IN THE CENTRAL FAMILY COURT — No. ZC23C50106

First Avenue House
42-49 High Holborn
London WC1V 6NP

Friday, 22 March 2024

Before:

HER HONOUR JUDGE JACKLIN KC

(**In Private**)

B E T W E E N :

LOCAL AUTHORITY — Applicant

- and -

(1) I
(2) A
(3) THE CHILDREN
(Through their Children's Guardian) — Respondents

ANONYMISATION APPLIES

MR J CHURCH appeared on behalf of the Applicant Local Authority.

MR S BICKLER KC and MR P FROUD appeared on behalf of the First Respondent.

MS A GRIEF KC and MS G KELLY appeared on behalf of the Second Respondent.

MR J TADROS appeared on behalf of the Children (through their Children's Guardian).

J U D G M E N T

JUDGE JACKLIN KC:

1 This judgment is given at the conclusion of what is known as a fact finding hearing within care proceedings issued by a London Borough in March last year. I wish to record my thanks to all six counsel involved in this case, for the sensitive manner in which they have handled it, and the enormous assistance which they have provided to this court.

2 The children who were made the subject of these care proceedings initially numbered four: three children who were aged 16, 12 and 10, and a baby, aged six months. In fact, the parents, whom I shall identify only as I and A, have five children; there is an elder child who was over 17 at the time these proceedings were issued, and I shall refer to the parents as the mother and the father respectively.

3 The family came to the attention of the local authority because, late on an evening early in 2023, the parents attended their local hospital with the baby (whom I shall refer to as E), who had swelling to both sides of the head. Scans and x-rays carried out at the hospital established that E had sustained bilateral parietal skull fractures with overlying haematomas, known generally as swellings. The parents could not offer any explanation as to how the factures had been sustained. The mother is recorded in the hospital notes as saying that the baby could not have banged the head on anything. The radiologist at the hospital expressed the view that there were historical rib fractures of different ages. Again, no explanation for those was offered by the parents. A safeguarding referral was made to the local authority by the hospital, and about a week after admission of E the police and the social workers attended the hospital where the child remained, and the parents were arrested. During police interviews both denied any knowledge of any events that could have caused the injuries. E was discharged from hospital after nearly three weeks, once the swellings had disappeared. The parents agreed to the child being accommodated by the local authority pursuant to s.20 of the Children Act and E was placed into foster care.

4 At a hearing on 19 April Her Honour Judge Robertson was satisfied that the test for an interim care order was passed under s.38 of the Act, namely, that there was reasonable cause to believe that E was suffering significant harm or was likely to do so, due to unreasonable parenting. E has remained in foster care since that time but has had contact with the mother up to five times per week, and other family members have joined at different times. On 19 April the learned Judge declined to make any statutory orders in respect of the other three children because she was not satisfied that the s.38 threshold had been crossed in respect of them. Those children have remained at home throughout these proceedings, and the proceedings were withdrawn in respect of the elder of those three on reaching the age of 17.

5 There is no evidence of any concerns by any child care professionals about the care of these five children prior to the presentation of E with the parents at the hospital last year. This is what is termed by lawyers as a single issue case, and the case was listed for a fact finding hearing this week, to consider the evidence and seek to determine what happened.

6 The parents filed statements setting out that they were not aware of anything that had happened to E that may have caused the injuries. As is standard procedure in such cases, a single joint expert was appointed in the form of Dr Olsen, consultant paediatric radiologist, who is highly regarded by his peers and regularly consulted in cases involving fractures to children. He was asked to provide an independent opinion regarding what injuries were demonstrated on the scans and x-rays and to offer opinions on ageing and causation of such injuries as were found. That opinion was provided in the middle of June last year. Firstly, he expressed the opinion that the images and scans taken at the hospital reveal no evidence that there have been any rib fractures. Secondly, there are linear defects

in the skull, the lines are in both parietal bones and one fairly horizontally from the coronal suture at the front to the lambdoid suture at the back. The two defects are symmetrical. Young infants can sometimes have variant anatomy of similar nature, so called 'accessory sutures'. Accessory sutures with the observed configuration have been described in the medical literature. Therefore, opined Dr. Olsen, it could not immediately be concluded that the findings represent fractures. Further radiological examination was unlikely to be of any assistance since both fractures and accessory sutures eventually close and the timing is highly variable for both.

