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Judgment: approved by the Court for handing down | *Delivered:* **18/11/2005**
(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION

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Record No. 05/7682

BETWEEN:

SOUTH AND EAST BELFAST HEALTH AND SOCIAL SERVICES TRUST

Applicant;

-and-

E AND C

Respondents.

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McLAUGHLIN J

Introduction

[1] In order to protect the identity of the child I shall refer to the main parties as follows:-

N – the child who was born on 9 December 2004.
E – mother.
C – father.
S – uncle of the child (seven years old).
MGM – maternal grandmother of the child.
MGF – maternal grandfather.

[2] This is an application for a care order pursuant to Article 50 of the Children (NI) Order 1995 which is in the following terms:-

> "50.-(1) On the application of any authority or authorised person, the court may make an order –
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> (*a*) placing the child with respect to whom the application is made in the care of a designated authority; or
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> (*b*) putting him under the supervision of a designated authority.
>
> (2) A court may only make a care or a supervision order if it is satisfied –
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> (*a*) that the child concerned is suffering, or is likely to suffer, significant harm; and
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> (*b*) that the harm, or likelihood of harm, is attributable to –
>
> (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or
>
> (ii) the child's being beyond parental control."

The application arises from the fact that N was presented to the medical staff at the Accident & Emergency Department of the Ulster Hospital, Dundonald, when she was just three weeks old, with severe head injuries for which no explanation was forthcoming from its carers.

Summary of Medical Findings

[3] N arrived at the Accident and Emergency Department of the Ulster Hospital, Dundonald at approximately 6.00 pm on 31 December 2004. Her parents said she had been brought because of the presence of swelling on the left side of her head and she had stopped breathing twice. On admission she was noted by the duty doctor to be pink and crying and had experienced two further episodes of apnoea: one of these episodes required the administration of oxygen and the other was self-limiting.

[4] Dr Paul Raj, duty Paediatric Registrar, arrived in casualty at which time oxygen was being given by a face mask. N was not breathing at that point and had some tremulous movements of the chin. On examination by Dr Raj swelling on the left side of her head was noted together with bruising of her left hand: he ordered x-rays of the skull.

[5] Dr Anne Black, Consultant Paediatrician, was sent for and arrived at approximately 7.00 pm. She spoke to both parents and later to both the maternal and paternal grandparents who were in attendance. On examination she noticed was N was pale and alternatively sleepy or extremely irritable; there was a discreet boggy swelling, approximately 3 cms in diameter, on the left parietal region of her scalp which seemed to be extremely tender and was very egg shaped. There was also a V shaped healed abrasion on the forehead approximately 1 cm in diameter which was very faint. On the back of her left hand there was (i) blue/red bruising on the middle phalanx of her little finger, (ii) bruising over the proximal inter-phalangeal joints of her ring and middle fingers of the left hand, (iii) a 2 cm long linear blue/red bruise on the back of the left hand, (iv) on the inner aspect of the left forearm there was a 1½ cm line of petechiae. Her condition was monitored closely over the next few hours and remained intermittently irritable and sleepy. When asleep her respirations were irregular with periods of very shallow respiration during which time her oxygen level dropped. Although these episodes were brief and self-limiting, and she did not require any extra oxygen, it was decided to transfer her to the Intensive Care Unit of the Royal Belfast Hospital for Sick Children. At about the time she was being prepared for transfer Dr Black noted that whilst the swelling of her scalp had decreased bruising was beginning to appear. It was also noted, again within a few hours of her initial admission, that two small oval shaped bruises, approximately 1 cm in diameter, had appeared on the left side of her forehead.

[6] During her stay overnight in the Intensive Care Unit N stabilised and was returned to the Ulster Hospital later that day. Upon her return she was noted to be pink and well perfused, the swelling on the left side of her scalp had almost gone but had been replaced by a defuse area of bruising. There was also some swelling of the scalp on the right side; thereafter she improved rapidly.

[7] Given the presentation of N in casualty it was suspected immediately that this might be a case of non-accidental injury. Doctor Black spoke to both parents and both sets of grandparents with a view to eliciting any relevant history but no explanation of any kind was forthcoming from any of the persons present.

