Neutral Citation No: [2026] NIFam 16 *Judgment: approved by the court for handing down (subject to editorial corrections)**	*Ref:* **HUM13070** *ICOS:* ***25/043378*** *Delivered:* **12/06/2026**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION
(OFFICE OF CARE AND PROTECTION)

Between:

A HEALTH AND SOCIAL CARE TRUST

Applicant

and

KJ

and

DC

Respondents

[Care proceedings; non-accidental injury; expert evidence]

Tracy Overing (instructed by the Directorate of Legal Services) for the Applicant
Louise Murphy KC & Amy Kerr (instructed by Donnelly & Wall) for the first Respondent
Martina Connolly KC & Kathryn Murray (instructed by CMG Cunningham Dickey) for the second Respondent
Moira Smyth KC & Claire Collins (instructed by Curran Bowles Family Law) for the child through the Children's Court Guardian

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HUMPHREYS J

This judgment has been anonymised as it involves a child. The ciphers given to the parents and the child are not their initials. Nothing must be published which would identify the child or her parents.

Introduction

[1] The applicant Trust seeks a care order, pursuant to Article 50 of the Children (Northern Ireland) Order 1995, in respect of a child, FC. It is alleged that FC suffered significant harm whilst in the care of her parents.

[2] FC presented at hospital in the afternoon of 18 February 2025 in the company of both her parents, KJ and DC, who had observed a significant bump on the side of her head that morning. They had attempted to contact the health visitor and GP prior to attending the A&E department. FC was admitted and radiological investigations were commenced. The parents were later arrested and FC discharged to the care of her maternal grandmother.

[3] In the course of the ensuing care proceedings, the court has had the benefit of a series of medical reports prepared by both the treating clinicians and medico-legal experts. It is evident therefrom that there is a significant difference of opinion between the experts in relation to a discrete issue, namely whether FC suffered a fracture to her skull.

[4] It was agreed between all parties that it would be an effective and proportionate use of court time and resources to deal with this factual issue separately from the other issues in the proceedings.

[5] A hearing was therefore convened to hear the evidence relevant to the question of whether FC suffered a fracture to the skull. I am grateful to the legal representatives and, in particular, to the medical witnesses for the careful and considered approach which was adopted by all concerned.

The legal principles

[6] There are a number of fundamental legal principles which underpin public law care proceedings.

[7] Firstly, the burden of proof rests with the applicant Trust to prove its case on the balance of probabilities. It must therefore establish that it is more likely than not that a particular event occurred.

[8] In *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35, [2008] Baroness Hale stated:

> "[70] My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under s 31(2) or the welfare considerations in s 1 of the 1989 Act is the 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.
>
> [71] As to the seriousness of the consequences, they are serious either way. A child may find her relationship with her family seriously disrupted; or she may find herself still at risk of suffering serious harm. A parent may find his relationship with his child seriously disrupted; or he may find himself still at liberty to maltreat this or other children in the future."

[9] Expert evidence is never a substitute for the court's own decision-making process. The court does not delegate or defer to an expert but must give their evidence relevant weight. The respective roles are sometimes described as "the expert advises, the court decides."

[10] When faced with competing expert opinions, the court must assess each, based on their underlying factual assumptions, reasoning and evaluation, and come to an independent conclusion.

[11] In *A Local Authority v K, D and L* [2005] EWHC 144 (Fam), Charles J commented:

> "[44] …in cases concerning alleged non accidental injury to children properly reasoned expert medical evidence carries considerable weight, but in assessing and applying it the judge must always remember that he or she is the person who makes the final decision."

[12] Medical experts in cases where non-accidental injury is alleged may take into account the conduct of parents in arriving at an opinion as to whether the injury is indeed non-accidental. In *Re BR (Proof of Facts)* [2015] EWFC 41, Peter Jackson J stated:

> "[15] It would of course be wrong to apply a hard and fast rule that the carer of a young child who suffers an injury must invariably be able to explain when and how it happened if they are not to be found responsible for it. This would indeed be to reverse the burden of proof. However, if the judge's observations are understood to mean that account should not be taken, to whatever extent is appropriate in the individual case, of the lack of a history of injury from the carer of a young child, then I respectfully consider that they go too far.

> [16] Doctors, social workers and courts are in my view fully entitled to take into account the nature of the history given by a carer. The absence of any history of a memorable event where such a history might be expected in the individual case may be very significant. Perpetrators of child abuse often seek to cover up what they have done. The reason why paediatricians may refer to the lack of a history is because individual and collective clinical experience teaches them that it is one of a number of indicators of how the injury may have occurred. Medical and other professionals are entitled to rely upon such knowledge and experience in forming an opinion about the likely response of the individual child to the particular injury, and the court should not deter them from doing so. The weight that is then given to any such opinion is of course a matter for the judge."