7 However, Dr. Olsen made further observations. On the left the defect is slightly displaced at a segment towards the back and that would not be expected for a conventional or accessory suture. And the CT scan demonstrates swelling of the scalp to both sides, confined to the extent of the parietal bones and centred on the respective defect. The scalp swelling would not be associated with an accessory suture; it would, however, represent a typical adjunct finding in the case of a skull fracture. Since the swelling disappeared from the x-ray images over the interval of three weeks whilst the child was in hospital, it is likely that the swelling to both sides was traumatic in nature. The reported sudden onset would presumably suggest the same, but, in Dr. Olsen's view, this is in principle the domain of the court's paediatrician.

8 Dr. Olsen concluded that on balance the radiological evidence favours fractures over accessory sutures, and hence that the presence of two skull fractures is more likely than the presence of two accessory sutures. He could not confidently exclude the possibility of accessory sutures, but that alternative would imply that there has been trauma to both sides of the head causing independent scalp swelling exactly overlying accessory sutures.

9 He went on to advise that it is not possible to identify the date of skull fractures from the fractures themselves, but by reference to what he refers to as 'common agreement' between the professionals, it is understood that soft tissue swelling caused by an acute skull fracture, usually a haematoma, will resolve within approximately half a month. Most skull fractures do have associated haematoma and the haematoma appears acutely, very unlikely beyond one to two days after the fracture. He observed that the last date when there was definitive swelling that could be seen on the skeletal survey was a few days after the child was presented at hospital and on that basis he expressed the opinion that the fractures occurred at some point within the two weeks previous to the x-ray in question.

10 Regarding causation he said this:

> "The injury therefore most likely resulted from impact to the left side of the head and impact to the right side of the head. Theoretically the injury could have resulted from a single traumatic event had the head been resting sideways on a hard unyielding surface while a hard object impacted against the upward facing side of the head. This could be considered a single application of force causing impact to both sides at the same time. The likelihood of this being the true cause would depend on the accounts of the carers."
>
> "Two sided skull fractures can result from a single impact to the top of the head, but such fractures have a vertical rather than a horizontal course (as is the case for here). I would dismiss this as a viable possibility."

11 It is also common practice in cases such as these to instruct a single joint expert consultant paediatrician to provide an opinion on the injuries, causation, effect, et cetera. Dr Rylance, consultant paediatrician, who is also highly regarded and commonly involved in advising the court in these situations, was duly instructed. He accepted the opinion of Dr Olsen regarding the fractures and the swellings and that there were no rib fractures. He also accepted the opinion that there were skull fractures and not accessory sutures. By reference to several research study reports which he cited, he concluded:

> "It is possible for bilateral haematomas to result from one impact, but this would need to be from a compression impact of short (as in a blow) or more sustained (more than a few milliseconds) duration. Such compression is effected if a child is lying on the side or falls in that position as a result of heavy furniture falling on the lying child or forces the child into that position. Impact onto the side of the head with the other side being trapped against an unyielding object (e.g. the floor) in such circumstances affords the mechanism.
>
> Bilateral fractures can be caused by impact close to the mid-line at the top of the head. In that case two haematomas, one on either side, would not have resulted from such an impact. Any bleeding on the periosteum bone covering would be small in extent and most would be from blood vessels damaged directly by the impact. The two separate side haematomas overlying fractures are therefore an indication that each would be the result of impact and that two haematomas (and two fractures) would not have been caused by a single impact unless it involved compression from both sides as previously described."