[8] The investigations with a view to establishing the nature of the extent of N's injuries included X-rays, CT and MRI scans. I shall consider these in

more detail later but, in a letter of 7 February 2005 in the form of a report for social services personnel, Dr Black summarised the position as follows:

> "The initial skull x-ray showed a depressed fracture of the left parietal bone with the fracture crossing the sagittal (midline) suture and extending into the right parietal and temporal bones. A CT scan of her brain done that night showed a contusion (bruise) with some surrounding oedema in the right parietal lobe of the brain. In other words N had bruising of the opposite side of the brain to the fracture due to the brain hitting the opposite side of the skull with force. An MRI scan of her brain done on 7 January showed an area of infarction in the right parietal lobe of the brain. There were small areas of haemorrhage seen within the left parietal, right parietal and right frontal lobes of the brain."

In Dr Black's opinion, expressed at that time, this was obviously a severe head injury in a very young baby and could not have occurred when the baby was lying in her cot, another person must have been present at the time this injury occurred and would be fully aware that a serious injury had happened. She stated in her report:- "this injury would have required N's head to hit a hard object with considerable force and the person with N at the time would have been aware that this happened".

Explanation for presence of injuries

[9] It was a notable feature of this case that from the moment of presentation of N at hospital and for a considerable period thereafter no explanation of any kind was forthcoming to account for the extensive injuries which she had sustained. It remains the case that neither parent has any explanation to give. On Monday 21 February 2005 however a possible explanation emerged. On that date S, who is seven years old, and the uncle of N, had been in trouble at school. He had been suspended for lashing out at and hitting two teachers and three children. That evening S was spoken to by his mother, MGM, when he was going to bed and she tried to talk to him about what he had done that day at school. It appears that he became quite upset and stated several times that he did not hit anyone and then added, apparently quite spontaneously, that he had not hit N. This came as a surprise to MGM as she had not been discussing the injury to N. She asked S to tell her the truth about N and that he was not in any trouble. He then gave his account.

[10] The following day MGM and E attended the Templemore Avenue office of the Trust and reported the conversation to Mags Mooney, social worker. She completed a "Significant interview/event report" and recorded the account given to her. As she has recorded it the sequences of events was explained to her by E rather than MGM to whom it had been given. The account however was given in the presence of MGM and she confirmed the account. In view of its importance I shall set it out in full.

> "She stated that on the day N received her injury, N was upstairs in the Moses basket and Sam was up with her showing her his toys. She advised S was holding up various toys so N could see them. E said that he was showing her remote control cars, which were quite big, and that he had left them on the floor beside the Moses basket.
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> She said he was excited and ran to get another toy, a double decker bus, to show her. When he returned to N's room he had the bus in his hand and tripped up over his bigger toys, which were on the floor. He fell towards N and hit her with the bus."

[11] The Police Service of Northern Ireland was informed as they were then conducting a criminal investigation. In consequence the police arranged to interview S. In fact two interviews of S were conducted, one had already taken place on 13 January 2005, well before he made the disclosures, and then a follow up in consequence of these which was conducted on Friday 25 February 2005, some six weeks after the first interview and four days after the disclosure. In his first interview S had been unable to cast any light on the causes of the injury to E and had been able to say little more than when he had gone upstairs into the bathroom he heard N crying. After he had been to the toilet he heard her crying "really loud and then I called E and then C came up and lifted N". When asked if there was anything else happened after that he replied "she just went to the hospital".

[12] When interviewed on the second occasion after some preliminary conversation and questions in order to make him comfortable, S was asked about N and how she got hurt. He was asked "Can you just tell me in your own words what happened please" to which he replied:

> "After I was showing her some toys I slipped over one, the big toy and I accidentally the bus hit her on the head, accidentally fell back, the bus hit her on the head and I called my mummy and I said I was I didn't want to tell her just cause I was afraid I was going to get into big big trouble."

After some further questions he was then asked to explain again and after saying he heard N crying he stated:

> "I was rubbing her on the cheek and then after that I went into my room, showed her some and I went into E's room again with some, a couple of my toys, accidentally slipped, hit her on the head by an accident and I didn't want to tell youse cause I thought I was going to be in big big trouble."

