Neutral Citation Number: [2012] EWCA Civ 1477

Case No: B4/2012/2039

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM SHEFFIELD DISTRICT REGISTRY
HER HONOUR JUDGE CARR QC
SE12Z00226

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/11/2012

Before :

LORD JUSTICE MCFARLANE

Re: A (A child)

Mr Michael Shrimpton (instructed by Brendan Fleming Solicitors) for the **Appellant**
Mr Anthony Hayden QC and Mr Charles Prest (instructed by **Rotherham Metropolitan Borough Council**) for the **First Respondent**
Ms Jo Delahunty QC and Mrs Denise Marson (instructed by Howells Solicitors) for the **Second Respondent**

Hearing date : 1 November 2012

Approved Judgment

Lord Justice McFarlane :

1. This is an application for permission to appeal which relates to a young boy, C, who was born on 3rd October 2009 and is therefore now aged just over three years. At the very beginning of his life, when he was only some four weeks old, it was discovered that C had sustained no fewer than twelve fractures of different types to different parts of his body. Expert evidence indicated at least two separate dates upon which the fractures had been sustained. In addition a week or so earlier concerning signs in his genital area had indicated either some form of infection or inflicted trauma.

2. Once the existence of the fractures had been discovered, C was not returned to the care of his parents and he became the subject of care proceedings. At the conclusion of a fact finding hearing on 5th July 2010, HH Judge Carr QC sitting in the Sheffield County Court concluded that all of the injuries to which I have referred were inflicted upon baby C by one or other of his parents. Following an assessment of the options for C's future care, in a further judgment on 21st June 2011, Judge Carr ruled out the rehabilitation of C to his parents and made a full care order. The case returned for a third and final time before Judge Carr in June 2012. On that occasion the judge heard an application made on behalf of the parents by their solicitor for the fact finding process to be re-opened. In a reserved judgment dated 18th June 2012 the judge dismissed that application and granted the second application, which was by the Local Authority for an order authorising them to place C for adoption. By an application dated 8th August 2012 the parents applied to this court for permission to appeal the two determinations made by the learned judge in June.

3. A direction has been made that nothing is to be published as a result of this hearing which would seek to identify C as a child who is the subject of these proceedings or his parents as being the parents of such a child.

4. In order to establish the context in which this application is made it is necessary to descend to some detail. C was born on 3rd October 2009, apparently some ten to fourteen days beyond his expected due date. The delivery was assisted by forceps, but was otherwise unremarkable and baby C was described as fit and healthy. On 26th October, at 5.13 a.m., the parents brought baby C to their local Accident and Emergency department where he was found to be suffering from:

    (a) bleeding into his nappy

    (b) swollen scrotum and penis

    (c) a cut to the base of his penis

    (d) bruises to the perineum and left outer thigh

5. On the occasion of that referral the doctors concluded that the signs were probably as a result of infection and C was discharged home with a prescription for antibiotics.

6. C was next presented at the hospital some four days later on 30th October 2009 at 22.14 hours with a swollen right leg. A subsequent skeletal X ray disclosed multiple fractures of ribs, fractures to his tibia and fibula which were metaphyseal in nature together with a transverse fracture of his right femur. There were twelve fractures in

all which had been sustained by this four week old baby who was obviously not self-mobile.

7. The fact finding judgment of 5th July 2010 records that the parents were given full rein by the court to identify and instruct whatever relevant medical experts they considered might be able to assist the court in understanding how baby C came to manifest the injuries and symptoms that I have described. In particular Professor Bishop, who holds the chair of Paediatric Bone Disease at Sheffield Hospital, and who is regarded internationally as an expert in paediatric bone conditions, was jointly instructed by all parties to the proceedings. It is a feature of this case that at the fact finding hearing each of the respective experts were unanimous in their conclusion that the probable cause for the groin symptoms and the fractures was trauma inflicted on baby C at some time after his birth. On the basis of that expert opinion, but also on the basis that the judge, for reasons given in the judgment, found that the parents' evidence indicated fault lines in their relationship and in their credibility when giving evidence to the court, HH Judge Carr made a very clear finding that baby C had indeed been injured in the period between birth and final presentation at the hospital and that the only possible perpetrators of the injuries were the mother and/or the father.

8. The parents' application to the learned judge in June of this year was to re-open the whole fact finding process. The application was widely based and the skeleton argument on the parents' behalf identified no fewer than twenty six factors which, it was submitted, now fell to be reconsidered in the light of suggested developments in medical understanding or which had not been given sufficient prominence at the original hearing. In a reserved judgment delivered on 18th June 2012 the judge reviews each of the points made to her on behalf of the parents and, in turn, rejects each one. Before doing so the judge noted that at the previous hearing "the court allowed the instruction of every expert/test requested by the parents, including, in particular – and contrary to medical opinion – genetic testing for possible bone disorder" and "even during the course of the hearing the court checked with those representing the parents whether there was any other expert evidence they sought – and was told 'no'".

9. During the course of the June hearing the judge was taken to two recent decisions, *London Borough of Islington v Al Alas and Wray* [2012] EWHC 865 (Fam) and *A County Council v M and F* [2011] EWHC 1804 (Fam). The first of these cases, which I will refer to as *"Wray"*, achieved national publicity. In the *Wray* case, Mrs Justice Theis held that bone injuries seen on a young child were the result of rickets rather than inflicted injury. HHJ Carr, in the present case, considered that neither of these two new authorities involved any new point of law, and did not necessarily assist her evaluation of Baby C's case. She drew particular attention to the following caveat given by Theis J in the *Wray* judgment:

> "It is important to remember that my conclusions set out below are entirely related to this case. Despite their differences of opinion, all the medical experts agree this case is extremely complex. By their very nature, cases such as this are very fact specific and great caution should be adopted in using any conclusions I reach to support any wider view outside the very specific facts of this case…"

10. Despite the fact that it is possible to summarise the June 2012 judgment in short terms, concluding as it did that each of the points raised on behalf of the parents took matters no further, it is right to record that the judgment itself indicates a significant amount of time and consideration given by the learned judge in which she traces each of the factors relied upon back to the evidence and conclusions that were current in the 2010 process.

11. The Notice of Appeal in support of the present application for permission to appeal was couched in similarly wide terms but, relying on the *Wray* case, argued that the development of medical understanding in relation to vitamin D deficiency, rickets and brittle bones justifies the Court of Appeal now considering whether or not the judge was correct in refusing to permit the re-opening of the fact finding exercise.

12. When the application for permission to appeal came before me for oral hearing on 19th September 2012 counsel for the parents, Mr Michael Shrimpton, was able to cast the parents' case in a much more focussed manner. In the course of the judgment that I gave on that day I summarised the position as follows:

> "6. What is the point that the parents seek to make? It can be put in very short lay terms. They contemplate, understanding as they and their advisors now do on the basis of medical knowledge, that it is possible for an unborn child to develop a deficiency in vitamin D to the extent that their bones are unduly soft, or otherwise be symptomatic of congenital rickets. The baby is born, and this was a difficult birth which may have been beyond term, although as I understand it the dates were not precise; and it is possible, say the parents, for the birth process, without any negligence or rough handling on the part of the medical team involved, to have caused the fractures in this case. The child is then born, no doubt it is postulated as at that moment deficient in vitamin D, but the child is then fed either entirely upon prepared milk or a mixture of breast and prepared milk, the prepared milk having vitamin D supplement within it.
>
> 7. Baby C was born on 3 October 2009, and his vitamin D was not measured at all until tests were undertaken in November, a month or more later. Those tests were normal. The argument on behalf of the parents is that it is not remarkable that the child's vitamin D levels, once he ceased to be dependent upon the mother's system, were up at normal levels because of the supplement he had been obtaining in the milk, and it does not prove one way or the other what his vitamin D level will have been at the moment of birth. I use the phrase "once he has ceased to be dependent upon the mother's system" because it is a fact established on the medical evidence in the case that the mother herself has a modest -- and I think it is modest -- vitamin D insufficiency, and that therefore she may have been compromised in her ability to provide through the placenta an

adequate supply of vitamin D to her unborn child. That is the synopsis of the parents' case.

8. My concern on reading the papers was that, whilst it is possible to understand that process, it would be impossible now, three years after C's birth, to have any firm clinical readings or tests which could prove one way or the other, or even indicate one way or the other, that what is put forward by the parents was anything more than an intellectual possibility. The way the case was put before the judge indicates that she was not given any firm clinical hook upon which to see that the parents' case might hang.

9. This morning, on asking counsel, Mr Shrimpton, who represents the parents, whether there is any material that points one way or the other, I have been told of the abnormal liver readings which were obtained on 26 October, and, without now reading into this judgment the six different levels that I have been given, it is plain from what I have been told that two of those six indicate a modest low reading outside the "normal" range, one reading which is modestly above the range, but three which are quite markedly outside the normal range. The submission is made by lawyers to a judge, therefore between people who have no medical background, that the liver function is important in the sequence of production of vitamin D, and these abnormal liver readings may provide some base of clinical evidence to give support to the process that the parents now contemplate may have been involved.

10. Looking at HHJ Carr's judgment, it seems that before her the point was not made in any way that is similar to that in which it is now made to me. At page 12 of her judgment, at (n) in the list of symptoms, the judge says this simply about C's liver:

> "Abnormal liver function – this was well-known at the time of the Finding of Fact."

And so far as the mother's vitamin D insufficiency, she says this at page 13:

> "(g) vitamin D deficiency – this was well-known at the time of finding of fact. It misses the essential point: [C]'s vitamin D level was normal."

> And of course, C's vitamin D level was normal. The way in which the case is now put before me, as I have indicated, draws together the mother's vitamin D insufficiency and the abnormal liver readings to indicate that there may be a possibility of concluding that the baby's vitamin D level was insufficient at the time of his birth.
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> 11. I am concerned now, having been exposed to the way in which the case is now put, that the conclusions reached in the fact-finding may be more susceptible to review than will have been obvious to HHJ Carr in the way that the case put to her. On enquiring why, as between June of this year, when HHJ Carr heard the case, and September, three months later, when I am hearing it, the matter is put in different ways, I am told that an expert, a Professor Nussey, who is an endocrinologist at St George's Hospital in Tooting, who was an expert in the *Wray* case, has been instructed in another case in which the same solicitors who represent the parents here are instructed, and that between June and now Professor Nussey has produced his report in that case and given prominence to the liver readings for the child in that case, which leads to the more finessed and focused submissions that Mr Shrimpton has been able to make today."

13. In consequence of the way in which the case was put in September, I adjourned the application for permission to appeal, gave permission to the parents to identify and instruct an appropriate expert, and directed that the case be re-listed as soon as possible after four weeks on notice to the Local Authority and Children's Solicitor so that a balanced and informed view could be taken on the question of permission to appeal.

14. Fortunately the parents were able to instruct the expert of their choice for this purpose. He is Professor Stephen Nussey, who is professor of endocrinology and a consultant endocrinologist at St George's Hospital in London. Following a letter of instruction which came from the parents' solicitors alone, Professor Nussey produced his first report dated 2nd October 2012. He then responded to various email queries raised on behalf of the parents before producing an addendum report dated 23rd October 2012. This court is extremely grateful to Professor Nussey for undertaking this task within the very tight timetable that had been set.

15. The following would seem to be the important highlights from Professor Nussey's reports.

    a) Blood results for baby C's mother during the period of pregnancy demonstrate vitamin D deficiency in her system. Professor Nussey therefore states:

> "thus, it is likely that C was subject to vitamin D deficiency for the majority of his inter-uterine life";

b) Haematology results for baby C's mother indicate that:

> "she became progressively iron deficient during pregnancy though this was not confirmed by formal iron studies and it seemed to improve without iron supplements between August and October 2009."

Professor Nussey explains that iron plays a role in collagen (the protein affected in osteogenesis imperfecta) synthesis and is an essential part of the enzyme that converts inactive vitamin D to its active form in the kidney. The professor knows of no studies examining the effects of combined vitamin D and iron deficiency during pregnancy and infancy;

c) Whilst it is likely that C was born with vitamin D deficiency and low iron stores, it is clear that C was bottle fed with vitamin D and iron supplemented proprietary feed. By 6th November 2009 all readings relating to baby C reflected a normal serum vitamin D concentration.

d) Professor Nussey concludes:

> "Thus, whilst it is recognised that the quantities of vitamin D in formula feeds are calculated to prevent rickets rather than to optimise bone mineralization it is, on the balance of probabilities, unlikely that vitamin D deficiency played a significant role in bone fragility predisposing the fractures which C presented";

e) Later Professor Nussey also concludes:

> "There appears to be no medical condition linking the presentations due to fracture and its sequelae on 2nd November and 4th December 2009 to that on 26th October 2009." (The latter date being the day that C was taken to A&E with symptoms around his genitals).

f) The final question asked of Professor Nussey was "having considered the medical evidence available to you, please indicate whether or not you have sufficient material to conclude whether or not the child has a medical condition to account for his injuries and if not, what further evidence you would require to draw a conclusion". To which Professor Nussey replies:

> "From the material available, within my expertise in endocrinology, I do not think there is a medical condition to account for C's injuries. "

g) In relation to the liver readings which were given prominence at the hearing before me in September, Professor Nussey's opinion is:

> "C's recorded liver function tests were only mildly abnormal and not of a degree that was likely to affect the first activation step."
>
> Reference to "the first activation step" is to the first stage in any process whereby abnormalities in a baby's system might affect the formation of bones.

16. On 1st November 2012 the application for permission to appeal was restored before me and was fully contested by leading and junior counsel instructed on behalf of the Local Authority and the child, respectively. In that regard it is of particular note that the solicitor and junior counsel for the child sought to instruct Miss Jo Delahunty QC who was brought into this case for the first time with the specific instruction of advising "if any areas in this case warranted further examination in the light of the science explored, and expert evidence given in, [the *Wray* case]". The significance of this instruction is that Miss Delahunty was leading counsel for the parents in the *Wray* case and therefore likely to be fully aware of the scientific implications of that decision from the perspective of parents who have been accused of child abuse. The decision of the children's solicitor and junior counsel to instruct Miss Delahunty was, in my view, both wise and responsible. The result has been a very thorough document produced in the form of a skeleton argument which expresses confidence in the safety of the findings made by HH Judge Carr in the present case and seeks to identify, for a number of specific reasons, why this case regarding baby C is in no manner one which falls to be reconsidered in the light of the *Wray* case.