12 Later in the report he expressed the view that:

> "Although the total extent of medical literature indicates that relatively low level falls are unlikely to cause skull fractures, it would seem possible that the force required to cause a linear skull fracture could be generated in a fall from a typical bed or sofa height onto the floor even when covered by carpet. However, the likelihood of a fracture occurring in these circumstances is small. This may be because rolls from sofas or beds to floor tend not to result in the head being first contact, and if it were the velocity at impact would be reduced by the friction effect of contact with the edge of the sofa or mattress surface. The terminal impact velocity is therefore usually less than in freefall. A fall onto an uncovered hard wooden floor would tend to increase the chance of an injury compared to a fall from the same distance onto a carpeted floor. One fall will lead to one impact and not one affecting each side to cause bilateral fractures."

That report was available in July last year.

13 On 19 October, His Honour Judge Talbott gave permission for the joint instruction of Dr Hogarth, consultant neuro-radiologist. The purpose of making the Part 25 application for permission to instruct, and the reason why the application was granted, was because of the potential significance of the possibility that the appearances on the scans of fractures may be accessory sutures. Dr Olsen, whom I have always found to be fair and objective, had accepted that he could not exclude that possibility absolutely.

14 Dr Hogarth's report was available at the end of January. He agreed with Dr Olsen that these were skull fractures and not accessory sutures, for similar reasons. He also agreed with the other two experts that there were three possible causative mechanisms in operation here, namely: (1) bilateral impact injuries to both parietal bones; (2) a single impact to the head (either at the back of the head or the vertex); (3) a crush injury between two surfaces. He had observed in his report that bilateral parietal skull fractures have been reported in the research papers from single impact injuries. He said:

> "These are usually linear and symmetrical or vertical and meet at the sagittal suture. It is possible for a single impact to produce two separate sites of soft tissue swelling over the fracture line",

and that opinion was based on extensive research papers which he cited in his report. In his conclusions he referred to the parts of Dr Rylance's report where he had expressed the opinion that:

> "Whereas bilateral fractures can be caused by impact close to the mid-line at the top of the head, in that case two haematomas, as one on either side, would not have resulted from such an impact."

And the later observation of Dr Rylance that:

> "Although an impact in a fall onto the top central or back central positions on the head is reported in the literature to cause bilateral skull fractures, bilateral scalp haematomas would not occur in such a scenario",

and Dr Hogarth went onto say that in his opinion:

> "It is possible for a single impact to produce bilateral skull fractures and that scalp swelling associated with the skull fractures could occur due to the fractures themselves, that is without there being an impact injury at the sites of the soft tissue swelling."

and again he referred to research papers which supported that opinion.

15 The report of Dr Hogarth was sent to Dr Olsen and to Dr Rylance, who both provided short addendum reports early this month in which they appear to be accepting Dr Hogarth's opinion. An experts' meeting was held on 12 March, only six days before the commencement of this hearing. The lateness of that experts' meeting carried with it the capacity to derail this hearing whilst everyone awaited a transcript of the discussion, but that risk was removed by the simple expedient of video recording the remote meeting, chaired by the child's solicitor. That video was made available to the parties very quickly and all representatives were able to watch it and replay it to ensure that they had understood all that had passed between the experts. I also watched that recording, which I found most helpful to assist me in fully absorbing the import of the discussion and conclusions. I also noted there were several discrepancies between the transcript, which came along much later, and the recording, and some of those discrepancies were potentially important. I hope that the video recording of experts' meetings, and the provision of that recording in a timely manner to advocates will become common practice if it has not become so already, because it saves time and public resources, as most parties are legally represented in these proceedings, and the provision of the video in this case certainly did avoid the risk of a last minute adjournment.

16 What came out of that meeting was a consensus. Dr Hogarth expressed the view that there is quite a wide variation in the skull's response to head impact injury, just as if you crack an eggshell you will get different patterns if you do that with lots of eggs; he expressed the view that a single impact to the back of the head or to the top of the head, were both plausible explanations for the injuries that were seen in the case of E, and both Dr Olsen and Dr Rylance agreed with that. They also agreed about the timing of the injuries, namely within the previous two weeks of presentation at the hospital, and although none of the experts could exclude the possibility of a crush mechanism, none of them were inclined towards that as a favoured explanation.