Concurrent evidence

[13] The purpose of expert evidence is to assist the court in its decision-making process by providing opinion evidence on matters within the particular witness's field of expertise.

[14] In recent times, judges across all areas of legal practice have found, in certain cases, that the giving of evidence concurrently by experts of similar discipline can be an efficient and effective way of achieving that purpose. This process is sometimes colloquially referred to as "hot-tubbing."

[15] Care proceedings have a particular inquisitorial character and this approach enables experts to engage directly with one another on specific issues whilst in the witness box. This can be more beneficial than the sequential model of experts being examined, cross-examined and re-examined in turn. It seemed appropriate to the court that the experts in the instant case give their evidence concurrently on the basis of a judge-led approach with counsel able to ask any supplementary questions of their own or other party's experts.

[16] Ultimately, I found the approach adopted to be of significant benefit both in terms of focussing the issues and saving court time. It is recognised that this may not be the most advantageous procedure to adopt in every case but it is always one worth considering as part of the case management process, particularly where there is a multiplicity of experts. Helpful guidance can be found in the England & Wales Practice Direction 35 – Experts and Assessors at para 11.

The medical evidence

[17] The court heard evidence from:

(i) Dr Piers Osborne, consultant radiologist;

(ii) Dr Caroline Corry, consultant paediatric radiologist;

(iii) Dr Roisin Hayes, consultant paediatric radiologist;

(iv) Dr Naeem Ahmad, consultant paediatrician.

[18] Dr Osborne and Dr Corry were both treating clinicians whilst Drs Hayes and Ahmad were instructed as experts for the purposes of this litigation.

[19] In their reports certain terminology is used to describe the images obtained of the child's skull and these are best illustrated by reference to the 3D reconstructed imagery prepared by Dr Osborne and which appears as the first image in Annex A to this judgment.

(i) Parietal bones – the bones to the side and roof of the skull as indicated by the orange (left) and pink (right) arrows;

(ii) Occipital bone – the bone to the rear of the skull where the blue, red and green arrows are located;

(iii) Lamboid suture – shown by the dark blue arrow as the area where the parietal bones meet the occipital bone;

(iv) Lucency – refers to the dark line as indicated by the pink arrow.

[20] The term "accessory suture" refers to an anatomical development in certain individuals where an additional suture is present beyond those normally observed.

[21] The second image in Annex A shows the location of the lucency relative to the area of soft tissue swelling.

Dr Osborne

[22] Dr Osborne first became involved in the care of baby FC on 20 February 2025 after a report had been received from a registrar and a decision made to carry out an X-ray skeletal survey. He explained that when such a decision is made, any CT head scan is subjected to review by a second paediatric radiologist.

[23] The initial CT head scan in this case was carried out on 18 February 2025 and reviewed by Dr Osborne two days later. He observed a relatively extensive area of subcutaneous haematoma overlying the right parietal bone superiorly. He identified that underlying this haematoma was what he described as a "fairly straight

lucency/defect in the underlying parietal bone" which began centrally and travelled posteriorly toward the right lamboid suture, widening as it did so.

[24] The question, on Dr Osborne's analysis, was whether this defect was a fracture or an accessory suture. He identified seven reasons for his conclusion that this represented a skull fracture:

(i) Accessory sutures normally have a zig-zag configuration whilst fractures are linear or straight;

(ii) Accessory sutures tend to have well defined sclerotic edges whilst the edges of fractures are ill-defined;

(iii) Accessory sutures tend to be bilateral whilst fractures are unilateral;

(iv) Widening of a defect as it approaches the lamboid suture is a feature seen almost exclusively in fractures and not accessory sutures;

(v) Crossing the lamboid suture is a feature of a fracture, not an accessory suture;

(vi) The abnormal widening of the accessory suture in the occipital bone is explained by the extension of a fracture into the accessory suture; and

(vii) The presence of the haematoma overlying a linear skull lucency makes it considerably more likely that the lucency is a fracture rather than an accessory suture.

[25] Dr Osborne found that the lucency in question was quite straight with ill-defined edges. The defect was unilateral and it widened as it approached and then crossed the lamboid suture.

[26] In relation to point (vii), Dr Osborne identified that the lucency was "very closely associated" with the soft tissue swelling, or haematoma. The defect was not found directly beneath the apex of the haematoma but, on Dr Osborne's evidence, this is not unusual. Much may depend, for instance, on the location and age of the injury as soft tissue can move and distort with gravity and pressure.