After still further questioning he stated:

> "I slipped over a big car and the bus came out of my hand and hit N. After I got up I saw the bus inside the Moses basket."

At a later point he also stated:

> "I put that down, showed her that one and then I fell over that one with that one in my hand."

He was asked to explain what happened when the bus hit her and stated:

> "She started crying really loud and I called my mummy up and I said what happened first and then C came up first and then E came up and gave her a bottle and she wasn't eh getting it and then I realised the bump on her head and I called my mummy and got her something cold on her head and then after that she stopped breathing in the car and in the house."

[13] Again follow up questions were put and he was asked "when you fell over did, where you still holding the bus when it (inaudible). The answer given was "No" and it was considered that the tape at the inaudible portion may have failed to pick up the words "hit her" which would seem to make sense.

Subsequently he described the incident again and said:

> "I went, running into her room, stroke her on her cheek, I went into my room, got her some toys, showed her a toy, I slipped over and the bus went into the Moses basket, hit her head by an accident and I thought I was going to be in big trouble."

Finally, he described it in the following terms:

> "I was showing, I came, I went into my room so as and to get went back in show her some toys and I slipped over one, hit her head with the bus and called mum, she stopped, and C came up and E came up last and then my mummy came up."

[14] The accounts do not make it clear whether S was still holding the bus when the impact occurred between it and the baby's skull. This is a particularly important matter in the light of the opinion expressed by Dr Glasgow which is set out in more detail later. Neither is it clear that he actually fell forward into the Moses basket because it remained on its stand and was apparently undisturbed and undamaged. It is important to note however that in one of his answers he makes a clear linkage between the event which he was trying to describe and the baby beginning to cry loudly, calling on the grown ups downstairs, noticing the bump on her head and her stopping breathing.

The burden of proof

[15] In this, as in most civil cases the general rule is that "he who asserts must prove". It is for the applicant Trust in this case to establish all the pre-conditions and other facts entitling it to the order sought. This was reaffirmed by Lord Nicholls in *Re H & R (Child Sex Abuse: Standard of Proof)* [1996] 1 FLR 80. At page 95E he stated the following:

> "The power of the court to make a care or supervision order only arises if the court is 'satisfied' that the criteria stated in Section 31(2) exist. The expression 'if the court is satisfied', here and elsewhere in the Act, envisages that the court must be judicially satisfied on proper material. There is also inherent in the expression an indication of the need for the subject matter to be affirmatively proved. If the court is left in a state of indecision the matter has not been established to the level, or standard, needed for the court to be 'satisfied'. Thus in Section 31(2), in order for the threshold to be crossed, the conditions set out in paras (a) and (b) must be affirmatively established to the satisfaction of the court."

Section 31(2) of the Children Order 1989 and Article 50(2) of the Children (NI) Order 1995 are in identical terms.

The standard of proof

[16] This matter was also considered in *Re H & R*. In that case the local authority had failed to establish allegations of sex abuse of the child, who was the subject of the application, by her mother's partner. This followed his acquittal in the Crown Court on charges arising out of the same allegations. The court therefore was obliged to proceed on the basis that the child had not suffered significant harm in the past. In that case the core question, upon which the House divided by 3:2 was the approach to be adopted in respect of future risk, ie. whether or not unproven allegations of mal-treatment could form the basis for a finding by the court that either limb of Section 31(2)(a) was established. Lord Nicholls of Birkenhead stated the following at pages 95H-97C:

> "The standard of proof
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> Where the matters in issue are facts the standard of proof required in non-criminal proceedings is the preponderance of probability, usually referred to as the balance of probability. This is the established general principle. There are exceptions such as contempt of court applications, but I can see no reason for thinking that family proceedings are, or should be, an exception. By family proceedings I mean proceedings so described in the 1989 Act, ss 105 and 8(3). Despite their special features, family proceedings remain essentially a form of civil proceedings. Family proceedings often raise very serious issues, but so do other forms of civil proceedings.
>
> The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability. Fraud is usually less likely than negligence.

