. I think it is fair to say that the author did observe some

tensions in the family dynamic, and she was also concerned about the relationship between the father and B, his stepdaughter. She felt that B was invisible to him and recommended that the case needed to be reviewed not just from S's perspective but also from B's. She felt that B's needs have been overlooked. As to the tensions between the parents, the assessor considered that they demonstrated a fragility in their relationship with different parenting styles and assumed gender roles which they had not communicated between them. She recommended that they receive direct support and modelling to understand what it means to be in rhythm and tune with S as the mother has a somewhat 'romantic' view of being a parent and the father's approach is somewhat simplistic.

31.
There have been some tensions between the parents in relation to the father going drinking with friends and not changing dirty nappies. The mother has been doing the lion's share of the care of the children and managing the home whilst the father has been out working. The assessor watched some interaction between the parents and S and thought there was a mix of over and under-stimulation, mostly from the father.

32.
In this case the local authority arranged for the parents to be able to stay in the family home with both children with 24 hour supervision from agency workers. This means that the parents have been observed constantly with the children for a period of about six months. The observations have been almost uniformly positive. Despite the stress that must come with having people living and observing in the family home all the time there has never been an occasion when anyone has expressed any concern that either of the parents were rough or impatient with either S or B. Indeed there is no evidence of any anger or aggression involving either parent or the children at all. The height of any problems are as identified by the parenting assessment. There was an anonymous allegation made in February 2021 but these were not supported by independent evidence.

33.
It is important to put all these observations together. The more detailed parenting assessment prepared by the social worker identified areas of tension and matters that could and should be worked upon; but the issues that were raised are not necessarily uncommon in families and would not attract the attention of the professionals.

Analysis

34.
The medical evidence in the case is clear and unequivocal, namely that metaphyseal fractures such as this do not occur in normal or even over exuberant/rough handling. Someone who was responsible for causing the fracture must or ought to have been aware that they had mishandled O, even if they did not realise he had suffered a fracture. Therefore in most cases where a fracture is discovered the absence of a contemporaneous explanation or an inadequate explanation from a parent is very telling and suggests that they have behaved in a way they wish to conceal. This is not to reverse the burden of proof but simple common sense. Fractures do not happen in the ordinary course of events and in the case of a non-mobile baby somebody (in this case one of the parents) must have been aware of the event at the time.

35.
The strength and unequivocal nature of this medical evidence is such that, despite all the positive evidence that there is about the parents and indeed from them, because there is nothing in anything they have said to suggest that either of them is dishonest or has given inconsistent accounts to

anyone, I am driven to the conclusion that that there must have been an event, in the care or one or other of the parents when O's left leg was pulled and twisted so as to cause those fractures.

36.
The difficulty is that there is no context for this at all. The significance of the fractures was not appreciated for about eighteen months after O's death so that the parents were not asked to consider possible explanations for them for a very long time indeed. Of course memorable events do stay in the mind, but a brief event causing a metaphyseal fracture which did not apparently lead to any worrying symptoms thereafter might not be a memorable event in the light of the terrible shock of O's death very shortly afterwards. It is clear from Dr. Rylance's evidence that what I am being asked to consider is a very brief, one off, event when excessive force was used, whether this was by someone pulling and twisting O's leg by hand in a moment of frustration or by pulling O thoughtlessly or impatiently out of a chair or swing in a way that causing his foot to be bent and twisted.

37.
I make a finding that the fracture happened by the use of momentary excessive force but I cannot say any more about the circumstances save that the action would have caused O pain and distress. In particular I cannot say that the act came about through any hostility or anger directed at O.

Threshold

38.
The question that I have to decide is not whether O suffered significant harm within the mearing of s31 CA 1989. I am dealing with S and B. Neither of them has suffered significant harm. What I have to decide is whether either of them is likely to suffer significant harm as a result of the care that is likely to be given to them by one or other of the parents, based on what happened to O.