[27] Skeletal surveys were performed on 20 February and 6 March 2025 in accordance with established protocols. They revealed no other acute or healing fracture.

[28] On the basis of the evidence, Dr Osborne concluded that there was a fracture of the right parietal bone.

Dr Corry

[29] Dr Corry became involved in the case following the CT head scan on 18 February 2025 which was reported to show a skull fracture. This was discussed with her on 19 February and a skeletal survey arranged for the following day. Both parts of the skeletal survey (20 February and 6 March 2025) were double reported by her and Dr Osborne.

[30] In accordance with established practice, the CT scan was further considered by one of the consultants reporting on the skeletal survey, in this case Dr Osborne. 3D reconstructions were produced on the basis that these are a better way of differentiating fractures from sutures.

[31] She concluded that the lucency was a fracture not a suture for the following reasons:

(i) It was underlying the scalp swelling;

(ii) The lucency was sharp and straight and widened as it approached the lamboid suture, which are characteristics of a fracture; and

(iii) Accessory sutures are usually bilateral and symmetrical.

Dr Hayes

[32] Dr Hayes is a consultant paediatric radiologist with considerable experience of giving expert evidence in the courts. In her conclusion, FC sustained a moderate soft tissue injury but there was no convincing evidence of an associated skull fracture.

[33] Her evidence was that accessory sutures in the parietal bone, unlike those in the occipital bone, can be linear rather than zig-zagged in nature. She accepted that it is rare to see a unilateral accessory suture but these do occur.

[34] Dr Hayes stated:

> "Accessory sutures are commonly seen in babies' skulls. It is very important that they not be misdiagnosed as skull fractures. In general, following significant head trauma, the haematoma should lie directly over the skull fracture."

[35] Dr Hayes' particular focus was on this specific issue. She observed that this swelling was centred over a region of the skull which was superior and anterior to the lucency. For this reason, she determined that the lucency was highly unlikely to represent a skull fracture. Dr Hayes also took into account the circumstances of the child's arrival at hospital, the absence of any other suspicious findings and the later explanation offered by the father for the injury as contra-indicators to a skull fracture.

Dr Ahmad

[36] Dr Ahmad is a consultant paediatrician who also has extensive experience of medico-legal work, particularly in the field of child protection. He provided an expert report addressing the issue of whether the injuries caused to FG were, on balance, non-accidental in nature. This was based on the premise that the skull was fractured.

[37] Dr Ahmad readily accepted that he is not a radiologist and deferred to the expertise of the other medical experts on the discrete issue of whether or not the child had sustained a skull fracture.

Medical literature

[38] The court has been referred to, and derived considerable assistance from, a paper published in May 2010 by Sanchez et al in the journal Emergency Radiology ((2010) 17:413-418).

[39] In this article the authors consider the difficulties associated with the identification of skull fractures in children, particularly when using plain film radiography. They stress that the use of 3D reconstructions can be of considerable assistance in differentiating fractures from accessory sutures.

[40] The paper explains that the 3D imagery can enable, in most cases, the distinction to be drawn by reference to the following characteristics:

Skull fracture	**Accessory suture**
Sharp lucency with non-sclerotic edges	Zigzag pattern with sclerotic borders
Widening on approach to suture	No associated diastasis
Can cross adjacent suture lines	Merges with adjacent suture
Often unilateral, asymmetric if bilateral	Often bilateral and symmetric
Associated with soft tissue swelling	No soft tissue swelling

Consideration

[41] The court must make a determination, on the balance of probabilities, bearing in mind the legal principles set out above. I had the benefit of reading each of the doctors' careful analyses and hearing each of them give evidence.

[42] On balance, I prefer the evidence of Dr Osborne and Dr Corry and I have concluded that the child FC did sustain a fracture of the skull.

[43] I have reached this conclusion for the following reasons:

(i) The lucency identified was sharp and straight with non-sclerotic edges;

(ii) It widened on approach to the lamboid suture;

(iii) It was unilateral in nature;

(iv) The lucency crosses the lamboid suture; and

(v) Whilst it did not lie directly under the apex of the haematoma, it was nonetheless closely associated with this area of significant soft tissue swelling.

[44] It is evident that the lucency under consideration in this case had all the characteristics identified in the literature. On this basis, I find that it is more probable than not that FC suffered a fracture to the skull.

[45] At this stage, the court makes no other findings but will make directions in relation to the other issues to be considered in these care proceedings.

ANNEX A