Deliberate physical injury is usually less likely than accidental physical injury. A stepfather is usually less likely to have repeatedly raped and had non-consensual oral sex with his under-age stepdaughter than on some occasion to have lost his temper and slapped her. Built into the preponderance of probability standard is a serious degree of flexibility in respect of the seriousness of the allegation.

Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established. Ungoed-Thomas J expressed this neatly in *Re Dellow's Will Trusts, Lloyd's Bank v Institute of Cancer Research* [1964] 1 WLR 451 at p 455:

> 'The more serious the allegation the more cogent is the evidence required to overcome the unlikelihood of what is alleged and thus to prove it.'

This substantially accords with the approach adopted in authorities such as the well-known judgment of Morris LJ in *Hornal v Neuberger Products Ltd* [1957] 1 QB 247 at p 266. This approach also provides a means by which the balance of probability standard can accommodate one's instinctive feeling that even in civil proceedings a court should be more sure before finding serious allegations proved than when deciding less serious or trivial matters.

No doubt it is this feeling which prompts judicial comment from time to time that grave issues call for proof to a standard higher than the preponderance of probability. Similar suggestions have been made

> recently regarding proof of allegations of sexual abuse of children: see *Re G (No 2) (A Minor) (Child Abuse: Evidence)* [1988] 1 FLR 314 at p 321, and *Re W (Minors) (Sexual Abuse: Standard of Proof)* [1994] 1 FLR 419 at p 429. So I must pursue this a little further. The law looks for probability, not certainty. Certainty is seldom attainable. But probability is an unsatisfactorily vague criterion because there are degrees of probability. In establishing principles regarding the standard of proof, therefore, the law seeks to define the degree of probability appropriate for different types of proceedings. Proof beyond reasonable doubt, in whatever form of words expressed, is one standard. Proof on a preponderance of probability is another, a lower standard having the in-built flexibility already mentioned. If the balance of probability standard were departed from, and a third standard were substituted in some civil cases, it would be necessary to identify what the standard is and when it would apply. Herein lies a difficulty. If the standard were to be higher than the balance of probability but lower than the criminal standard of proof beyond reasonable doubt, what would it be? The only alternative which suggests itself is that the standard should be commensurate with the gravity of the allegation and the seriousness of the consequences. A formula to this effect has its attraction. But I doubt whether in practice it would add much to the present test in civil cases, and it would risk causing confusion and uncertainty. As at present advised I think it is better to stick to the existing, established law on this subject. I can see no compelling need for a change.
>
> I therefore agree with the recent decisions of the Court of Appeal in several cases involving the care of children, to the effect that the standard of proof is the ordinary civil standard of balance of probability."

[17] He made clear that there should be no difficulty in applying the standard when considering the first limb of Article 50(2)(a) because it deals with an existing state of affairs, namely, that the child is suffering significant harm. He described the relevant time for the purposes of that consideration and made clear that whether the child was suffering significant harm is to be decided by the court "On the basis of the facts admitted or proved before it. The balance of probabilities standard applies to proof of the facts". In dealing

with the second limb, namely the risk of significant harm arising in the future, he stated:

> "The same approach applies to the second limb of Section 31(2)(a). This is concerned with evaluating the risk of something happening in the future: aye or no, is there a real possibility that the child will suffer significant harm? Having heard and considered the evidence and decided any disputed questions of relevant fact upon the balance of probability, the court must reach a decision on how highly it evaluates the risk of significant harm befalling the child, always remembering upon whom the burden of proof rests."

[18] At this stage the court must act on facts which have been established to the normal civil standard in the sense which he had earlier described. If relevant facts have not been established then the court could not act upon suspicions or anxieties that may linger where proofs have come up short. He made clear that "unproved allegations of mal-treatment cannot form the basis of a finding by the court that either limb of the section was established". The test could only be satisfied if there was other evidence, actually proved sufficient to satisfy the test of the likelihood of future harm. After explaining that Parliament had used the threshold test as the line between the protection of the privacy and integrity of the family and the point at which public intervention for the protection of children began, he made clear that the likelihood of future harm did not require proof that it was 'probable'. At page 94H he states:

> "In this context Parliament cannot have been using 'likely' in the sense of 'more likely than not'. If the word likely were given this meaning, it would have the effect of leaving outside the scope of care and supervision orders cases where the court is satisfied that there is a real possibility of significant harm to the child in the future but that possibility falls short of being more likely than not. Strictly, if this were the correct reading of the Act a care or supervision order would not be available even in a case where the risk of significant harm is as likely as not. Nothing would suffice short of proof that the child will probably suffer significant harm. ….'.