17 In the meantime, and before she was made aware of that consensus between the experts, the mother had informed her solicitor that the child had suffered a fall onto the head in the early afternoon of 24 February last year. Her account is as follows: she was alone in the house with E at around 1.30 to 2 p.m. The baby was placed on a changing mat on the sofa in the living room. The mother had undressed E in order to wash the child, and she had put shampoo and water on the baby's body with the intention of wiping E down with a wet sponge or baby wipes. She said E was not able to roll over but was able to wiggle the arms and legs. The mother turned her body for a few seconds to grab something, either a nappy or a vest, and she did not see E fall, she just heard a bang, and as she turned the baby was on the floor, and she assumed that E had slipped from the changing mat due to the soapy body and the friction against the plastic material. By the way that E was lying on the floor the mother believed that the baby had fallen backwards and landed on the floor and hit the head. The height between the top of the seat on the sofa and the floor was about 50 centimetres, and the floor was hard laminated flooring, which the baby had landed on. The mother immediately picked the child up from the floor. E was visibly distressed and crying more loudly than usual; it was a different cry to when hungry or tired. There was no bruise or bump, but the back of E's head was very warm when her mother touched it. The mother said she was trying to soothe the baby, who she believed cried for about five or ten minutes but she could not be sure how long as she was trying to make sure that the baby was okay. She said she fed E a little bit but the baby vomited, so she put the child down for a nap for a couple of hours, and when E woke the mother noticed that E's head had swollen a bit, and the baby was not as playful as it normally is; indeed the baby was very quiet. She said that she had realised there was something wrong with the baby's head, so she gave E Calpol but did not call the ambulance or 111 at that time because she hoped that the swelling would go down. The mother noted that E did not seem to be in any pain, did not vomit again, and was not crying after the initial crying phase.

18 The swelling got bigger and bigger as the afternoon went on and the mother says she became increasingly worried. She said:

> "I feared telling anyone what had happened in case they thought I had done something to hurt the baby."

When her eldest child returned home from work they called an ambulance. The mother says she had realised at that point that the baby was not going to get better and the swelling was not going to go down.

19 Given the consensus between the experts as I have just described, it was expected that they would agree that the event as described by the mother was a possible explanation for the child's head injuries, but rather than put the matter to the experts during their attendance at court, they were sent the mother's statements in which she set out the account and then more detail was given in response to queries raised by other parties. All experts agreed that what

was described by the mother was a plausible explanation for these injuries. In those circumstances no party wished to put any further questions to the experts and they were de-warned. I heard oral evidence from only the mother and the father.

20 In her oral evidence the mother gave the same account with some minor differences of detail, for example, that she had fed E before the fall and the baby vomited afterwards; that E had slept for 30 to 60 minutes which was not her usual time, and usually she slept at 11 a.m. for two to three hours. I do not regard those discrepancies such as to undermine the overall credibility of her evidence. She was asked:

> "Why did you not tell the truth about what happened until last week?"

And she said this:

> "First I was scared of my husband's family and my own family, and to be seen in the community as someone who was a liar. I did not want anyone to say I was a bad woman or a bad mother. We live among a lot of people from [X state]. In my community women, when they are together, will start talking about someone, and they will talk about me saying, 'It's because of her that the authorities came and took her child'."

And she expressed her deep regret for lying until recently.

21 The local authority did not challenge the mother's account. From my observations of the mother they were right not to do so. She was understandably nervous and came across as ashamed at having lied to all the professionals, but she also came across as sincere and truthful. The social worker was in a far better position to have assessed the mother's credibility as she has worked with the family, but in particular the mother, for the past 13 months, and she has found the mother to be fully co-operative and well engaged. The social worker went to see the mother after the account was known and the mother gave her own account to the social worker. The social worker also took measurements of the sofa and photographs, and it appears that she has accepted the mother's account as a true account of what happened, and I have no reason to depart from that position.