17. Despite the fact that the opinion of Professor Nussey is almost entirely unsupportive of the parents' position, Mr Shrimpton on behalf of the parents renews his application for permission to appeal at this hearing by relying upon the professor's specific confirmation that baby C was vitamin D deficient at birth (see paragraph 15 (a) above). He describes this as the "key finding" in the professor's report. He argues that this is at odds with the understanding held by the experts at the fact finding process and he regards it as therefore necessary for those experts to be now instructed to review their conclusion in the light of that finding.

18. Mr Shrimpton developed his submission by pointing to the fact that the use of forceps during the delivery provided a potential for trauma to the long bones through a pulling and twisting mechanism sufficient to produce metaphyseal fractures if the bones were weak. He also described the birth process itself, during which the baby's body is squeezed, as being a sufficient mechanism for rib fractures to occur if the normal consistency of the baby's bones is compromised by vitamin D deficiency. Mr Shrimpton accepts for the purpose of his argument that the X rays indicate that the fractures were sustained on at least two different dates, but he argues that the earlier set of fractures could have been sustained pre-birth when baby C was still in his mother's womb.

19. Mr Shrimpton submits that the evidence before the judge in 2010 relating to the date of fractures was based upon an assumption of normal vitamin D levels and therefore now fell to be reconsidered. Mr Shrimpton argues that Professor Nussey's finding is one that establishes that baby C had "congenital rickets at birth". He told the court that "the clinical consequence of vitamin D deficiency is congenital rickets". When asked to point to evidence in support of that latter comment, all that Mr Shrimpton

could do was refer to page E 43 of the original trial bundle in which one of the specialists identifies as part of her CV that she is a specialist in "vitamin D deficiency (rickets)".

20. Mr Shrimpton argues that once it has been established that the understanding of no vitamin D deficiency at birth is not sustainable, all the dating evidence is called into question. He points to Professor Barnes, an expert paediatric neuro-radiologist who gave evidence in the *Wray* case, as stating that the dating of fractures in infants is in any event problematic. Mr Shrimpton therefore submits that Professor Nussey's finding "sweeps away the basis for the dating of the fractures given by the experts". He argues strongly that all of those experts now need to re-evaluate their conclusion and he seeks leave to instruct a fresh expert, Dr Julie Mack, a paediatric radiologist based in America.

21. Separately Mr Shrimpton points to Professor Nussey's identification of low iron level during pregnancy and a probable low iron level at the time of birth. This is relevant to bone formation for the reasons given by Professor Nussey. Mr Shrimpton then goes on to identify what he claims are six signs of congenital rickets. These are:

(a) Some signs of soft dysmorphic features;

(b) Hypertelorism

(c) Two hernias

(d) The identification of Professor Nussey of some sign of intracranial bleeding which might be the result of "birth trauma"

(e) The October 2009 symptoms in Baby C's groin, which Mr Shrimpton says are a result of infection.

22. Pausing there, it was not possible to understand how evidence of some intracranial bleeding or the fact that the child might have had an infection could be set up as positive signs of "congenital rickets". In any event all six signs (the hernias being two) were features of the evidence at the original fact finding and have not been taken forward by Professor Nussey in his reports.

23. The judge was plainly impressed by the fact that the symptoms seen in baby C's groin were separate and distinct manifestations unrelated to brittle bone disease. Mr Shrimpton seeks to challenge that position by submitting that a child with low vitamin D would be more vulnerable to infection. It is, however, of note that the groin injury occurred some three weeks after birth and at a time when, as the later readings show, it seems probable that baby C's vitamin D levels were returning to normal or had already achieved normality.

24. In response to the application Mr Anthony Hayden QC for the Local Authority presents a robust defence for the process undertaken at the fact finding hearing and then earlier this year in considering the application to re-open the findings. He submits that a wide range of extremely experienced experts presented evidence to a seasoned specialist judge whose judgment demonstrates the conspicuous care that she brought to evaluating all of the relevant material. The findings are clear and, submits

the Local Authority, nothing has changed. They argue that, far from undermining the process, the reports from Professor Nussey endorse the fact finding conclusion.

25. In particular Mr Hayden points to the prominence that the liver function tests of 26 October 2009 played in persuading this court to adjourn the case in September of this year so that Professor Nussey might be instructed. I have already set out Professor Nussey's opinion on the liver function tests (paragraph 15 (g) above) and Mr Hayden submits that that opinion comprehensively erodes one of the central issues upon which the parent's case had been based.

26. Although Professor Nussey is an endocrinologist, he offers a clear opinion as to the causation of the fracture, and concludes that they were not the result of a medical condition. At stages in his report the Professor is clear in indicating where opinion is sought which is outside his experience or expertise, but on this point he is prepared to offer a clear opinion and the court should give it weight.

27. The Local Authority submit that where, on an application for permission to appeal, an applicant seeks the court's indulgence to obtain a fresh expert's report, and where that report is delivered and is negative to the applicant's case, the applicant asks further questions of the expert and receives a yet more negative response, it is an abuse of process for the court to consider further adjournment so that additional expert opinion can be sought.

28. At the core of the Local Authority's case is a plea for the court to consider the impact of any further delay on this child, who has been in the public care system from the age of some four weeks and is now over three years old. He urgently needs, it is submitted, to move on to a permanent home.

29. The argument on behalf of the child is put in similarly robust terms by Miss Delahunty QC. I have already described how she was brought into the case to provide an informed and independent audit of the expert evidence. Her skeleton argument engages comprehensively with the central argument presented by Mr Shrimpton on behalf of the parents to the effect that, following the *Wray* case, this case, relating to Baby C, must now be reconsidered.

30. Miss Delahunty is rightly critical of the way in which this matter was presented to me in September. The 2010 fact finding judgment and bundle of expert opinion was not then made available to the Court of Appeal. In view of the need for urgency in resolving this issue I was persuaded to grant the adjournment sought rather than take further time seeking additional paperwork. However, Miss Delahunty argues that the fact finding judgment, which was plainly in the possession of the solicitors acting for the parents, would have demonstrated that HH Judge Carr had before her experts who had a particular expertise in bone disorders and vitamin D deficiency. These experts had been particularly asked to consider the very points now being made relating to the mother's vitamin D deficiency and the possibility that the baby may have had vitamin D deficiency at birth and that that in turn may explain some or all of the fractures. The experts were also asked to consider if the birth itself could cause fractures and a neonatologist was specifically instructed to address the birth process.

31. Miss Delahunty took the court to the report of Dr Takon, a consultant paediatrician with expertise in rickets who confirmed (page E128) that "rickets does not resolve

without treatment". She also referred to the evidence of Professor Bishop (page E108) where he stated that "it would be difficult to see how C could have been severely deficient at birth, have normal-looking X rays and normal blood tests four weeks later without treatment-level intervention."

32. Having looked at this matter in depth Miss Delahunty summarises the position as follows:

> "From different specialism the same answers were given: birth could not account for the fractures. Neither could vit D or bone density disorders. The experts gave clear answers to clear questions. Vit D deficiency, even had it existed at birth, could not account for the type and age of the fractures identified upon admission."

33. In dealing with the oral submission now made by Mr Shrimpton, Miss Delahunty challenges counsel's assertion that the clinical consequence of vitamin D deficiency is rickets. She accepts that vitamin D deficiency at birth may progress to rickets, but it does not equate to rickets. Miss Delahunty challenges Mr Shrimpton's approach of cherry picking small parts of the expert evidence from the fact finding process when the total picture presented by all of the experts was entirely contrary to the argument now made.

34. Miss Delahunty characterises the mother's vitamin D deficiency as "very minor" and therefore the potential for this factor affecting the child's bones is remote. She describes the parent's argument as "without hope" and the application for a further adjournment to disclose papers to experts as being totally unjustified.

35. The point made is that vitamin D could go from being down at birth but normal at four weeks, but weakened bones could not go back to normal in that time. It is submitted that Mr Shrimpton seeks to conflate the former, which is established by Professor Nussey, with the latter, which was the position of the experts at the fact finding hearing. The experts' position is therefore unaffected by Professor Nussey's insight into the intra-uterine vitamin D levels and that is confirmed by Professor Nussey's own opinion that the vitamin D is, on a balance of probability, not related to the fractures.

36. I have been impressed by, and grateful for, the thorough process that Miss Delahunty QC and Miss Denise Marson, her junior, have undertaken. I propose to extract section E and F from their skeleton (pages 13 – 19) and publish them as an addendum to this judgment in order that both the thoroughness of the exercise and its clear conclusions can be understood.

Conclusions

37. Plainly Professor Nussey's contribution is insufficient to persuade this court to grant permission to appeal at this hearing. Mr Shrimpton accepts that this is the case but applies for an adjournment in order to canvass the opinion of the fact finding experts and to seek a fresh opinion from Dr Mack.

38. I am, as I was at the September hearing, profoundly aware of the impact of any further delay upon the welfare of this young boy. However, if I concluded that there was potential substance in the case as it is now put, I would sanction an adjournment for a further limited period, just as I did at the September hearing.

39. I have given anxious consideration to the matters now raised by Mr Shrimpton. I have done so because of the importance of the court keeping an open mind to the clarification of medical knowledge as it progresses over time. I also do so because I am well aware of the draconian nature of the orders made and the fact that they are entirely reliant upon the opinion of medical experts.

40. I have approached the evaluation of Mr Shrimpton's arguments first of all as they have been made, which is by taking Professor Nussey's confirmation that C probably had vitamin D deficiency at birth as the core starting point for his arguments and, at that stage, ignoring Professor Nussey's overall conclusion, which is plainly adverse to the applicant's application. Having done so I am totally unpersuaded that Professor Nussey's vitamin D deficiency at birth conclusion supports the string of consequences that Mr Shrimpton seeks to extrapolate from it.

41. Firstly, no evidential basis has been put before the court for the assertion that low vitamin D establishes that C had congenital rickets at birth. Rickets is a systemic condition which, once established, continues to be present in the child unless and until it is treated. It arises from the inability of the child's own system to produce vitamin D and is therefore not a condition which arises from the fact that a child may be under-supplied with vitamin D by his mother's system whilst in the womb.

42. Secondly, no evidence has been put before the court to suggest, let alone establish, that this baby's bone formation was detrimentally affected by a lack of vitamin D prior to birth. This was a matter that was thoroughly canvassed by the experts at the fact finding hearing, whose number included Professor Bishop, an expert in this field of international renown, and the conclusion was that this was not a factor.

43. Thirdly, and this to my mind is the crucial point, I agree with the Guardian's submission, which I have already summarised at paragraph 35. Mr Shrimpton does indeed conflate the finding of probable vitamin D deficiency at birth, which can resolve without trace in four weeks, and, on the other hand, inadequate bone formation which would not. For the reasons given more fully in Miss Delahunty's skeleton, the experts in the fact finding were justified in holding that the absence of any evidence of bone weakness at four weeks was conclusive as to the existence of weakness at birth.

44. Having summarised my main conclusions on Mr Shrimpton's core submissions, without reference to Professor Nussey's own overarching opinion, I look more briefly at Mr Shrimpton's other points.

45. The "six signs of congenital rickets" that he drew attention to, were all known at the fact finding hearing and were not considered diagnostic, or even, it seems, indicative, of rickets by the experts then instructed. The fifth "sign", namely the groin infection, is not in any event established as an infection. If it were an infection, that would take the case no further and could not possibly be a positive sign that the child had vitamin D deficiency at that stage which is mid way between birth and the discovery of the

fractures. The sixth "sign", relating to an apparent bleed in the brain, is not specific as to its causation, and is no more a "sign" that C had rickets than it is a sign of a number of other possible causations.

46. Finally, in dealing with the parents' case as it is now put, Mr Shrimpton's submission that the groin symptoms are probably an infection arising from vitamin D deficiency is based on the premise that the vitamin D level was still low at 26th October. There is no evidence to support that and, indeed, the evidence is that once the child was on a supplemented feed, his vitamin D level would rise, as indeed the later readings show that it did. All of the evidence at the fact finding hearing supported the judge's conclusion that the groin signs were not as a result of infection and not related to vitamin D deficiency. This is now confirmed by Professor Nussey.

47. Thus far I have avoided all but a passing reference to Professor Nussey's conclusions, but it is impossible to ignore the reasoned and entirely neutral opinion which this court now has from this eminent expert. I agree with the submission of Mr Hayden in this regard. Once a court has been persuaded to take the step of putting the previous court's orders on hold so that the applicants are permitted to instruct the expert of their choice for the purpose of investigating and analysing the primary theory that is said to support their application for permission to appeal, and once the result of that process is a wholly adverse conclusion, which entirely knocks out one of the primary planks of the applicant's case (the liver readings) and expresses a clear conclusion that, despite vitamin D deficiency being present at birth, there is not medical condition identifying a cause for the fractures, it becomes very difficult for the applicant to persuade a court to adjourn further so that additional investigation can take place. That position is compounded where, as here, the applicants ask the expert to re-consider certain aspects of the case and, for a second time and in more explicit terms, the expert confirms his opinion.

48. Having engaged in detail with all of the matters raised by Mr Shrimpton on behalf of the applicant, for the reasons that I have given I am entirely clear that there is no basis for now taking time to canvass the opinion of the fact finding experts or that of a new expert.

49. Before concluding I wish to acknowledge the genuine public interest which followed the *Wray* case and the reporting of the first hearing of the permission to appeal application in the present case. More generally the court is aware of sustained press comment to the effect that child abuse allegations which turn, as here, primarily upon medical evaluation, are conducted with superficial examination by the courts, reliant upon experts chosen and paid for by the Local Authority and where the evidence is not disclosed to the parents, who are not themselves permitted to instruct experts of their own choosing.

50. So that those who are interested in these matters may see what has occurred in this case and form their own view of the thoroughness and fairness of the process adopted by the Family court, an anonymised copy of the two key judgments in the case is to be released for publication alongside this judgment.