At page 95D he continued:

> "In my view, therefore, the context shows that in Section 31(2)(a) likely is being used in the sense of a real possibility, a possibility that cannot sensibly be ignored having regard to the nature and gravity of the feared harm in the particular case. By parity of reasoning, the expression likely to suffer significant harm bears the same meaning elsewhere in the Act; for instance, in ss 43,44 and 46. Likely also bears a similar meaning, for a similar reason, in the requirements in Section 31(2)(b) that the harm or likelihood of harm must be attributable to the care given to the child or 'likely' to be given to him if the order were not made."

[19] In deciding the truth or otherwise of the allegations made by the Trust in this case I must apply the civil standard of balance of probability, but, having regard to the gravity of the allegations I must look for evidence which is sufficiently cogent to overcome the inherent unlikelihood that a person would so seriously injure a three week old helpless child.

Evidence of Dr John F T Glasgow

[20] Dr Glasgow produced reports dated 14/4/05, 20/5/05 and 26/9/05. At the time of his first report he did not have a lot of the background information. After he considered that information he produced a second report. The conclusions set out in the reports are radically different. The third report was by way of an appendix to the second.

[21] Dr Glasgow has been a paediatrician since 1966, a consultant since 1971 and has specialised as a consultant paediatrician in accident and emergency medicine since 1988. He has investigated hundreds of children injury cases, including many head injury cases, and of these a large number involved suspected and proven cases of abuse. He is also a member of the Criminal Cases Review Commission. He has given evidence in these courts on many occasions and is considered as a distinguished and impartial expert witness. He concluded that this was a non-accidental injury, contrary to the views of four persons whom he accepted as distinguished colleagues. This is a most unusual situation and therefore the evidence of the experts must be looked at with great care and attention.

[22] In his first report he sets out details of the family background and the medical history after admission to the Accident and Emergency Department at the Ulster Hospital and considers the findings of Dr Black and the junior doctors; the skull x-rays, he considers CT and MRI scans are reviewed. His report is a most detailed one and deals with the issues known at the time in a

most comprehensive manner. In paragraph (n) under the heading *Mechanism of some of Brain Injury* he states:

> "At the moment of impact the brain would have been thrown violently away from the point of impact and would have struck against the skulls inner surface *on the opposite side*, thus causing injury – this is the well recognised injury described as contracoup (sic). The areas of haemorrhage within the skull and brain are the result of tearing blood vessels. Where this applies to brain tissue it will result in neuronal death because of the failure of oxygenation; brain is exceptional vulnerable to such events – hence the area of brain infarction (brain death) referred to earlier."

[23] At that point he was ad idem with the other experts who give evidence. He continued in the report that he believed the mechanism of the overall injury to have been inflicted injury – ie. non-accidental injury or deliberate injury and this was the most likely probability in the case. He did however go on to say that this may not be the sole explanation for what had taken place and stated:

> "In this case, one could conceive of the situation where somebody with access to the baby might have removed the child from her cot and in so doing dropped her …. So that she fell backwards and downwards onto a hard surface. One could imagine that given the injuries sustained it would be difficult for such an individual to make an admission at this stage".

He found it less easy to envisage the mechanisms of the injuries to the left hand and forearm of S.

[24] Dr Glasgow later obtained access to further information, including the contents of the police interviews of S, other interview transcripts and statements of family members together with the clinical notes from the hospital. The net result of his review of the case in the light of this additional information was that he changed completely his belief as to how the injury had been caused. Instead of his original conclusion that the injury was non-accidental, or perhaps the product of an undisclosed accident, he concluded on the balance of probabilities that the injury had indeed been caused accidentally, probably as described by S. He accepted immediately that if S had been running towards the child's cot and in tripping had let go of the toy bus so that it struck the baby when in freefall, it could not explain the injuries. Before his new analysis could be correct it was essential to establish that S, a

boy of approximately 25 kilos, had fallen forward onto the child in its cot whilst holding a toy in his hand and with the bottom of the bus impacting on the parietal area of the child's skull.