22 The father gave evidence and was cross-examined on the basis that he must have known about the injuries to the baby during the afternoon when he came back from his work for a while before going out to work in the evening, but I was satisfied that his account of not having any interaction with the child, and his wife not telling him about the swelling to E's head until later that evening by telephone, was truthful. He had been focused on having a sleep before going out to work again in the evening. Having heard his evidence, the local authority accepted his account and therefore that there is no basis for a finding that he provided unreasonable parenting to E.

23 Prior to this evidence the local authority had already agreed, in light of the conclusions of the experts, that E will return to the care of her parents and a transition plan over about two weeks is proposed, because E has been in foster care for 13 of the 19 months of her life and she is well settled. The local authority had agreed the discharge of the interim care order but seek an interim supervision order pending a final hearing, which has been listed in June.

24 The parents have made it clear that they would agree to E remaining accommodated under s.20 during the transitional phase, but they wish for her return to be much quicker than is proposed.

25 The legal framework for making a decision in this case can be summarised as follows: the court cannot make a care order or a supervision order unless it is satisfied that the child concerned is suffering, or is likely to suffer, significant harm and that harm, or likelihood of harm, is attributable to the care given to the child, or likely to be given to her, if the order were not made, not being what it would be reasonable to expect a parent to give her. This is the test in s.31(2) of the Children Act and is known as the threshold criteria, because the local authority must satisfy the court on the evidence that that threshold is crossed before the court has the power to make any order. So the burden is on the local authority to prove all aspects of the threshold. The standard of proof is the balance of probabilities, which means that it is more likely than not that the alleged act was committed, that the acts amount to unreasonable parenting, and that significant harm was caused to the child, or was likely to be caused, by that unreasonable parenting; the last being known as the attribution test.

26 Findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence. Findings of fact cannot be based on mere suspicion or speculation. The court must take into account all the evidence and consider each piece of evidence in the context of all the other pieces of evidence. The s.31(2) test is objective and is to be approached from the perspective of the child, not of the parents. The relevant date for assessing the threshold criteria is the date when protective measures were taken, in this case [2023] when E was placed with foster carers.

27 The harm must be significant enough to justify the intervention of the State and to interfere with the autonomy of the parents to bring up their children in the way that they choose. The harm must be significant enough to enable the court to make an order if the welfare of the child so demands. Significant means something more than commonplace failure or human inadequacy, it means something considerable, noteworthy or important, but it does not have to be intentional or deliberate. It has been established in case law in the House of Lords and more recently endorsed by the Supreme Court that the meaning of 'likely to suffer' is "a real possibility that cannot sensibly ignored, having regard to the gravity of the feared harm in the particular case."

28 The local authority in this case has continued to assert that the threshold in s.31(2) is crossed on the basis that the mother's parenting was unreasonable. It does not assert that the fact of the child falling off the sofa in the care of her mother was unreasonable parenting, rather, it accepts that it was an accident through a moment's inattention. In my judgment, they were right to accept that because it is the reality that many children sustain injury every day through a moment's inattention, but that is not of itself unreasonable parenting covered by s.31(2).

29 The local authority bases its case on two aspects of the mother's conduct. Firstly, failing to obtain medical attention for the child when the fall occurred, or at least when the mother noticed the swelling at about 4 p.m. The ambulance was called at 10.23 p.m., so there was a delay of about six hours in seeking medical attention. The second aspect of the mother's conduct relied upon by the local authority is the fact that she did not tell the hospital staff, the police and the social worker what had occurred, and the local authority asserts that by reason of that unreasonable parenting the children had suffered, or were likely to suffer, significant harm. Initially the local authority had sought to include in the threshold the middle two children, who are still the subject of these proceedings, by asserting that by reason of the mother's conduct in those two respects those two children were at risk of physical harm and suffered emotional harm as a result of the prolonged separation from E due to their mother's dishonesty. But the local authority withdrew inclusion of those two children during its final submissions in light of observations I made about the lack of

evidence (a) that they had suffered harm that could be characterised as significant, and (b) whether any such harm could be attributed to unreasonable parenting on the part of the mother. This point will be explained further on in this judgment because the same point arises in respect of E.