51. Those who take the time to read these judgments will note that at every stage the judge permitted the parents' legal team to instruct experts on any aspect of the case that they, the parents, considered relevant and that the parents' choice of expert was

accepted by the court. In addition the court agreed to testing of the child whenever such was sought on behalf of the parents, even on one occasion when that testing was contrary to medical advice.

52. In the same context two factors stand out from this short process before the Court of Appeal:

a) The parents have been permitted to instruct a nationally eminent expert of their choosing. This has occurred without even the knowledge of the Local Authority or the Children's Guardian let alone the active involvement of those parties;

b) The system, through the sense and wisdom of the solicitor and junior counsel for the child, has secured the introduction into the case at this stage of the very QC who represented the parents in the *Wray* case and established the existence of rickets. She was, quite properly, instructed to audit and evaluate the evidence in the case and to form her own independent view of the validity of the points now raised.

53. Drawing matters together, the application for a further adjournment so that further expert opinion may be sought is unsustainable. For the reasons that I have given the applicants have no reasonable prospect of persuading the full Court of Appeal to overturn HHJ Carr's refusal of their application to re-open the fact finding process. In the circumstances permission to appeal is refused.

ADDENDUM

EXTRACT FROM SKELETON ARGUMENT ON BEHALF OF THE CHILD FOR THE 'PERMISSION TO APPEAL' HEARING LISTED BEFORE McFarlane LJ ON THE 1ST NOVEMBER 2012

E THE MAIN ARGUMENT? VIT D DEFICIENCY AS A BENIGN CAUSE FOR THE INJURIES

This submission made on behalf the parents lacks a fundamental understanding of the interplay between Vit D Deficiency and rickets and ignores the following:

1) The skull is one of the first bones to lose bone density as its supply of Vit D and the formulation of calcium is sacrificed to the brain, blood and nerves. Vit D deficiency affecting the bones can manifest itself by wormian holes or craniotabes (softening or thinning of the skull). Baby C was delivered by Forceps. Dr Takon (Consultant Paediatrician with specific expertise in Vit D deficiency) advised that '*rickets result from deficiency in Vit D which affects adequate bone formation. This is a disease of the growing bone and does not occur in utero. It can be caused by nutritional causes such as when there is a diet deficient in Vit D. Rickets does not resolve without treatment. Children with malabsorbtion and abnormal renal function which affects Vit D can present with rickets. C's kidney functions, liver function and blood results were all normal. C had normal Vit D levels. The classic clinical signs of rickets are bone deformity. In infants the skull, the upper limbs and the ribs are the most affected due to the rapid growth of these bones during this period (Kruse). Deformity of the skull bones and bulging of the ribs are some of the bony changes that can be seen in addition to abnormal laboratory results. C had none of these biochemical or clinical features. He had normal Vit D levels'.*

2) If baby C was born with congenital rickets derived from Vitamin D deficiency in utero, Vit D supply would have been its lowest at birth and from that point on would have robbed the bones of their supply before the Vit D supplements provided by the formula milk had taken effect.

3) The dating of the fractures, in any event, takes the point of infliction of them from after birth: the oldest was the 6th rib. Even if we reject the expert opinion that this was not birth related and assume it may be (because of problems with dating the healing rate of calcium deficient bones) that leaves the

   a. Posterior fractures of the right 10th and 11th ribs;

   b. 8 metaphyseal fractures of both distal and both proximal tibiae, left proximal fibula; both distal tibiae and right distal fibula;

   c. Transverse fracture of the right femur.

4) These were all dated at less than 11 days as at 2.11.09 i.e.: sustained on or after the 22nd October 2009, Baby C's date of birth being 3.10.09 (Dr Halliday Page E39 (paragraph 5.4).

5) It is significant

   a. that they were thus most proximate to the normal Vit D reading obtained from Baby C on 6.11.09. and

   b. That they showed signs of healing (see the well formed callus on the Right femur between 30.10.09 and 4.12.09 and the signs of healing on other fractures between the X rays of 2.11.09 and 12.11.09). The healing process demonstrates that Baby C's bones were capable of utilising calcium to regenerate and form new bone.

6) This point was emphasised and addressed further by Professor Bishop (whose evidence was accepted by HH Judge Carr QC) at no. 7 page E108 *"It would be difficult to see how he could have been severely deficient at birth, have normal-looking x-rays and normal blood tests 4 weeks later without treatment-level intervention (3000 IU vitamin D/day; milk formula contains 40IU/100ml)";*[1]

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[1] **The jointly instructed expert , Prof Bishop , and his conclusions at E107:** *' C underwent a number of blood tests including two bone profiles, and had his serum PTH measured twice and his serum Vit D level measured once. His levels of calcium and phosphate were at the upper end of normal range for age as is frequently observed following fracture. His serum alkaline phosphates was not elevated (272 and 260 IU/l) and his PTH was suppressed (&) probably because his calcium level was higher than average. His Hydroxyvitamin D level was very good (76.7 n/mol/l on 6.11.09: higher than is seen in infants at that age. These are normal responses following fracture in a Vit D replete individual: prior vitamin D depletion would be unlikely given the formula feeds he had been on (which contain Vit D and his normal serum PTH and alkaline phosphates. His platelets were slightly elevated and on of the clotting test times were reduced, neither of these are associated with bone fragility. Maternal 25 Hydroxyvitamin D has also been measured and is sub optimal at 39 n/mol/l on 13.11.09 in association with a PTH is close to the upper limit of the normal range at 6.25 pmol/l; however this is not a particularly low level of Vit D for a pregnant mother and one would not expect it to impact on the Vit D status of the new born on transplancental calcium transfer (which is not dependent on Vit D).*

7) Dr Takon agreed '*calcium metabolism in the foetus usually involves transfer of calcium from the mother to the infant. The growing foetus does require increasing calcium requirements which continue to be derived from maternal supply through the placenta. During delivery , when the baby is born, there is an abrupt drop in the supply of calcium which then stimulates the baby's calcium regulating hormones kicking in and gradual stabilization of the calcium levels in the new born. The calcium levels can therefore be low at birth and then trigger secretions of Vit D in the infant to help stabilize the levels' (*E 128)

8) Prof Nussey agrees on this critical issue (@ CoA bundle 100) '*whilst it is likely that (baby C) was born with vitamin D deficiency and low iron stores, it is clear that C was bottle fed with Vit D and iron supplemented proprietary feed. In a population study in Canada a small number of bottle fed children with rickets have been reported (Ward et al Ref 5). However, the serum 25 hydroxyvitamin D on 6.11.09 was 76.7nmol/l and the serum calcium, phosphate and parathyroid hormone were all normal reflecting this serum Vitamin Concentrate. This, whilst it is recognised that the quantities of Vit D in formula feeds are calculated to prevent rickets rather than to optimise bone mineralisation it is ,on the balance of probabilities unlikely that vitamin d deficiency played a significant role in bone fragility pre disposing to the fractures with which C presented*'

9) It is highly relevant that all bar one of the bony fractures were

a. of the same age (less than 11 days old)

b. of which 8 were metaphyseal

c. posterior re ribs

The fractures (in position and type) were considered to be highly indicative of NAI

It is not just that those fractures which were present were characteristic of inflicted injuries but the absence of others which might tend to suggest rickets that is relevant

- No multiple fractures of multiple ages;
- No fractures where the majority were the oldest and most proximate to birth (before the fortified milk had ameliorated any deficiency);
- No fractures to the skull or the shoulders during the birth process and applied forces within it ;
- No fractures thereafter to those parts of the body most commonly handled in bathing, changing nappies and dressing / undressing.

We suggest that not only were the type of fractures sustained by Baby C most commonly associated with inflicted injury but he did not have those fractures which are suggestive of early onset of, and gradually resolving, bone fragility.

9 **Not only were the fractures not those of the type, distribution and multiple ages suggestive of rickets but there were also no radiologically evident signs of rickets**

For example see Dr Halliday @ E 119 just as an example: who had looked at the x rays for signs of oesteopenia (where the bones appear less white on an x ray) and wormian holes (small bones within the sutures of the skull). Nor were there visible signs of widening and splaying of the growth plates or widened periosteal reactions.

By itself, it may be that this was not conclusive evidence of the absence of rickets, BUT it is to be seen in conjunction with the point above and the points below.

10 **Bone Density/ Appearance.** Baby C's scans and x rays were examined by treating medics and experts for signs of any bone abnormality. This included the skeletal X rays and CT skull imaging.

None were found. Again, by itself it may be argued that this does not conclusively rule out rickets but it is highly relevant when considered in conjunction with the other matters in this section.

Dr West (Const Paed): *'no radiological of any underlying bone abnormality'* (E3)

Dr Halliday (Neuro Rad) *'there is no evidence of abnormality of C's bones on the radiograph which make him particularly susceptible to fracture. In particular there is no evidence of osteogenesis imperfecta or brittle bone disease* (E38) and again @ E119 *'rickets is also associated with osteopenia. Together with widening and splaying of the growth plates (cartilaginous strips at the end of the bone) and some times a wide spread perisosteal reaction. These features were not present on C's films'*

Prof Bishop (Prof Paed Bone Disease) *'the size and architecture of the bones looks normal to me. There is no evidence of loss of bone mass'.* and then @ E108 *'there is no evidence of any bone abnormality or bone fragility. The pattern of fractures is characteristic of non accidental injury rather than bone disease. In my opinion C's bones are normal and he has been the victim of non accidental injury.*

11 **Vitamin D deficiency affects the whole of the central nervous system of a baby's body, it is essential to feed the nerves and brain cells, it follows (as Al Alas explored at length) that its absence makes the baby -**

1. vulnerable to seizures (prone to hypocalcaemic fits)
2. with an increased susceptibility to infection and
3. with a decreased ability to recover from infection

These are the clinical signs of Vit D deficiency. (see Dr Takon @ E47)

Baby C exhibited none of them either at the time of his admissions or on report of the parents between them. He did not have an infection. (see Dr Takon @ E48/ E 50/ E 55/ E 126)) If he did have an infection he had been able to fight it off.

Clinically Baby C did not show signs of Vit D deficiency

Conclusion: In Baby C's case all the multiple ways of detecting rickets and Vit D deficiency pointed in one direction and away from it being a causal factor in the fractures he sustained:

- **The absence of the type, number and age of fractures more likely attributable to rickets**
- **The presence of fresher fractures close to the normal Vit D testing and their type**
- **the lack of radiological evidence of rickets**
- **the lack of biochemistry results indicative of Vit D deficiency**
- **the lack of clinical indicators of Vit D deficiency**

These factors, individually and collectively demonstrate that whatever condition Baby C may have been born with, rickets and on going Vit D deficiency does not provide a benign cause for the fractures he sustained.

This is not news . Dr Takon in her report @ E 60 considered and pulled together the significance of the mothers Vit D levels, her bone density scan and concluded that baby *'C does not show any physical, biochemical or radiological features of Vit D deficiency'*. As did Prof Wyatt @ E 100 and Prof Bishop @ E 107.

Moreover, Baby C did not only suffer from fractures found to have been inflicted, he also sustained genital injuries which were found to have been inflicted. There is no link identified by Prof Nussey between the genital presentations and the fracture related presentations.

F THE GENITAL INJURIES

Whilst baby C's genital symptoms (injuries) seen by Mr Roberts on the 26.10.2009 were initially diagnosed and treated by him as an infection for which he prescribed antibiotics, there is in fact, no objective evidence of infection. There were no clinical signs of infection, C's temperature was normal, C's blood test results were normal[2]. (see Dr Takon @ E56) . Baby C had no other treatment or diagnosis for infection in the first four weeks of his life. The conclusion of those experts who considered Baby C's genital injuries were that they were 'unusual and worrying' and the result of traumatic injury where no accidental explanation had been given by the parents (e.g.: see Prof Wyatt @ E 93)

With no evidential base for rickets/vitamin D deficiency and no evidential base for infection, there is no underlying reason why C should present with injuries to his genitalia.

Prof Nussey agrees and can see no linking cause between the presentations.

Ms Jo Delahunty QC
Mrs Denise Marson

[2] It is of significance that the blood was taken from C whilst at Rotherham District Hospital (RDH) this was prior to antibiotics being prescribed at Sheffield Children's Hospital (SCH), see F23 from the original care proceedings bundle re discharge from RDH, and F173 – F174 re admission to SCH. See also further reference at page 98 of Prof Nussey's report. The lack of infection 'markers' was NOT as a consequence of antibiotics having been prescribed.

IN THE SHEFFIELD COUNTY COURT

[redacted]

ROTHERHAM METROPOLITAN BOROUGH COUNCIL

Applicant

[redacted]

JUDGMENT

INTRODUCTION.

1. This hearing has been concerned with a finding of fact to establish the threshold criteria pursuant to Section 31 of the Children Act 1989. The child concerned is [redacted] and his parents are [redacted] I shall hereinafter refer to the parents as father and mother. The purpose of this hearing has been to determine unexplained injuries that [redacted] suffered in the first month of his life.

2. The hearing commenced on the 21 June 2010 and principally involved the calling of medical experts. The hearing concluded on 1 July with closing submissions.

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BACKGROUND.

3. C is father's fourth child. His 3 older children are who is now years old and his second and third children are who was born on the and born The second and third children are as a result of father's marriage to from whom he separated in 2000. C is mother's first child and she had never expected to fall pregnant as she suffers from polysystic ovaries. Although mother and father have known each other, for according to father about 16 years, they did not commence living together until 2007. Both mother and father put the date as the 17 November 2007. It seems to be agreed that they moved from in March 2008.

4. The due date for C s birth was the 21 September 2009 but he was not in fact born until 8.14pm on 3 October 2009 weighing 7lbs 9ozs. It was a forceps delivery at General Hospital and by all accounts C was fit and healthy at birth as the paranatal summary and the new born examination showed in the papers (F36-42) before me.

5. On the 8 October 2009 mother was admitted to H with a subdural tear as a result of her epidural and remained in hospital for 48 hours whilst father and maternal grandmother cared for C It seems from the maternal grandmother's statement to the Police (G11) that she stayed with mother, father and C until about the 16 October 2009.