[25] It was the belief of Dr Glasgow that the incidental findings further supported this theory in that the two small oval bruises on the left side of the forehead could equate to the distance apart of the wheels on the bus and could explain the bruising injuries to the baby's fingers and back of its hand. He conceded that he had no explanation for the patechiae on the volar aspect of the left arm. As envisaged by Dr Glasgow the head injury was caused when the skull was compressed due to S falling onto the parietal area. He considered this would explain the fracture and also the injuries to the right side of the brain, the mechanism being that the brain was compressed on the left side and thrust across the skull so as to impact on the opposite side and so cause the damage. He said it was clear there was injury to the right and left sides of the brain and that the impact had deformed the skull and thereby caused damage and tearing of blood vessels in the dura which could account for the injury on the left hand side. He did not accept that the head had to be moving freely just before impact to explain these injuries and did not accept that it was a completely contrecoup injury in the accepted sense.

[26] The conclusions of Dr Glasgow are based not just on his interpretation of the medical findings, and the possibility of an explanation which, whilst different from that understood the other medical examiners, was valid. He went on to state that as a paediatrician he had to set the actual medical findings in the overall context of the social history and the implications of any conclusion that this was a non-accidental injury. This he termed the holistic approach and he set out for me the following matters which he took into account individually and cumulatively in coming to the conclusion which I have just set out.

> (i) The absence of any initial explanation/exculpatory excuse.
> (ii) The circumstances of the disclosure by S – namely that he had been misbehaving at school and had been sent home in circumstances which showed he was capable of hitting out at others.
> (iii) The consistency of S during the course of his interviews with the PSNI during which he gave seven possible accounts of the incident.
> (iv) The fact that the physical and medical findings can be explained in a manner consistent with accidental injury and with the explanation given by S.
> (v) His belief that the explanation was consistent with the physical findings externally.

(vi) The requirement that a complicated conspiracy by the parents and the maternal grandmother would be necessary to conclude that S was being blamed by them with a view to deceiving the authorities.
(vii) The selection of S to be the fall guy when he was a child of only seven.
(viii) The need to rely on him to say the right thing and then stick to it after being coached.
(ix) The fact that S was the first to observe and comment on the presence of the bruise/lump on the left parietal region.
(x) The absence of any apparent delay in seeking help.

The combination of these events taken with the plausibility of S's account as he interpreted it, led him to believe the version now proffered to him was correct and this should be regarded as an accidental injury caused by S.

Evidence of Dr Charles Stephen McKinstry

[27] Dr McKinstry is a consultant neuroradiologist at the Ulster Hospital Dondonald. He was not involved in the initial examination or assessment of N but was asked to report in the unavoidable absence of a colleague who had been involved in the early stages. He adopted in full his report of 4 October 2005 in which he reviewed the x-rays of the skull and the CT and MRI scans of the brain. The latter were performed on 4 January 2005, some four days after the injury was sustained, but he made it clear in evidence this had no bearing on the validity of his assessment, or his ability to carry out his task. He confirmed the skull x-rays showed:

> "An extensive fracture involving principally the left parietal bone which passes forward to the coronal suture. The fracture also branches and passes superiorly towards and across the vertex of the skull into the opposite parietal bone."

He has also set out in his report a detailed technical analysis of the CT and MRI scans. In the course of his evidence he demonstrated these findings by showing me the actual plates. In view of the importance of his evidence I propose to set out his conclusion in extenso which was in the following terms:

> "Conclusion

The investigations confirm that this child suffered a significant head injury with skull fracture, subdural haematomas, subarachnoid haemorrhage and extensive infarction and contusion in the right cerebral hemisphere.

In children of this age, the skull is thin and more fragile than in older children and adults. Therefore, it is more likely to be damaged by lesser degrees of force than would be required later in life. It is noted that the site and patter of the fracture in this case do correspond to those more frequently reported in association with non-accidental injury. A small amount of traumatic subarachnoid haemorrhage is also present. This is bleeding within the cerebrospinal fluid surrounding the brain and is again a recognised feature of significant head injury.