39.
I first consider S. The relevant date is the date of his birth, when protective arrangements were put into place. This was almost two years after the fracture to O's leg. One of the parents must have been responsible for causing O to be injured, even if they do not now remember the event after so much has happened. Does a one-off event like this involving a parent who has demonstrated no other propensity to violent, dangerous or even careless behaviour with a child either before or in the two years afterwards lead inevitably to a finding that a newborn baby is at risk?

40.
Mr Vater KC for the mother, supported by Ms Chapman for the father, submits that, as well as all the positive evidence that was available as at the date of the proceedings, I am entitled to take into account all the evidence about the parents and their relationship with the children from the detailed observations of the social work agency which has been supervising them 24 hours a day since October 2022. This, he says is 'after acquired' information which can go to prove whether or not the state of affairs as alleged at the time protective arrangements were put into place existed. In other words, we now have a lot of evidence to show that neither of these parents is volatile, temperamental or aggressive even in the face of the very significant stress of caring for two children with strangers in their home all the time.

41.
After careful consideration I have come to the conclusion that at the relevant date S was not likely to suffer significant harm. Whilst his older brother did suffer an injury, this was a single event in unknown circumstances over two years before these proceedings were started. Apart from this there

is no evidence that either of the parents has a problem with anger or aggression albeit there are some arguments about changing nappies or going to the pub. The parents have cooperated with the professionals throughout (including the investigation into O's death) and they appear to have interacted openly and honestly with them, without rancour.

42.
In the intervening period between O's death and S's birth the local authority evidence was overall that B received good care from her mother in the home they all share. Whilst the parenting assessment raises some issues as to the relationship between B and her stepfather the day-to-day observations have not raised major concerns.

43.
There is enough evidence now to show that there is a strong and loving bond between S and both his mother and father. That bond could not have been there in the same way at the time S was born, but the after acquired evidence does assist in proving that the mother and father are loving and caring and able to weather stress. In those circumstances, I do not find that there was a real possibility that S would suffer significant harm by way of being injured in the care of his parents at the time of his birth in August 2022. The same is true now.

44.
It follows that I find that the threshold criteria are not met in relation to S. I also find the same to be true of B. The case so far as B was concerned was never so compelling because not only has she never suffered any injury, but she is also now older and less vulnerable.

45.
A week before the case commenced, I was invited to vacate the fact finding hearing and to bring the proceedings to an end. This application was made by the father but supported by those representing the mother. It was also supported by the local authority who had made it clear for some time that the care plan they were proposing, whether or not the court made any findings, would be the same. The Guardian was given little notice of the local authority position, and at that hearing invited the court to proceed to hear the evidence. I agreed with the Guardian's stance and have heard the case.

46.
There will be cases where there is no advantage in proceeding with a fact-finding hearing, as demonstrated by the decision of Lieven J in Derbyshire County Council v AA and others [2022] EWHC 3404 (Fam). Each case will very much depend on its own facts. In this case, the matter was already listed for hearing only a few days after the application to vacate was made, with the expert witness booked to attend and counsel instructed. Some resources might have been saved had the case been taken out at the last minute, but in the overall scheme of things and the resources expended to date I did not consider that an overriding factor. I was also acutely aware of the stress of these proceedings upon the parents, but there was not long to wait for the outcome.

47.
Cases where a child has suffered a single injury are worrying, because a single injury may be the harbinger of something much more serious, even in a case where there are no other outward features of anger, ill treatment or neglect. Decisions such as have been made in this case are difficult, and not risk free. In this case, whilst the threshold has not been met there are some findings about that original injury, even if of a one off episode at the lower end of the scale of force. This will enable everyone to move on and work from here on the basis of the child in need plan. I hope that this family will now be able to look ahead to a different phase of their lives, as S and B grow up alongside the

memories of O. They will need the assistance of the local authority as they do this, as they have all suffered considerable trauma over the last few years. I wish them the very best.