6. On the 26 October 2009 (Monday) C was taken by mother and father to the Accident and Emergency Department at GH. They were seen at 05.13 by a specialist registrar Dr as C had a bleeding penis, and a swollen penis and testicles, C was prescribed by Dr paracetamol and was referred to GH's paediatrics department. He was later seen on the 26 October 2009 by a consultant paediatrician Dr who "flagged up" non-accidental injury but ordered C transfer to the Children's Hospital CH) for a surgical opinion.

7. A colour photograph of C genital area was taken at GH and on arrival at 13.00 hrs on the 26 October 2009 he was seen by a specialist paediatric registrar (Dr at 13.40 for the taking of a history and differential diagnosis. He was later seen by a consultant paediatric urologic surgeon (Mr who ultimately discharged C home with his parents, having prescribed antibiotics.

8. On the 28 October 2009 father collected his second and third children from so they could come and visit mother and father and C at their home in

9. On the 30 October 2009 (Friday) C was taken by mother and father (and indeed to the Accident & Emergency Department at CH at about 22.14 with a swollen right leg. The following day, 31 October 2009, (Saturday) a specialist registrar Dr filled in the Child Protection Medical Pack and the next day Social Services Department were contacted by CH and on Monday 2 November 2009 various skeletal surveys were ordered effectively of C whole body. He

was found to have multiple fractures in the ribs, and in his tibia and fibula which were metaphyseal fractures together with a transverse fracture of his right femur.

10. This triggered a police investigation, with the parents being interviewed (on 3 November 2009) at length by the police. Further tests were undertaken of C and as at 5 November 2009, C from an orthopaedic point of view, was ready for discharge. The Applicants' issued care proceedings and the matter was transferred to the Care Centre.

11. C was in fact discharged from to foster carers, under an interim care order, on 11 November 2009 and directions were made by the Recorder of Sheffield.

12. on the same date, were interviewed by the police and the following day a repeat skeletal survey was carried out and pursuant to the Recorder's order mother and father filed statements setting out their version of events. Timetabling took place on 26 November 2009 with a guardian being appointed on 9 December 2009. There were further directions on 15 January 2010 and 26 February 2010 with the case coming before me on 8 April 2010. Since that date I have had the case management of this matter.

13. The timetable has been tight because the parents' clear unequivocal stance has been that there is a medical reason for the multiple fractures and the scrotum injury that C sustained. From the father's perspective he believed it to be as a result of birth injuries and from the mother's perspective she believed it was some form of

bone fragility. This stance has been maintained throughout the proceedings, with father also adopting mother's arguments.

PROGRESS OF PROCEEDINGS.

14. Given that C was such a young child and with the multiple injuries he sustained, part of the evidence has been from the treating doctors, and once it became apparent that the treating doctors considered that his injuries may be inflicted, the court has been concerned to ensure, that there has been a constant overview by other medical experts. In late December 2009 Professor who holds the chair of Paediatric Bone Disease at University suggested that the pattern of fractures C sustained was far more suggestive of non-accidental injury than it was of osteogenesis imperfecta (OI) and he would not recommend genetic testing.

15. By the 15 February 2010 a report had been obtained from Dr who is a consultant paediatric radiologist based at 's Hospital

16. On the 23 February 2010 Dr a consultant paediatrician at Hospital also reported. She like, Dr had been instructed to provide an overview.

17. By 9 April 2010 a consultant neonatologist (Professor) reported and on 18 April 2010 Professor reported following instructions from all parties as to whether or not OI was a possible explanation for presentation on 30 October 2009.

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18. On 20 April 2010 Dr a clinical scientist was asked by the parents to perform genetic testing for OI in spite of Professor 's and indeed Dr s concerns as to the assistance this may render the court in determining C s presentation on the 30 October 2009. A general practitioner (Dr) failed to take blood from C 23 April 2010 however on 11 May 2010 a general paediatrician (with an interest in child protection) Dr from Hospital in successfully took a blood sample from C to enable genetic testing to take place.

19. Dr eported on the 10 June 2010 dealing with the genetic testing that she had carried out. Thereafter the case proceeded to the finding of fact on the 21 June.

INJURIES SUSTAINED.

20. It is admitted by the parents that on or about the 30 October 2009 C suffered fractures as follows:

(a) transverse fracture of the right femur

(b) fracture of the anterior end of the left 6th rib.

(c) fractures of the 10th and 11th ribs.

(d) fractures of both tibae and fibula metaphyseal

(e) metaphyseal fractures of both femora

A total, therefore of 12 fractures, in a baby who was non mobile and not yet one month old.

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21. Both parents admit that on the morning of 26 October 2009 C was taken by his parents for treatment for swelling of his genitalia whence it was also found there was a cut/tear to his penis and a bruise on the outer side of his left thigh.

THE PARENTS' CASE.

22. It is the parents' case that the injuries have a medical cause. They both emphatically deny that either of them have inflicted any injury on C They do not seek to blame any other person for the injuries as detailed by the doctors.

23. The only explanation prior to the hearing, ever given by either of the parents for the injuries was by father, in terms of an accidental injury, to C's ribs as a result of his winding technique. However what is clear is that father is an experienced parent, unlike mother who is not.

24. The local authority suggest that all the injuries are non accidental in origin and that is the findings they seek.

ISSUES.

25. The issue in this finding of fact is to attempt to resolve the position of the parents in the context of the evidence that has been called. Of lesser note is that, although C has been medically examined subsequent to his placement with foster carers', (15 February 2010 by Dr T and 30 March 2010 by Professor no fractures have been seen. He was also seen by Dr for a short period of time on the 11 May 2010 and none of these doctors saw anything indicative of C fracturing his bones again.

LAW.

26. The House of Lords in their decision Re: B (children) FC 2008 UKHL 35 considered the standard of proof to be applied to the finding of fact. At paragraph 3 Lord Hoffman said

> *"the effect of the decision of the House in re H (minor sexual abuse): (standard approved) 1996 AC563 is that Section 31 (2)(a) of the Children Act 1989 requires any facts used as a basis of a prediction that a child is likely to suffer significant harm to be proved to have happened, every such factor is to be treated as a factor issue..... it is this rule which this house reaffirms today"*

27. In considering the standard approved to be applied (at paragraph 70) Baroness Hale of Richmond held;

> *"the standard of proof of finding the facts necessary to establish the threshold under Section 31 (2) or the welfare considerations in Section 1 of the 1989 Act is a simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account where relevant in deciding where the truth lies".*

28. The test has been set out again by Baroness Hale of Richmond in her judgment in the case of Re: S-B (children) (non-accidental injury) 2009 UKSC 17: (2010 1FLR 1161 at paragraph 43) where she held

"if the evidence is not such as to establish responsibility on the balance of probabilities it should nevertheless be such as to establish whether there is a real possibility that a particular person was involved. When looking at how best to protect the child and provide for the future the Judge will have to consider the strength of that possibility as part of the overall circumstances of the case".

29. It seems that the law is now settled in terms of attributability as a result of Baroness Hale explaining the decision of the House of Lords in Re. O and another (minors) (care): preliminary hearing (2003 UKHL 18) which was concerned with the common problem where a child has been harmed at the hands of one of its parents but the court cannot decide which. The attributability condition is satisfied in that case as Lord Nichols held in Re: O (paragraph 27)

"Quite simply it would be grotesque if such case had to proceed at the welfare stage on the footing because neither parent was considered individually to have been proved to have been the perpetrator, therefore the child is not a risk from either of them. This would be grotesque because it would mean that the court would proceed on the footing that neither parent represents a risk even though one or other of them was the perpetrator of the harm in question".

30. As Baroness Hale explained in Re: S-B

"The Judge at the disposal hearing will take into account any views expressed by the Judge at the preliminary hearing on the likelihood that one carer was or was not the perpetrator or the perpetrator of the inflicted injuries. Depending on the circumstances, these views may be of considerable value in deciding the outcome

of the application for instance whether or not the child should be rehabilitated with his mother.

31. Similarly in Re: D (care proceeding: preliminary hearing 2009 EWCA Civ 472 as Wall LJ (as he then was) neatly put it

"If an individual perpetrator can be properly identified on the balance of probabilities then.....it is the Judges duty to identify him or her. But the Judge should not start on the premise that it will only be in an exceptional case that it will not be possible to make such an identification".

32. In Lancashire County Council –v- D & E (2008 EWHC 832) Charles J considered the approach to be taken in assessing whether the symptoms/injuries were organic or inflicted as:

(i) to determine the range of possible explanations for the injuries seen.

(ii) assess the degree of likelihood for each explanation.

(iii) decide which explanation/s can be established as a real possibility.

(iv) decide which real possibility can be established as an event that was more likely than not to have occurred (paragraph 26).

He further held:

"The correct position is that a medical view as to the most likely cause of injuries is that that cause is clearly established as a real possibility that has to be

considered in all the circumstances of the case, together with the other possibilities in determining whether a child was a victim of an inflicted injury".(paragraph 36)

The medical evidence in conclusion together with the reasoning underlying it, are, as I have explained, only parts of the overall picture of jigsaw, or be it important parts. Put at its simplest the court will have additional information and that information will include its findings relating to the evidence of the parents and thus the events in the household in the observations of the clinical presentation of the child" (paragraph 86).

33. These are factors that I have borne in mind, and when I say I have considered the Law it is against this backdrop, but more particularly that of the Human Rights Act 1998. I have been, since I have had the case management of this matter, anxious that the parents should have a full and proper opportunity to have the treating doctors opinions' tested by acknowledged independent experts. I am satisfied that this was right because the consequences, if these are inflicted injuries is extremely serious for C and his parents. The parents have had full and proper access to independent experts and have been able to challenge the opinions of the doctors and more particularly to have their questions answered by them. I have been determined to ensure that the Human Rights Act 1988 and in particular Articles 6 & 8 have been fully complied with, even though some of the decisions made at an interlocutory stage have been criticised by acknowledged experts in the field of medicine (such as the 01 genetic test).

34. I further remind myself, where I consider that there may have been some lying what the impact of those lies maybe, by providing myself with the type of direction that one would ordinarily give a jury pursuant to the case of R –v- Lucas 77 CR.APP .159 so that I must ask myself whether or not a party did in fact deliberately tell lies and to remind myself the mere fact that someone tells a lie is not itself evidence of guilt, but that a person may lie for many reasons, such as to bolster something that may be true, to protect someone, to conceal some other disgraceful conduct, falling short of an unlawful act, so that if there is an innocent explanation I should take no notice of any lies.

EVIDENCE CALLED.

35. I heard from Dr who was the treating paediatrician, specifically called in by the specialist registrar to examine C for non-accidental injury in respect of the scrotal presentation on 26 October 2010. I next heard from Mr who was the paediatric surgeon with a specific interest in urology. I heard from Dr who was the independently instructed paediatrician but sadly her evidence could not be completed during the course of the first day. Dr who is a clinical scientist and heads up the Molecular Genetic Service at the Hospital gave evidence on her comprehensive analysis of 2 of C genes particularly COL 1A1 and COL 1A2.

36. I then heard from Dr who took the blood from C to enable to Dr to carry out the tests that she was so ordered to do. Dr a paediatric radiologist instructed by all relevant parties next gave evidence, having examined the x-rays

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taken of C[redacted]s fractures. She also dealt with questions that arose during the hearing by way of e-mail on 28 and 29 June 2010.

37. Professor [redacted] was the next to give evidence and following his evidence Dr [redacted] was recalled to complete her cross-examination. Professor [redacted] consultant neonatologist gave evidence, who again was instructed by all parties and finally by way of doctors, Dr [redacted] who was the treating paediatrician for C[redacted] injuries seen on 30 October 2009. She came on the ward on 2 November 2009. I then heard in detail from the parents.

38. Having set out the live evidence that was called, it does not do justice to the four lever arch files which form part of the evidence in this case. It is obviously necessary to have a detailed knowledge of this evidence, which comprised the statements from the parents and the lead social worker together with all the numerous medical reports, (not all doctors being required to give live evidence), the medical records from [redacted]GH and [redacted]CH together with the police evidence in respect of their enquiries into C[redacted]s injuries.

39. The police case is still proceeding and both parents are presently on police bail. There are written statements from the maternal grandmother, from the treating paediatricians (Dr [redacted] and Dr [redacted]), a report from Mr R[redacted] together with witness statements from mother's brother ([redacted] and his partner ([redacted]).

40. A principal piece of evidence has been the police interviews which comprise over 700 pages and involve mother and father and also father's second and third children

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Although neither [redacted] were required to give evidence their police interviews have played a part in this case. The other pieces of evidence, all of which I have had the opportunity of looking at and reading, are the foster carers notes of the care they have been provided C[redacted] together with the contacts that the parents have attended for 1 ½ hrs each week day since C[redacted]' admission into care. All in all this is a very substantial case where the parents have not accepted, nor will admit that they have done anything to cause the injuries found on their son C[redacted]

ANALYSIS OF EVIDENCE.

INJURY TO C[redacted]S SCROTUM AND GENETAL AREA.

41. Dr [redacted] was the examining paediatrician of C[redacted] on the 26 October 2009. He found that C[redacted] suffered

(a) bleeding into his nappy

(b) swollen scrotum and penis

(c) a cut at the base of his penis, and

(d) bruises to his perineum and left outer thigh.

Dr [redacted] was clear about these 4 injuries, both in his notes, his written evidence and his oral evidence. The first 3 injuries were acknowledged by both mother and father in their evidence. Father, although he disputed the bruises to C[redacted]'s thigh and perineum accepted Dr [redacted] was clear about it. These injuries raised in Dr [redacted] a suspicion that they were non-accidental. It is also personate to note although, Dr [redacted] was not specifically asked about it, it is almost inconceivable when he had been asked to examine C[redacted] because members of his team were concerned about

the possibility of an inflicted injury to the scrotum that he would not have seen if C had a broken right femur.

42. Dr was concerned about the presentation of C's scrotum and correctly referred him to the CH for the opinion of a consultant paediatric urologic surgeon. There was nothing in Dr's evidence that the parents can properly disagree with. It is apparent that neither the cut to 's penis nor the bruising seen by Dr (c & d) can be explained by a diagnosis of infection. On any view these 2 symptoms of themselves, have to have been inflicted in an infant of this age as C was not able to inflict them to himself accidentally.