30 The final threshold presented by the local authority shortly before final submissions were made on behalf of the mother, was that the mother's failure to seek medical help and then be truthful to the medical professionals exposed E to the risk of significant physical harm. No description of what that significant physical harm would be was provided, nor was any explanation of how the local authority say any such harm would follow from the mother's conduct, or in the terms of the statute, be attributable to the mother's alleged unreasonable parenting.

31 On behalf of the mother, Mr Bickler KC, submitted that threshold is not crossed in this case. Firstly, he submitted that neither aspect of the mother's behaviour relied upon by the local authority amounts to unreasonable parenting. As for the failure to seek medical attention, his overarching point was that there is a range of responses by parents to a child presenting with an injury. He highlighted those aspects of the mother's statements and oral evidence where she said that the child did not appear to be in pain, there was no bruising, the child did not vomit after the first occasion, did not cry again, and appeared to be cheerful. He also pointed to the observations of Dr Rylance, who, in answer to the question:

> "How would E react at the time and in the hours and days following bilateral skull fractures?"

Said this:

> In the absence of any significant intracranial injury that would cause signs of encephalopathy close to the impact time (E did not demonstrate any encephalopathic features) it would not be expected that [the child] would behave differently after the immediate reaction to the pain of the impact than if [the child] had never had an impact injury at all."

And in answer to the question:

> "Would there be any indication to a carer that E had suffered skull fractures?:

Said this:

> Apart from the physical signs of a scalp swelling, behaviour change as a sign of fracture injury would not be expected. Many young children suffer head impacts which result in scalp swellings. Most of these are not apparently associated with underlying fractures. It would be advisable for a carer of an infant who has fallen or suffered an impact of the head in another way and is found to have such a swelling to have the child medically assessed. E's parents effectively followed this advice."

Nor is there any indication in the report of Dr Rylance that the delay presented a risk of causing harm, further harm, to the child.

32 Mr Bickler also relied on a case outlined in one of the research papers referred to by Dr Hogarth. In that case one of the parents was a medic and the child had fallen out of the mother's arms and fallen on the head. Swelling developed the day after and only three days after that did the parents present at hospital when the swellings on both sides measured 8 cms each, which he compared to the 4 to 5 cms which were measured in the case of E on presentation at the hospital. Mr Bickler also pointed to the medical notes which describe E as 'alert and smiling' when examined, and the mother is reported as saying that the child had been happy and smiling throughout the day with no fevers.

33 On behalf of the guardian it was argued that the mother's reasons for not seeking medical attention (she had said in her statement that she feared telling anyone what had happened in case they thought she had done something wrong to hurt the baby, and that was part of the reason why she did not call the ambulance), are not proper reasons for failing to get medical attention and that renders her parenting unreasonable. I have reminded myself of what the mother herself said about this:

> "If I had known it was very serious I would have called the doctor or gone to the hospital. I did not think it was serious because it was not swollen. When it was swollen I realised something had happened to [the] head and [the child] should go to the hospital."

I have reflected on that and it seems to me that the mother was acknowledging that once the swelling appeared she knew the child should go to hospital, but she did not do so for other reasons, namely, her concern about what others would say, and I have come to the conclusion that she was protecting herself. I conclude that that was unreasonable parenting and that most parents would take the view that medical attention must be sought straightaway; the fact that there is an example in the research of parents who did not do so for some days, does not alter my view on that in the circumstances of this case, given what the mother has said.