43. I accept Dr 's evidence and his raised concerns about the possibility of non-accident injury.

MR

44. Mr is a consultant paediatric and urologic surgeon. He saw C on 26 October 2009 at about 4.00pm in the afternoon. He conducted an examination of C without seeing any medical notes and in particular the letter of referral written by Dr The evidence of Mr is particularly important as it was he, who reached a working diagnosis of infection, but he set out clearly both in writing and in evidence that had he received the information that should have been made available to him he would have taken a different course, in that he would have kept C in hospital for child protection checks, have ordered an ultrasound and it is therefore highly likely on the basis of the evidence, that this would have most likely revealed one broken rib.

45. In evidence Mr [redacted] categorically ruled out

(a) torsion

(a) hernia

(b) hydrocele

(c) orchitis

(d) epididymitis

46. At the time of C[redacted]'s examination he was not running a temperature but blood and urine had been taken from him. The blood and urine tests were clear which would have been the expected markers for infection, that is orchitis (c) or epididymitis (d). Mr [redacted] had not seen the photographs of C[redacted]'s genitalia which had been taken at [redacted]H and thereafter his opinion hardened. I accept Mr [redacted]'s opinion both as an expert and also as the paediatric surgeon who examined C[redacted] When he was asked to give his opinion now, but on the basis, without regard to the bone fractures, which were subsequently found, he was left with the view that the genital injuries were inflicted injuries and therefore non-accidental, in effect negativing his working diagnosis of infection.

FRACTURES ON 30 OCTOBER 2009.

47. C[redacted] at this stage was less than 4 weeks old. he was immobile and obviously entirely dependant on the care given to him by adults. Just as with the genital injuries, the parents have provided no explanation of an accident or other evidence which plainly raises a high level of concern, that the fractures were caused by inflicted injury. In respect of the fractures 2 consultant paediatricians Dr [redacted] and Dr [redacted]

gave evidence. Dr [redacted] obviously gave an overview and had had the advantage of reading all the papers in the case and also examined C [redacted] on the 15 February 2010. Dr [redacted] at [redacted] CH was the examining consultant paediatrician from when she came on duty on 2 November 2009 and was immediately concerned with the lack of explanation from the parents and the multiplicity of fractures. Simply looking at the evidence, both of Dr [redacted] and Dr [redacted] they were of the view that a transverse fracture of the femur, which involves direct impact on the leg is usually associated with non-accidental injury. The metaphyseal fractures are consistent with non-accidental injury and of course these affected both of C [redacted] legs. The rib fractures are caused by compression, a substantial force from squeezing and bruises are not necessarily seen. Just as the transverse fracture to the femur usually involves a direct blow any marks can fade very quickly. On any view according to the paediatricians C [redacted] would have been a very unsettled baby, having as he did, all these multiple fractures. I accept the evidence of the 2 paediatricians, who gave clear evidence that these were all inflicted injuries.

DR [redacted]

48. Dr [redacted] is a paediatric radiologist and she provided an overview. She gave clear, concise, and definite evidence. She found no radiological abnormality. She was very clear, that this level and quantity of fractures, where there is no bone diseases is really only indicative of inflicted injury. Dr [redacted] was particularly useful as to dating. She had of course had the opportunity to see the whole of the evidence presented in this case. She obviously examined, in great detail the x-rays taken. She was completely clear that 11 of the 12 fractures could not be caused at birth as there was no bony evidence of healing and therefore they had to be less than 11 days old from

when she looked at the x-rays which were taken on 30 October and 2 November 2009. Of the 11 out of the 12 fractures they had to have occurred sometime between the 19 October – 30 October 2009.

49. As to the rib fractures, she saw no formation of callus on any bar the left 6th rib. That therefore put the dating for the left rib between the 3 October – 26 October but if she had to put an estimate on it, she would put it at the 12 October. So far as the other fractures are concerned they would effectively date from 22 October 2010.

50. Dr [redacted]'s evidence was put in clear and simple terms namely, that short of an explanation for some form of accident in a baby of this age, 11 out of the 12 fractures were caused after his birth. She stated that metaphyseal fractures are very rare and that there was nothing unusual with [redacted]'s bones and overwhelmingly the injuries that she saw were inflicted and therefore non-accidental. She went further and informed the court that the injuries were inflicted on a **minimum** of 2 different dates and the fractures involved a **minimum** of 3 different inflictions of force however Dr [redacted] could conceive of the metaphyseal injuries all being caused together. The posterior fractures to the right 10th and 11th ribs could be caused together and the transverse fracture of the right femur was likely to be caused being by a different application of force, but at the same time as the metaphyseal injuries. Obviously, on the basis that the scrotum injury is non-accidental, there has been a fourth infliction of force in respect of that injury. The anterior fracture of the left 6th rib had the callus forming around it and therefore was earlier. She believed the rib injuries were caused by squeezing and that winding would not cause fractures. The metaphyseal fractures

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were caused by twisting and torsion and the femur by direct blunt force. These same mechanisms were also agreed by Dr [redacted] and Dr [redacted]

51. I unreservedly accept the evidence of Dr [redacted] and indeed it is not disputed by the parents that C[redacted] suffered the fractures as identified by Dr [redacted] on the x-rays. They simply dispute the mechanism and believe the fractures to be organic and due to a medical condition.

PROFESSOR [redacted]

52. Professor [redacted] is a consultant neonatologist at [redacted]. He was specifically instructed to provide a medical opinion or explanation as to whether any of the injuries could have occurred, as maintained by the parents, during pregnancy, birth or delivery. The scrotum presentation as seen on 26th October 2009 caused him considerable concern, but correctly he deferred to Mr [redacted] and acknowledged there were no positive indicators of infection.

53. At the crux of father's case was that the fracture to the femur was caused at birth. Professor [redacted] effectively ruled this out particularly in a normal birth, albeit assisted by forceps. Professor [redacted] had also examined the medical records relating to the obstetrics and midwifery notes. There was nothing at all in mother's medical records to suggest any problem at birth nor did he find any evidence of bone disease. He was clear that none of the injuries were caused at birth.

54. Father was concerned that he might have caused the fractures by winding. Mother and father have consistently maintained that there was no accident that they could

think of. Somewhat late in the day father suggested in oral evidence that he might have trapped C's leg between himself and the chair. This explanation I really discount on the basis of all the other evidence and particularly, the first time it was mentioned was during the course of father giving evidence. As regards the rib fractures being caused by father's winding mechanism I bear in mind that the mother of is a paediatric orthopaedic nurse and father told me that he learnt winding technique from her. Professor did accept that holding a baby in a certain way and winding him could potentially cause the rib fractures, but he regarded it as unlikely and he specifically linked it, to an inexperienced carer whereas father is not. Father's account in any event was of gentle rubbing and patting and that was what was seen by his older children and indeed I find it highly unlikely, to such a degree, that I can discount any suggestion that father could have caused the rib fractures by his winding mechanism.

55. Professor could not support any of the injuries having occurred at birth and as such I can effectively discount that also.

BONE FRAGILITY.

PROFESSOR AND DR

56. This is essentially mother's case supported as it is by father, notwithstanding he told the social worker on the 15 March 2010 that he did not think that C suffered from bone disease. Father has now changed his stance and considers that the cause may well be bone disorder or OI.

57. Of necessity in the light of the stance taken by the parents and the fact that mother has maintained that there is some bone disorder in her own family and some possibility in father's family ([redacted]) the question of OI had to be seen as a real and distinct possibility. Professor [redacted] accepts referrals from the whole of Western Europe and he examined [redacted] for about an hour and was satisfied that in his clinical judgment [redacted] did not present with OI or other brittle bone disease. At the crux of Professor [redacted]'s findings was that metaphyseal fractures only accompanied bone fragility in extremely rare cases, in fact Professor [redacted] has only seen one such metaphyseal fracture and then there was an obvious explanation for it.

58. Professor [redacted] also emphasised the gravity of metaphyseal fractures when viewed by pathologists as of course the bones attach the growth plates in children. He also stated that multiple metaphyseal fractures is "out with my experience of children with brittle bone disease or OI".

59. It is this crucial factor, as he emphasised during the course of his detailed and careful evidence, that led him to the clear conclusion, with no radiological evidence to support OI or brittle bone disease, nor anything in his clinical examination to support any bone fragility that these were inflicted injuries. The fact that children with bone fragility do not suffer metaphyseal fractures and the multiplicity fractures sustained by this non mobile 4 week old baby led him to be unambiguous that the injuries had to be non-accidental.

60. On his examination he did state that he did not believe [redacted] to have dysmorphic features but even if he were wrong in that they are not ones associated with bone

fragility. The aspect of dysmorphic features arose as a result of Dr taking blood from C for the purpose of the genetic testing and her reporting that she thought C may have "soft" dysmorphic features. This view was not shared by either Dr or Dr who saw C over a period of time nor indeed was it shared by Professor all who did not consider C to be dysmorphic.

61. As the result of Dr suggestion, at one time it was muted, and in this there was passive support from Dr namely if C had dysmorphic features it may be that an assessment by a clinical geneticist would assist. However effectively Professor ruled out any suggestion of engaging a clinical geneticist because metaphyseal fractures are not seen in the babies and young people, he sees, who have bone fragility..

62. Dr as a clinical scientist examined C blood for COL 1A1 and COL 1A2 being the genes responsible for causing the great majority of bone fragility. C also had negative results of vitamin D test for rickets nor he was premature and or course his bones were seen by Dr to be normal on x-ray. All in all, as Dr stated clearly and unequivocally bone fragility in C is exceptionally unlikely and statistically now very unlikely, such that it can be discounted.

63. There is no evidence to suggest that has suffered any further fractures whilst in foster care and of course he has been seen by many doctors over that period.

64. Even if there was bone fragility (which there is not) it would not of course explain the genital injuries, particularly the bruising and the small cut even if (which I do not

think) the other injuries to his scrotum were infection. All in all the evidence from Professor [redacted] and Dr [redacted] discounted any prospect of bone fragility as being the cause of the fractures. I am also satisfied that [redacted] is not dysmorphic and that mother is correct not to seek a full skeletal survey to clarify whether or not [redacted] has suffered any further injuries. In respect of both applications I would have been inclined, once I heard the evidence from Professor [redacted] and the responses from Dr [redacted] to discount any further invasive investigations of [redacted] be they in the form of skeletal surveys or assessment by a geneticist.

THE PARENTS' EVIDNECE.

[redacted]

65. [redacted] believed that she was unable to have children and in her statement to court and in her interview with the police it is quite apparent that she minimised the stress that she was under. This has been corroborated by [redacted] on arrival from [redacted] with father to visit his home in [redacted] on the 28 October (G443) and again on their return from the cinema on 30 October 2009 (G25). It is also clear that mother was so concerned about father's reaction to her pregnancy that she was worried that he may leave her and certainly spoke to members of his family prior to telling father she was pregnant. Indeed this is confirmed by Ms Ford in her helpful and full submissions, in that mother accepts that she made an offer to [redacted] that she would "go it alone" if he did not want her to proceed and there were discussions in the early days of the pregnancy about a separation.

66. Mother maintains that such thoughts were fleeting but she did tell her mother and sister first, that she was pregnant and spoke to [redacted]'s sister [redacted] for advice

on how to broach the topic with him. I am quite satisfied that mother's statement to the court is both disingenuous and untrue where she presented as if she and father were a calm and delighted couple on news of her pregnancy. Further the undoubted stresses she was put under post birth, together with the infection she suffered, and with a baby who appeared to have been quite demanding, were not detailed in either her statement or police interviews.

67. I was extremely surprised that [redacted] who holds down a good job was simply unable to remember very many reasonable details that were sought from her by Mr Prest, such as who changed [redacted] on the night his scrotal injury was noticed.

68. She has continued in her belief that a medical explanation will be found for [redacted] injuries and she will continue her fight to search for the same. She emphasised this to the court in a handwritten letter she read out. It is apparent that [redacted] has been the subject of medical investigations that are not medically justified and indeed even during the currency of this hearing, further investigations were canvassed by the parents, in particular the mother.

69. I do consider that mother did want [redacted] to be a girl. Even though, I accept, she was under considerable stress whilst being interviewed by the police she twice referred to [redacted] as 'her'. The fact that father confirmed this adds weight to it. I am also quite satisfied that mother attempted to give the impression that everything was 'fine' in her relationship with father when the reality is, they were under considerable pressure both as a couple and embarking on parenthood (again for father) and for the first time for mother.

70. It is inevitable given the way in which the case has been run and the fact that mother maintains, in the light of the overwhelming medical evidence, that there is a medical cause for [redacted]'s injuries, anyone who had [redacted]'s interests as paramount would have very great concern for her ability to parent [redacted] at all with the substantial risks of physical and emotional harm he may suffer. There is an argument that mother has attempted to prioritise her own needs over [redacted]'s by the way in which this case has proceeded.

71. The stress in the parents' relationship was shown in the final cross-examination by Miss Ford (on behalf of mother) when she suggested that father had failed to take the oath and he chose to affirm. This obviously makes no difference at all to the court but it is an indication of the stresses in their relationship and mother should look long and hard at the injuries that [redacted] has suffered and accept that there is no medical explanation for them and decide where best to go forward not only for her sake but also for [redacted]

[redacted]

72. In many respects I make exactly the same findings regarding [redacted] as I do of [redacted] He should look long and hard at this judgment and the fact that there is no medical explanation to support an organic reason for the injuries sustained by [redacted] and decide which way the case should go. It is for this reason that I order position statements once the parties have had time to reflect on what they both acknowledge and accept are now inevitable findings in the context of how the medical evidence has stood up to the full and detailed challenge made by their representatives.

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73. I have been concerned about [redacted]'s evidence. It is quite apparent that father did not want another child, stating he was "not a happy bunny". He also sought to portray, mother as loving every minute of parenthood, when it is quite apparent that she did not. I have been disquieted by the fact that father has twice discussed with mother that he is prepared to falsely admit he caused the injuries so that [redacted] could be returned to mother's care.

74. I struggle why in his statement to the court he did not tell the truth, when again he is an intelligent man who has for sometime been self-employed as an IT consultant. He stated they were "astonished and delighted when [redacted] found out she was pregnant" (C23) I simply do not accept that to be the position in the light of his oral evidence. The fact that the parents maintained to the police, and father in his statement, that there were no stresses in their relationship belies the truth. I find it incredible that father could not recall whether he discussed with mother having a termination when it is quite plain that must have been so when he learnt of mother's pregnancy.

75. Father also prepared a statement which he read out in court which Mr Prest described as 'extraordinary' and indeed I so find.

76. Having found that father did not desire a fourth child I have struggled with whether or not he said "goodbye little girl" twice to [redacted] as was heard by a nurse. On balance I can think of no reason, other than that the nurse did hear father say this, not once but twice, otherwise why would she record such a fact if it were not true? To some extent

this fact causes real concern as both mother and father appear to have desired a girl and C[redacted] 3 ½ weeks suffered the very unpleasant genital injuries.

77. As things stand father will continue in a fruitless search for a medical explanation for C[redacted] injuries.

IDENTIFICATION OF PERPETRATOR.

78. The parents have never suggested that anyone else could be a perpetrator. There is simply no other person who had the sole care of C[redacted] in the timeframe when these injuries were sustained (save for the fracture to the 6th rib) as all the other injuries were less than 11 days old on the 2 November 2009 and therefore sustained on or after the 22 October 2009. Although maternal grandmother [redacted], had care of C[redacted] following his birth no one suggests that she should either have been made an intervenor or that she had anything whatsoever to do with the injuries that C[redacted] has sustained.

79. The pool of perpetrators is therefore reduced to 2 people namely mother and father. I simply cannot make any identification as to who, between mother and father, was the likely perpetrator. Put simply each had the opportunity. In the light of the judgment of Re: S-B I am very conscious that I should refrain from attempting to give an indication of which parent may be more likely to have inflicted any of the injuries and I should do nothing further where it is not possible to identify the perpetrator.

CONCLUSION.

80. I have reached the clear and unequivocal conclusion that this case is one that involved inflicted injuries on a baby. There is much that was not revealed on the papers that came out in evidence, in particular the nature of the parents' relationship and as it was picked up by father's 2nd and 3rd children. I also note that father has never provided any contact details for either his eldest child [redacted] or [redacted]'s mother. This is in itself, in the light of the parents' evidence causes me some concern.

81. The local authority ask for findings to be made and I have reached the clear conclusion that the findings they seek are overwhelming and I so make them on the basis of the injuries as found by the various doctors which will be set out as a court order.

82. I urge the parents to consider this judgment carefully and reflect on the evidence that they have heard, which I am satisfied they fully understood, and decide what role, if any, they wish to have in the future of [redacted]. As a result of my findings it is plain that [redacted] suffered painful injuries, his testicles were hit or crushed. Further he had broken ribs, his knees and ankles were stripped or sheared. His femur was cracked all the way through. He is now a 'startled' baby, it is not known what (if any) psychological effects he will suffer in later life. He has been made to undergo blood tests which he has found distressing (Dr [redacted] His fracture to his femur has not fully resolved and he will require a paediatric overview for at least 3 years. Unless the parents are able to provide a clear position statement to the court, then the court will inevitably, in the light of these grave findings, proceed and look for alternative carers for [redacted] throughout his minority and more likely beyond..

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83. The parents' are required to produce position statements by 21 July 2010 and also to name and give contact details to the local authority of any family members they wish to be assessed in respect of [redacted]. These should be provided by 21 July 2010 and thereafter the matter will be listed for directions on 30 July so that further progress may be made in the case.

84. The latest that I am prepared to allow a final hearing to take place for the second stage of this matter is the 24 January 2011. In reality I would hope that it could be sooner, with the possibility of 5 days from 6 December 2010 and I urge the parties to consider this.

HER HONOUR JUDGE CARR QC

5 July 2010

u:\judnotes\SE09C01273 HHJ CARR ar

In the High Court of Justice [redacted]

Family Division

Sheffield District Registry

[redacted]

Rotherham MBC

[redacted]

Re: C Judgment

Introduction

1. The main application in this matter is by the applicants, Rotherham MBC for a placement order in respect of [redacted] (C[redacted] who is the child of the first and second respondents (hereinafter called mother and father). C[redacted] was born on [redacted] and is therefore now aged two years eight months.
2. Within the placement application C[redacted]'s parents have indicated that they wish to challenge the findings of fact made by me in care proceedings under case number [redacted]. In support of this application, mother and father's solicitors have filed a document headed 'Application to Rehear Factual Evidence'. On 12 June 2012 they

indicated that they no longer wished to challenge the final care order made by me on 21 June 2011. The documentation which had earlier been filed, in readiness for the case management conference on 10 May 2012, has been rendered otiose. In this judgment when I have referred to the 'first skeleton argument' it is that document, although at this hearing its arguments contained therein have been effectively abandoned.

This will be the third judgment therefore that I have delivered in respect of C[redacted]

Background

3. Mother and father are not married to each other but mother adopted father's name so that she would have the same name as C[redacted] Both parties share parental responsibility and are now represented by the 'Wrongly Accused' team of Brendan Fleming solicitors Birmingham. It is mother's third set of solicitors and father's second. The solicitors representing C[redacted] have not changed and indeed Junior Counsel instructed by Rotherham MBC and the children's guardian have been the same throughout these lengthy proceedings. Mr Prest junior counsel for Rotherham MBC has helpfully prepared a detailed skeleton in reply to the skeleton filed by the respondents. I consider that Mr Hayden QC and Mr Prest's skeleton fairly and accurately sets out the response to the application and in large parts I have adopted it.

The care proceedings

4. In the care proceedings (matter number [redacted], at the threshold stage, on 05.07.10 the court made findings that within 4 weeks of his birth C[redacted] had suffered (see Findings Made at [A29a – b]):

(a) 12 bone fractures (of different kinds and to different parts of his body) and genital injuries;

(b) inflicted on a minimum of 2 different dates and involving a minimum of 4 different inflictions of force;

(c) Caused non-accidentally by Mother and / or Father.

5. It must be noted that:

(a) Those findings were made on the basis of very extensive medical evidence. As well as the evidence of the treating doctors at both [redacted] District General Hospital and [redacted] Children's Hospital there was additional expert evidence from Dr [redacted] Consultant Paediatrician), Dr [redacted] (Consultant Paediatric Radiologist), Prof [redacted] Consultant Neonatologist), Prof [redacted] (Professor of Paediatric Bone Disease), Dr [redacted] (Consultant Clinical Scientist and Head of [redacted] Molecular Genetics Service), and Dr [redacted] (a second Consultant Paediatrician) (see judgment paras 35 – 37 [A12 – 13]);

(b) the court allowed the instruction of every expert / test requested by the parents, including, in particular – and contrary to medical opinion – genetic testing for possible bone disorder (see judgment para 33 [A11]);

(c) even during the course of the hearing the court checked with those representing the parents whether there was any other expert evidence they sought – and was told 'no' (judgment para 64 [A23]);

(d) the expert evidence was 'all one way' – this is not a case in which the warning of Butler-Sloss P in *Re U (Serious injury: standard of proof) Re B [2004] EWCA Civ 567, [2004] 2 FLR 263* : *"particular caution is necessary in any case where the*

medical experts disagree, one opinion declining to exclude the reasonable possibility of a natural cause" applies;

(e) in particular, the result of the genetic testing was that there was no evidence of any genetic abnormality related to any bone disorder (care bundle [E134] and judgment para 62 [A22]);

(f) there was a full hearing (lasting 6 days of evidence, plus submissions and judgment) in which the parents had every opportunity to cross-examine those witnesses;

(g) the findings were not only of multiple fractures but also of genital injuries, all caused non-accidentally.

6 At the welfare stage, on 21.06.11, the court made a full care order on the basis of a plan that C[redacted] would be placed with his paternal aunt [redacted] and her husband [redacted], with restricted and diminishing contact with his parents, and with the express contingency plan that if this placement broke down C[redacted] should be placed for adoption outside his birth family [A30 – 39]. It should be noted that by then.

(a) Mother had by then obtained fresh legal advice (her second firm of solicitors and different counsel);

(b) The court again allowed the parents to instruct every expert they requested, notably [redacted] of [redacted];

(c) The whole point in instructing [redacted] was because he specialises in situations where the court has made adverse findings but these are not accepted by the parents. There would have been no purpose in instructing him if the parents' case had been that the findings were wrong and should be appealed / reheard;

(d) At the final hearing in June 2011, the parents declined to cross-examine the experts instructed for the welfare stage, accepting that there was no support from the experts for their hope that despite the findings C[redacted] might be rehabilitated to them;

(e) In Mother's case, that decision was taken with the benefit of advice from leading counsel;

(f) At no stage was it suggested that the findings made on 05.07.10 should be re-opened.

(g) Neither the findings nor the Care Order have been appealed. Both stand and are the foundation of these proceedings

Law in relation to the Parent's Application to Rehear Factual Evidence

7 Rotherham MBC has never disputed that the court has power in these proceedings to conduct a rehearing of the facts found on 5 July 2010 in the care proceedings. The leading authority on the issue is the decision of Hale J (as she then was) in *Re B (children act proceedings)(issue estoppel) [1997] 1FLR 285* which I have paid particular attention to. Hale J specifically identified, towards the end of her judgment various factors and whilst no one can suggest this is an exhaustive list it is a useful tool and analysing these factors I find as follows:

Of *"the court will wish to balance the underlying considerations of public policy"*:

(a) *"there is a public interest in an end to litigation …"*: any rehearing would be (very) lengthy and (very) expensive to the public purse and in its use of the resources of the court;

(b) *"any delay in determining the outcome … is likely to be prejudicial to the welfare of the child"*: it would cause further, serious delay to C[redacted] (attempting to identify adoptive parents will inevitably, in practice, stall) who has already been seriously delayed in achieving permanency. At the end of the Finding of Fact the court intended that C[redacted]'s future should be determined no later than 24.01.11 (see judgment para 84 at [A29]). C[redacted] is now more than twice as old as he would have been then;

(c) *"the welfare of the child is unlikely to be served by relying upon determinations of fact which turn out to have been erroneous"*: it is of course true that C[redacted]'s welfare is unlikely to be served by relying on determinations of fact which turn out to have been erroneous but it is a fact that there is no real likelihood of this in this case;

(d) *"The court's decision … 'must be applied so as to work justice and not injustice'"*: together with. the overriding objective in FPR 2010, Pt 1;

(1) *"The court may well wish to consider the importance of the previous findings in the context of the current proceedings …"*: Obviously the findings made in the care proceedings are at the heart of its application for a Placement Order;

(2) *"Above all, the court is bound to want to consider whether there is any reason to think that a rehearing of the issue will result in any different finding from that in the earlier trial …"*: there is no (good) reason to think that a rehearing of the issue will result in any different finding. On the contrary, it is overwhelmingly likely

in the circumstances of this case that the same findings would be made.:

(a) *"whether the previous findings were the result of a full hearing in which the person concerned took part and the evidence was tested in the usual way"*: the previous findings were the result of a full hearing in which the parents took a full part and the evidence was tested in a full way;

(b) *"if so, whether there is any ground upon which the accuracy of the previous finding could have been attacked at the time, and why therefore there was no appeal at the time"*: the previous findings could have been appealed against at the time, or later in the care proceedings (when the mother had changed her legal team for the first time), or since the care proceedings finished. It has only been raised now following the breakdown of the family placement with [redacted] and Rotherham MBC issuing an application for a Placement Order. The points now made on behalf of the parents, along the lines of, 'the experts failed to take into account …' – that is to say essentially everything in the list (a) – (z) at para 9 of the Application to Rehear Skeleton Argument [D249 – 252], which is at the heart of their argument – should, if there had been any substance in them, have resulted in a prompt appeal in 2010;

(c) *"whether there is any new evidence or information casting doubt upon the accuracy of the original findings"*: despite the volume of papers produced on behalf of the parents, there is little if any new evidence or information casting any real doubt upon the earlier findings. In particular the extracts from Mother and C[redacted]s medical records attached to the 'Application to Rehear' Skeleton on behalf of the parents are,

almost without exception, documents that pre-date the Finding of Fact hearing.

d) The parents in their application have cited two cases being *London borough of Islington v Al Alas & Wray [2012] EWHC865* and *A County Council v M and F [2011] EWHC 1804* and I am bound to say neither decision assists the court nor indeed the parents for the following reasons:

3 Neither *London Borough of Islington v Al Alas and Wray* nor *A County Council v M and F* involves any new point of law.

4 *In London Borough of Islington v Al Alas and Wray*, Theis J very clearly prefaced her judgment by saying:

"It is important to remember that my conclusions set out below are entirely related to this case. Despite their differences of opinion, all the medical experts agree this case is extremely complex. By their very nature, cases such as this are very fact specific and great caution should be adopted in using any conclusions I reach to support any wider views outside the very specific facts of this case ..." (para 6 of judgment, [D34])

Differences between *Jayden Wray's* case and C[redacted]s case are stark. For example, in the *Wray* case:

(1) It involved a baby who had died and had as its central issue non-accidental head injury and the application of the triad (see e.g. para 9 of judgment, [D35]), which is a highly complex, contentious and a rapidly evolving area of medical science. C[redacted]s case self-evidently did not;

(2) It proceeded on the common ground that Jayden Wray did indeed have rickets (see e.g. para 5 of judgment, [D34]). In C[redacted]'s case, while the parents continue to assert that C[redacted] had / may have had rickets, all the medical experts who have considered the issue have ruled it out;

(3) Jayden Wray was vitamin D deficient (para 5 of the judgment [D34). C[redacted] was not (care bundle [F132] and e.g. [E106]);

(4) Further in the *Wray* case, it was acknowledged by all the medical experts that it was extremely complex. By contrast, C[redacted]'s case is one which, at least as regards the fractures, all the medical experts regard as clear-cut and straightforward;

(5) The *Wray* case involved sharp divergences of opinion between experts (the root of this, but not the only issue, was the difference between the two pathologists Dr Scheimberg and Dr Cary about the cause of death, the former concluding that it was the result of hypoxic ischemic injury, cause undetermined in the context of vitamin D deficiency and rickets, the latter concluding that it followed Non Accidental Injury (shake / impact)). By contrast, C[redacted]s case is one in which there was no significant difference of opinion amongst the experts;

(6) In the *Wray* case the legal system cleared the parents at the first time of asking, in both the criminal and the family courts. It was not a miscarriage of justice case. By contrast, in C[redacted]s case, his

parents are asserting that the findings made on 05.07.10 amount to a miscarriage of justice.