34 As for not telling the medics at the hospital what had happened, Mr Bickler argued that the mother was fearful, embarrassed and concerned what people would think, all of which I do accept, but I remind myself that threshold is to be assessed, and therefore reasonable parenting is to be assessed, by reference to the child, and in my judgment a reasonable parent is expected to put the child first and the mother did not do so. It struck me immediately as unreasonable parenting because on attendance at hospital a reasonable parent would surely want the medics to have all relevant information for diagnostic and treatment purposes so that the child would receive optimum care. The fact that, as it turned out, it made no difference to the medical investigation or subsequent events, does not affect that, as the mother would not have known at that moment that that was how things would transpire; indeed the mother's own evidence on this, regarding when she was at the hospital, was that she was scared to tell them that the baby had suffered fractures. I have concluded that that was, looking at it objectively, unreasonable parenting.

35 No significant physical harm flowing from the mother's conduct has been identified. Clearly E had suffered significant harm by reason of the fractures but that was the result of the fall and that is not relied upon as unreasonable parenting. The emotional harm asserted is the fact that E suffered the sudden and prolonged separation from the family, but in my judgment the attribution test has not been satisfied. The local authority cannot prove that, if the mother had told the medics at the hospital about the fall, in the circumstances of this case it would have made any difference to the investigation and treatment of the child, who would still have been detained in hospital and monitored due to the swellings which overlay the fractures. Nor is it likely that the mother's account would have made any difference to

the actions of the local authority and the removal of the child into foster care for these past 13 months. I say that because firstly, the radiologist at the hospital identified rib fractures; if the mother had told the medics of the fall without an explanation for the alleged rib fractures, the local authority and the police would still have become involved, because the presence of rib fractures in a child who cannot walk or move much at all on their own, is highly suspicious of inflicted injury, and therefore it is more likely than not that the interim care order with removal to foster care would still have been made. It was not until the expert opinion of Dr Olsen was received in June that it was established that there were in fact, and never had been, any rib fractures, but that change in the evidence is not likely to have resulted in the return of E to her parents; that was because of the opinions expressed by Dr Olsen and Dr Rylance. I make no apology for repeating para.8.8 of Dr Olsen's report:

> "Two sided skull fractures can result from a single impact to the top of the head but such fractures have a vertical rather than a horizontal course, as is the case for here. I would dismiss this as a viable possibility."

36 It was not until a few days before this hearing that the consensus between the experts was established, and it is from that time that the local authority has changed its position so that E will go home shortly. So the local authority cannot establish that the mother's failure to give a truthful account is a reason why the child remained in care with the attendant emotional harm that would have been caused as a result.

37 I pause to make this observation about the instruction of Dr Hogarth; there is some pressure on judges to limit the instruction of further experts, but the outcome in this case, where this child is to be returned to her parents, may not have been achieved but for the instruction of Dr Hogarth.

38 Having analysed the evidence, I conclude that I am not satisfied that the threshold is crossed under s.31(2). It follows that I do not have the power to make any orders in respect of this child under Part IV of the Act.

39 The local authority had suggested that there should be a parenting assessment of the parents. Bearing in mind the conclusion I have just come to I cannot see any need for such an assessment. These parents have brought up four children previously without any concerns expressed by any professionals. These proceedings came about due entirely to E sustaining the fractures as a result of a moment's inattention which the local authority accepts.

40 There is a divergence of view between the local authority and the guardian on the one hand and the parents on the other regarding the pace at which E should be returned to the parents' care; the proposal has been that it should be sometime after Easter and it should be focused on E's needs not the parent's needs. I am informed that the parents have readily agreed that, on the discharge of the interim care order they will agree that E remains accommodated under s.20 whereby the transition home can be effected with care. The father has offered the facility of the foster carer visiting the family home to advise them on issues about feeding and routines, et cetera. But it seems to me that these parents are so child-focused, so ready to acknowledge that they need to proceed with care, that their judgment on the right time ought to carry a great deal of weight in arriving at the right time. For myself I would very much hope that E is returned to the loving care of the parents, and the rest of the family, before the Easter break.

41 That is my judgment.

CERTIFICATE

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