(7) Similar comments may equally well be made about the decision of Mostyn J in *A County Council v M and F* in that it takes the parent's case no further.

Abnormalities in C[redacted] and Mother as now asserted

8 This is the linchpin of the application made by the parents for a re- hearing.

C[redacted]

a) Hernias – this was well known at the time of the Finding of Fact. They were, for example, referred to in the report of Prof [redacted] (care bundle [E106])

b) Blue sclerae – this was well known time of, and cross examined about at, the Finding of Fact. Prof Bishop does not say that C had blue sclerae. What he says is *"C[redacted]s sclerae have a slightly blue tinge but it is not deep blue"*. He was clear C[redacted]s sclerae were not the blue sclerae that are associated with bone disease, as were all the other experts who were asked about it. In passing, C[redacted] was also checked again for blue sclerae at [redacted] DGH on 19.04.11 because Mother continued to press the point, and again he was assessed as normal [C36]

c) Poor gross motor mobility – this is an effect of injury, not its cause. At 13 months old C[redacted]s ' *motor milestones are mildly delayed but progressing'*. This is hardly surprising given that he had had a severely fractured femur as a result of which he was in a harness for five weeks [C33].

d) Legs of uneven length – this is an effect of injury, not its cause. The reason that C[redacted]s right leg was longer than his left on 6 May 2011 was as a result of his fracture, it having nothing to do with the cause of the fracture.

e) Soft dysmorphism etc – these were well known at the time of the Finding of Fact. Although Dr [redacted] had raised possibility of dysmorphism no other expert thought C[redacted] had this, and Prof [redacted] was clear that whether or not C[redacted] had it, it was not the kind of dysmorphism associated with bone disease (judgment para 60 [A21]). I was satisfied on the evidence that C[redacted] was not dysmorphic (judgment para 64 [A23])

f) Re-fracture of femur in foster care – this was well known at the time of the Finding of Fact. The balance of evidence was that there was no such fracture and I so found: judgment para 63 [A22] However, more importantly, even if there was a re-fracture, whether it was of any significance. Here the medical opinion was unanimous, if there was a re-fracture it was through callus. As stated by Dr [redacted] *"A fracture through the callus is a recognised feature of even normal handling of the child and is different from primary fracture of a bone"* [D272] – a point that is clearly in the document referred to on behalf of the parents but not identified by them. The expert evidence at court was the same, that if there was a re-fracture it was not a sign of the cause of the original fracture but a consequence of it;

g) Symptoms of chronic bacterial infection – these documents were well known at the Finding of Fact

h) Hypersensitivity to sound – this was well known at the time of the Finding of Fact. It is likely this was attributable to the effects of the multiple abuse he suffered and the effects of being in hospital

i) Oral thrush in hospital – this was well known at the time of the Finding of Fact

j) Administered antibiotics – this was well known at the time of the Finding of Fact

k) Intermittent high temperature – this was well known at the time of the Finding of Fact

l) Thickening of tunica etc – these were well known at the time of the Finding of Fact

m) Hypothyroidism – this information was well known at the time of the Finding of Fact. There is nothing in the symptoms / complications in the documents produced linking it with bone disease or anything else

n) Abnormal liver function – this was well known at the time of the Finding of Fact.

o) Brachycephaly – this was well known at the time of the Finding of Fact – indeed the reference relied on is not to the medical notes but to the report of Prof [redacted]

p) Mongolian blue spot – this was well known at the time of the Finding of Fact.

q) Hyperpigmentation no one has been able to find a reference to this condition nor how I receive submissions on and I therefore ignore it.

In short, all these issues / the documents on which they are based were well known / available at the time of the Finding of Fact hearing, with the exception of c) and d) (poor gross motor mobility and legs of uneven length) when it is plainly wrong to suggest that they are connected to the cause of C[redacted]'s injuries but as a result of the fracture.

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[redacted] [Mother]

a) Carrier of group C streptococcus – this was well known at the time of the Finding of Fact

b) Required antibiotics in first trimester of pregnancy – this was well known at the time of the Finding of Fact

c) Signs of infection at birth – this was well known at the time of the Finding of Fact

d) Polycystic ovaries – this was well known at the time of the Finding of Fact

e) Prescription steroid inhaler to treat asthma – this was well known at the time of the Finding of Fact

f) Addiction to coca cola –I heard no evidence that Mother was "addicted" to coca cola or that the document produced [D378] comes close to establishing this, and nor, therefore, do I accept that Mother was suffering from "modern malnutrition". Even if this were true, I note that the document produced about the effects of coca cola provides no evidence of any effect upon the foetus [D379]. The point was, in any event, raised and argued on behalf of Mother at the Finding of Fact

g) Vitamin D deficiency – this was well known at the time of the Finding of Fact. It misses the essential point: C[redacted]s vitamin D level was normal (see care bundle [F132] and e.g. [E106])

h) Low bone density – the document to which reference is made is not evidence that Mother had low bone density but that she said she did. In any event this information was well known at the time of the Finding of Fact and misses the point that there is no evidence that C[redacted] had low bone density (e.g. care bundle [E38])

i) Oligomenorrhea – this was well known at the time of the Finding of Fact.

In short, all these issues / the documents on which they are based were well known / available at the time of the Finding of Fact hearing. It does not pass

the test in *Re B* particularly Hale J holding; ' *if so whether there is any ground upon which the accuracy of the previous finding could have been attacked at the time and why therefore there was no appeal at the time'*
Therefore if these matters were to be relied upon it should have warranted an appeal immediately, following the finding of fact hearing.

Criticism of the expert evidence at the Finding of fact hearing as detailed in paragraph 9 of the Respondents' skeleton argument to rehear factual evidence.

9 The parents maintain, as has been their stance throughout, that they did not cause the injuries to C[redacted]. To this end the skeleton produced details with Internet documents to try and put a different emphasis on the alleged abnormalities of C[redacted] and mother to explain his injuries. The majority of the parents written documents can only fall to be considered at the level of 'generic' since there has been no specific application to the individual facts and collection of symptoms experienced by C[redacted] They can be roundly discounted and to my mind the research takes the case no further forward although I propose to deal with their allegations as set out in paragraph 9 of the skeleton, point by point.

Bone Density

a) (i) It was not a presumption of normal bone density but expert opinion that *"there is no evidence of any abnormality of C[redacted]s bones"* (care bundle [E38], emphasis added). (ii) Dr [redacted] explained at trial how it was not just a matter of density but also other factors such as bone architecture that were relevant. (iii) It is ironic that the parents now seek to rely on articles by Drs [redacted] and [redacted] both of whom were involved with C[redacted] (respectively as expert and, albeit perhaps peripherally, as

part of the treating team) – they are likely to have been particularly alert to the point. (iv) It does not fairly represent what is being said in the articles. For example, immediately after underlining that *"... osteopenia is not detectable radiographically until 50% of the calcium is lost from the bone ...'*Dr [redacted] says *"However, this does not translate into proportional loss of bone strength, since live bone has considerable physiological reserve"* [D388] but this is not mentioned. I can see no reference to DXA scanning in Dr [redacted]s article.

Dating of Fractures

b) (i). There is no evidence of vitamin / mineral deficiency in C[redacted] (see care bundle [F132] and e.g. [E106]). (ii) Dr [redacted]'s evidence, both written and oral, recognised the limitations in dating but this does not affect the two essential points she made, that none of the injuries were as old as from birth (an opinion supported by Prof [redacted]'s evidence from a different medical specialism, and in the case of the broken femur), and that the left rib fracture is older than the others (care bundle [E39]). (iii) All this is consistent with what is stated in her article, and that the parents now rely on.

Vitamin D

c) (i) I do not accept the assertion, for which no evidence is provided, that the vitamin D test should have been repeated, (ii) but in any event the only evidence the court will ever now have is that the test done showed C[redacted]'s vitamin D level to be normal (see care bundle [F132] and e.g. [E106]).

Vitamin D continued

d). (i) On the *Jayden Wray* case It would only have been of relevance if C[redacted] was vitamin D deficient but, there is no evidence of this. (ii) It ignores the research filed on behalf of the parents with their first skeleton argument (to discharge the care order) that *"... suboptimal vitamin D status was not associated with a diagnosis of abuse or the presence of*

multiple fractures or rib or metaphyseal fractures" [D176]. (iii) There are many areas relevant to child protection in which there is a lack of research and (a) courts daily have to make child protection decisions in such cases, and (b) absence of research is a very limited foundation on which to mount a challenge.

Phosphoric Acid and Coca Cola

e)(i) The starting point for this argument depends on the mother's evidence in circumstances where her credibility has been seriously damaged by her lack of truthfulness previously. (ii) It ignores the fact that all the evidence that exists is that C[redacted] was a healthy, well nourished child with normal bones. (iii) The only article on the subject produced on behalf of the parents [D379], which speaks of how this *"may promote bone loss" "may be damaging their bones"* (a) refers only to *"may increase the risk of osteoporosis in later life"* and (b) provides absolutely no evidence of this being transmitted by a pregnant woman to the foetus.

Rickets

f) (i)This relies again on the *Jayden Wray* case. (ii) In any event, contrary to what is stated, the point was explicitly addressed by Dr [redacted] (care bundle E119) in that C[redacted] does not/ did not have rickets.

Metaphyseal Fractures

g) (i) This assertion is a misrepresentation of what the document produced actually says. All it says is *"There were no published comparative studies of children with metaphyseal fractures. Two studies of femoral fractures found that femoral metaphyseal fractures are more common among abused infants but data were not suitable for meta-analysis"* [D407]. (ii) The assertion is contrary to what is stated in two of the articles produced with the First Skeleton Argument on behalf of the parents: see para 17(2) and (3) of Skeleton above. (iii) Prof [redacted] gave careful written (care bundle [E108]) and oral evidence on the issue.

Inconsistencies in the Radiological evidence

h) (i) I do not accept that there were a lot of inconsistencies in the radiological diagnosis as alleged: see para 18(2) Skeleton above. (ii) I am not clear where in the report it is stated that 4 radiologists failed to detect rickets in Jayden Wray (no reference is given), but in any event (a) it is clear that at least one radiologist thought that Jayden Wray might have had rickets (judgment para 60, [D45]) and (b) if they were part of the team treating Jayden Wray they were responding to a critically ill (dying) child with no time for careful reflection.

Poor mineralisation and growth plate

i)(i) Again in the case of *Jayden Wray*, (ii) I do not accept that this is an accurate statement of the evidence of Prof Miller in *Jayden Wray's* case and in any event it does not represent a finding by the court. (iii) It depends on establishing that C[redacted] had vitamin and mineral deficiency which is contrary to the evidence. (iv)It depends on those involved with C[redacted] having in fact made that error.

Thickening and widening of the growth centre of the rib

j) (i)Further in the case of *Jayden Wray*, It leaves out a critical detail in Dr Barnes' evidence in *Jayden Wray's* case. He specifically identified *"the front part of the ribs near the breast bone"* in making this point [D400]. C[redacted]'s right 10th and 11th ribs were posterior fractures (care bundle [E37]). (ii) Again, this does not represent a finding by the court.

Absence of bruising to C[redacted]

k) With reference to *Jayden Wray*, (i) It ignores the bruising to C[redacted] that was seen with when he was admitted on 26.10.09 with genital injuries. (ii) It assumes that bruises for injuries on C[redacted], that cannot

be precisely dated, would still have been visible on 30.10.09. (iii) It ignores the fact that C[redacted]s right leg was quickly strapped / bandaged so any bruising that happened would not have been visible.

Alleged re-fracture of C[redacted]'s femur

l) There can be no argument, based on a possible re-fracture as it is on the evidence simply wrong. (i) It also chooses to ignore the much more striking feature of the evidence: that C[redacted] suffered multiple fractures in the first month of his life living with his parents, but has suffered no known fractures in more than 30 months since. (ii) If the final part of this point is suggesting that the broken femur which caused C[redacted]'s admission on 30.10.09 might have been a re-fracture it is plainly wrong. It is inconceivable that C[redacted] could have suffered an earlier transverse fracture of the femur without it being immediately obvious. (iii) In any event, it would simply beg the question: how was it broken in the first place?

Absence of risk factors in either parent

m) (i) This is not, essentially, a medical issue (ii) However it was well-known to the experts and, more importantly, to the court at the time of the Finding of Fact hearing. There is no basis for asserting that it was not taken into account. The problem was that despite this, the evidence that C[redacted]'s injuries were non-accidental was, as I held, *"overwhelming"*: (judgment para 81 at [A28]).

Mother's streptococcus infection during pregnancy

n) (i) All such medical information about Mother was well-known at the time of the Finding of Fact hearing and was, or at the very least, could and should have been, put to whichever medical experts as appropriate. (ii) Infection was considered in the differential diagnosis for C[redacted]'s genital injuries and indeed was the working diagnosis on

his discharge on 26.10.09. It was thoroughly cross-examined about at the Finding of Fact hearing: Dr [redacted] and Mr [redacted] (i.e. those who had actually seen C[redacted] at the time) believed this to be Non Accidental Injury. (iii) The article produced on behalf of the parents makes no reference to Group B Streptococcus causing fragile bones (osteopenia, osteogenesis imperfecta) but to osteomyelitis, the symptoms of which are not broken bones [D408]. In short, even if C[redacted] contracted this from Mother (or indeed anyone else) it is not the cause of his fractures.

Bacteria cultures

o) (i) I am unclear what this refers to. The footnote does not contain a cross-reference to any document in the bundle of papers supplied, nor is reference made to any page showing the culture test referred to (is it a test of C[redacted] or of Mother? If C[redacted], does it relate to admission for genital injuries on 26.10.09 or fractured femur on 30.10.09?). (ii) In any event it seems that the basic information was known at the time of the Finding of Fact hearing, and there is no basis for asserting that it was not taken into account.

C[redacted]s intermittent high temperature

p) (i) Again, the footnote does not contain a cross-reference to any document in the bundle of papers supplied. (ii) This information about C[redacted] was well-known at the time of the Finding of Fact hearing and was, or at the very least could and should have been, put to whichever medical experts as appropriate. (iii) There is no basis for asserting that it was not taken into account.

C[redacted]s alleged abnormal liver test results

q) (i) Contrary to what is stated, the extract from Dr [redacted]s report makes no reference to blood tests but to *"C[redacted]'s observations"*

[D410]. (ii) At its highest, this is not "the paediatricians misreported" but "a paediatrician" and as such can do no damage to the opinions of any of the other experts. (iii) It is clear from my judgment that the crucial evidence leading to the finding that the genital injuries were non-accidental (which is what this point is about) was that of Dr [redacted] and Mr [redacted] the treating doctors who actually saw C [A14 – 16] (I did not think it necessary to include a particular heading for Dr [redacted] who carried out a general paediatric review, in my review of the medical evidence in the judgment of 5 July 2010. [A14 – 23]). (iv)The other page referred to in the footnote supporting this point is an article about a hermaphrodite infant. I do not understand how this article can have any bearing on the point being made or, and more importantly, on anything to do with C[redacted] it presumably being common ground that he was / is not hermaphrodite.

Mother's polycystic ovaries

r) (i) all such medical information about Mother was well-known at the time of the Finding of Fact hearing and was, or at the very least could and should have been, put to whichever medical experts as appropriate. (ii) There is no basis for asserting that it was not taken into account. (iii) There is no evidence that Mother did pass excess testosterone to C[redacted]. (iv) There is no evidence C[redacted] suffered an adrenal crisis. (v) The pages referred to in the footnote are nothing to do with polycystic ovaries but are further copies of the hermaphrodite infant article already included at [D207 – 208] and [D411 – 412].

C[redacted]s lymphocytes

s) (i) The document in support of this [D414 - 416], albeit the final page is missing, is about lymphoedema following circumcision of a 50 year old morbidly obese man. This is wholly different from C[redacted]'s circumstances. (ii) If and insofar as this point is based on what is actually in C[redacted]'s medical records, the information was well-known at the time of the Finding of Fact hearing and was, or at the very least could and should have been, put to whichever medical experts as

appropriate. (iii) Dr [redacted] and Mr [redacted] were fully cross-examined about the differential diagnosis for the genital injuries, and there is no basis for asserting that I did not take it into account.

Failure of the hospital to carry out a light test on C[redacted]'s hydrocele

t)(i) The short point is that this is speculative. The matter can only be determined on the evidence there is.

Hydroceles affecting 6% of baby males

[redacted](i) This assertion is simply not true. The possibility that what C[redacted] presented with on 26.10.09 was caused by a hydrocele was expressly put to and wholly rejected by Mr [redacted] in his oral evidence. (ii) In any event it cannot account for the separate bruising and cut at the base of the penis as seen by Dr [redacted]

C[redacted]s gestation period

1. (i) The assertion that C[redacted]s duration of gestation and the asserted possible consequences of his having been born post-mature are addressed below. (ii) Whilst the point asserted relates to post maturity, the article purportedly supporting it is instead about pre-term and term babies [D424 – 426] and cannot support the argument or have any relevance to C[redacted]. As to 'C[redacted]s gestational period is unknown – Possibly Growing very slowly in womb' [D247] , I hold as follows;

   (1) the first step in this argument is the suggestion that C[redacted] was born at term + 18 days. This is entirely speculative. As the Skeleton makes clear it depends on if the last menstrual period is correct. Further, as the parents' own documents make clear, *"Although the last menstrual period (LMP) has been traditionally used to calculate the estimated due date (EDD) many inaccuracies exist in using this method in women who have irregular cycles ..."* [D338] (as Mother is known to have);

(2) instead the best evidence in the case will always be the evidence at the time Mother gave birth to C[redacted], and as it was taken to be at the Finding of Fact hearing, namely that C[redacted] was born at EDD plus 12 days (see care bundle e.g. Prof [redacted] E105], Prof [redacted] [E90]; and as recorded in my judgment at para 4 [A2]);

(3) the second step in the argument postulates that C[redacted] failed to thrive in utero. This builds speculation on speculation. The problem with that, is not only is there no evidence to support it, the evidence is overwhelming that he did not fail to thrive in utero:

(a) there is no suggestion in any of the contemporary medical records that C[redacted] was thought to be underweight / have failed to thrive in utero when he was born;

(b) on the contrary he weighed 3450g i.e. approx 7lbs 9 oz when he was born (Red book, care bundle [F214], judgment para 4 [A2]);

(4) this falls far outside the definition of IUGR given in the documents produced by the parents: see 'Definition of IUGR' [D330];

(5) the third step in the argument is to assert that post maturity "could cause infection and weakness to C[redacted] bones". But it is important to note;

(a) "could": there is no evidence that in fact it did;

(b) in any event, I cannot see where in the three articles cited [D338 – 349] there is any reference to whatever condition the article relates to, causing weakness in the infant child's bones. It does not appear under the headings 'Fetal and neonatal risks' [D339-340] and 'neo-natal and long-term complications' [D348];

(c) the parents then apparently place reliance on an article 'Post-maturity of the foetus' [D350-352]. This is extraordinary, because the article is more than 90 years old and cannot be

regarded as a safe guide to modern medical science / practice. Further, the paragraph marked is clearly about the risk of injury during delivery. It is inconceivable that C[redacted] femur was fractured during birth but was unnoticed in the following 4 weeks;

(6) in any event, these are all matters that plainly could and should have been raised at the original Finding of Fact hearing. Indeed it was for exactly this sort of reason (was there anything unusual about C[redacted]s birth or C[redacted] at birth ?) that Prof [redacted] consultant neonatologist, was instructed: as set out in my judgment para 52 at [A19];

(7) I also note that elsewhere the parents seek to rely on documents 'Late-onset Group B streptococcal cellulitis in a premature infant' [D372] and 'Inadequate growth and nutritional requirements of preterm and term babies' [D424] (emphasis added). They cannot have it both ways, arguing that C[redacted] was born post-term with complications arising from that and then relying on documents about pre-term babies. The whole argument that C[redacted] may have suffered his injuries as a result of growing slowly in the womb is completely unsustainable,

C[redacted]s inguinal hernias, and whether the bruising to his genitals was pigmentation and/ or thickening due to calcification

v) (i) This cannot be true. All these matters were well known at the time of the Finding of Fact hearing and Dr [redacted] and Mr [redacted] were cross-examined about them and this suggestion was roundly discounted.

Mother's anaemia during pregnancy

w) (i) Despite the footnote to this paragraph, no document is referred to in support of this matter. (ii) All such medical information about

Mother was well-known at the time of the Finding of Fact hearing and was, or at the very least could and should have been, put to whichever medical experts as appropriate.

Mother's fertility problem and Father's relationship with his other children

x) (i) All such medical information about Mother was well-known at the time of the Finding of Fact hearing and was, or at the very least could and should have been, put to whichever medical experts as appropriate. (ii) I concluded that Mother *"was so concerned about father's reaction to her pregnancy that she was worried he may leave her"* [A23] and that she *"did want C [redacted] to be a girl"* [A24]. As to Father, I rejected his account that they were astonished and delighted when Mother became pregnant [A26], and he has since remembered what he did not remember in 2010, that he discussed with Mother her having a termination [A26 and care bundle E184]. (iii) It has never been disputed that Father has a good relationship with his children [redacted] (but not with his first child [redacted]. This was common ground at the Finding of Fact hearing and there is no basis for asserting that I did not take it into account.

The medical experts (1)' sweeping comments and (2) conflict between treating and independent experts'

y) (i) The first part of this assertion is wholly unparticularised. (ii) In any event, all the experts were cross-examined at the Finding of Fact hearing. (iii) The second part misses the essential points that (a) the treating doctors who saw C [redacted] gave oral evidence at the Finding of Fact hearing, (b) they were clearly of the opinion that the genital presentation on 26.10.09 was Non Accidental Injury, i.e. inflicted

injury, and (c) it was their evidence, rather than that of the experts who subsequently reported without having seen C[redacted] at the time, that underpinned my findings on this issue. (iv) I agree that Dr [redacted] was asked / gave an opinion about the genital presentation and that this was (probably) outside her area of expertise. However her evidence was not the basis of my decision on this point. Nor does this undermine her expertise within paediatric radiology, as indeed is recognised by the decision to place reliance on an article by her with the First Skeleton Argument on behalf of the parents [D233].

Conclusions in relation to the Parent's application for a re-hearing of the factual evidence.

10 In addition to the authority of *Re B* above I have also borne in mind that the decision of Charles J cited in my earlier judgment in the case of *Lancashire County Council v D & E [2004] EWHC 832* that in assessing whether the symptoms were organic or inflicted the correct approach for the court to take is:-

(i) To determine the range of possible explanations for the injuries seen.

(ii) Assess the degree of likelihood for each explanation.

(iii) Decide which explanation/s can be established as a real possibility

(iv) Decide which real possibility can be established as an event that was more likely than not to have occurred and as Charles J held:

' The correct position is that a medical review as to the most likely cause of injuries is that that cause is clearly established as a real possibility that has to be considered, in all the circumstances of the case, together with the other possibilities, in determining whether a child was the victim of an inflicted injury'

Further at p.86 Charles J held, as indeed I cited at para 32 of my judgment in July 2010:

'The medical evidence in conclusion, together with the reasoning underlying it, are, as I have explained, only parts of the overall picture or jigsaw, albeit important parts. Put at its simplest the court will have additional information and that information will include its findings relating to the evidence of the parents, and thus the events in the household and the observations of the clinical presentation of the child.'

11 I cannot divorce my assessment of the medical evidence, including the generic evidence produced by the parents in this application to rehear because my assessment of the parents is all part and parcel of the same jigsaw. In the finding of fact hearing I reminded myself of the appropriate *'Lucas Direction '77Cr App 139 (A12(34) judgment).*I consider that I can confidently and properly dismiss the parent's application for a re-hearing. Contrary to what is argued by Mr Fleming on behalf the parents this is not a 'golden opportunity' to put an end to litigation by way of a re-hearing, but it is one where I have a duty as I have, with the assistance of the submissions I have received, to attempt to put an end to this litigation and proceed to consider C[redacted]'s placement application. In fairness to Mr Fleming he conceded that if I was against a rehearing then C[redacted]'s welfare throughout his life would demand he became a placed person.

It does behove me to give composite reasons having analysed the medical evidence and rejected the so-called new evidence produced to make plain that at the finding of fact case, although expressed in terms of the balance of probability, I was in fact satisfied well beyond the standard 51%. Indeed as I set out in my judgment at paras 80, 81 at [A28]:

(a) 'I have reached a clear and unequivocal conclusion that this case is one that involved inflicted injuries on a baby'

(b) 'I have reached the clear conclusion that the findings [the local authority] seek our overwhelming'

This was not a finely balanced decision and the medical evidence at the finding of fact hearing, as earlier as set out was all one-way. I do not consider that the parents have produced anything at all that would persuade this court to reopen the matter and rehear the case , even limited as Mr Fleming sought, to an experienced midwife and a blood expert. Although at D66 Mr Fleming sought to argue that the bloods taken from C[redacted] were abnormal I do not find that they were, particularly when one reads the footnote that bloods from babies can be three times above the limits whicht are otherwise considered normal. It has to be borne in mind that at the end of the finding of fact hearing the credibility of both parents was seriously damaged (paras 66-77) [A23-27] and nothing has occurred to undo the damage to their credibility. There is no new medical evidence regarding mother, and more importantly no new medical evidence regarding C[redacted], and the arguments mounted to suggest C[redacted] has legs of uneven lengths is simply disingenuous particularly as he suffered a fractured femur in the first four weeks of his life, which is the cause of the uneven length. I am satisfied, again well beyond the balance of probability, that a rehearing of the matters I dealt with in the finding of fact hearing in July 2010 would produce no different result other than causing delay in the planning and achieving long overdue permanency for C[redacted] and as such the application for a rehearing is dismissed.

Application for a placement order

12 The local authority seeks and the guardian strongly supports the making of a placement order. There can be no dispute that the care plan approved in my order of 21 June 2011 contemplated the fact that in the event that placement with [redacted] and [redacted] broke down, C[redacted]s welfare was best met by his being adopted. I am satisfied that the process has been compliant with ECHR and particularly Articles 6 and 8. As I have refused the parents of application for a re-hearing then the findings made on 5 July 2010 stand and the threshold is clearly made out. I have asked myself the simple question '*does C[redacted]'s welfare require*

*a care order to be made in accordance with section 1 Children Act 1989?*I approved the care plan on 21 June 2011 pursuant to S31A of the 1989 Act which clearly contemplated the possibility of a placement order. In accordance with sections 21(3)(a) and 52 of the Adoption and Children Act 2002 namely has parental consent been validly given in accordance with those sections or should parental consent be dispensed with in accordance with sections 21(3)b, 52 and 1 of the 2002 Act. Hardly surprisingly parental consent has not been given but it is clear that it should now be dispensed with because this is what C[redacted]s welfare now requires and in accordance with section 1 of the 2002 Act '*does the child's welfare 'throughout his life' require a placement order to be made?'*. I am completely satisfied that C[redacted] needs a secure permanent placement and that adoption is the best way to achieve this. I am also satisfied that the making of a placement order/adoption order thereby ending family life between C[redacted] and his birth family does not infringe Article 8 ECHR as it is a necessary and proportionate step (Article 8(2)). It is noteworthy that the parents concede, if I dismiss the application to rehear they have no argument that can properly be mounted against a placement order being made and so although I have considered the relevant aspects of the 2002 Act I do not set it out in detail but do rely on the closing submissions made by counsel on behalf of C[redacted], Mrs Marson and the Guardian's report of 11 June 2012 which plainly and absolutely supports the making of a placement order so as to secure C[redacted]'s future.

Her Honour Judge Carr QC

18 June 2012