The CT and MRI scans also show evidence of subdural haematoma formation. A subdural haematoma forms when bleeding occurs in the membranes surrounding the brain and is a typical finding following head injury in children. Again young children are more susceptible to such injuries.

There are some small areas of haemorrhage in the cortex of both parietal lobes indicating brain contusion (bruising). In addition, the scans also show extensive infarction (death of brain cells due to restricted supply of blood or oxygen) in the right cerebral hemisphere opposite to the site of injury. This type of injury may be due either to the direct effects of the head trauma or due to other cause of vascular insufficiency such as strangulation or smothering. There does not appear to be any suggestion of the latter in his case although it would obviously be important to exclude this.

Infarction of the brain is a recognised result of brain trauma in young children and I feel, therefore, that the changes in the right cerebral hemisphere are the result of the direct impact to the left side of the head which caused the skull fracture. It is likely that these changes have resulted from so-called contre-coup type injury where the force of impact causes movement of the brain within the cranial cavity and

> impaction against the inner surface of the skull vault on the opposite side.
>
> In conclusion, therefore, whilst skull fracture can occur in infants following milder head injury than in adults, the additional presence of extensive intracranial injuries, particularly to the right cerebral hemisphere, indicates at least a moderately severe degree of direct trauma to the head in this case."

[28] Dr McKinstry confirmed that the so called "contrecoup" brain injury typically resulted from a moving head hitting a stationary object, eg. if a person fell backwards and hit the back of the skull on the ground. The injury on the left side of the skull, which was obviously the point of impact, with relatively little damage to the adjacent area of the brain, but with extensive damage to the brain on the opposite side and with no direct damage to the skull, as found in this case, was a typical example. He said that a very young child is less susceptible to a contrecoup injury as the inner surface of the skull is smoother than in an older person and he concluded that a reasonably severe impact was required to cause the contrecoup type injury in a child so young.

[29] The classic nature of the pattern found here is demonstrated by the fact that some 75-80% of the brain damage is to the right hand side but with little damage to the left side adjacent to the point of impact. The main damage to the left hand side of the brain was in the form of bleeding between the membranes overlying the brain but with no damage deep to the fracture itself. If a hard object had moved towards the skull to cause the fractures on the left hand side, rather than the head moving towards the hard object, he would have expected contusion of the brain under the damage to the left side of the skull. He therefore ruled out the suggestion that the injury could have been cause when the head was stationary and was then struck by an object moving towards it. In particular he rejected the proposition that if the child's head was inclined to its right whilst it lay in the cot, and was therefore supported by the mattress, that sufficient movement of the skull would occur to allow this pattern of injury to result.

[30] He was asked to consider the possible reconstruction postulated by Dr Glasgow and this was put to him in detail, including the possibility that a child weighing 25kgs holding a hard object such as the toy bus, running towards the cot and falling onto the baby could have caused the injuries. The further possibility that such injuries could be caused by the crushing/compression of the left hand side of the head coupled with thrusting of the brain towards the right was also put in cross-examination. Dr McKinstry rejected both propositions roundly. He said that had a hard object borne by S hit the stationary head of the baby in the cot then he was unaware

of any such case where a contrecoup injury was produced. If a crush/compression force was applied to the stationary head of the child in the cot he would have expected soft tissue swelling and/or fracturing on the right side of the skull and more damage than was found on the left side of the brain.

[31] He considered that if the head was crushed between two hard objects to cause so much brain damage on the right side he would have expected similar damage to be found on the left. He could not therefore support Dr Glasgow's theory that the brain was compressed from the left side so as to push the brain across the skull to impact on the right side. He rejected the suggestion that this could be properly described as a depressed fracture of the skull, which suggested to him penetration of the brain by the skull; rather it should be described as a branching fracture. Finally when asked to comment on Dr Glasgow's crush/compression thesis he said that he could not accept it because if he did so "I would be contradicting learning on the subject".

Evidence of Professor Jack Crane

[32] Professor Crane if the State Pathologist for Northern Ireland. He acknowledged he did not have the same experience as Dr Glasgow in dealing with children or indeed with living people. He admitted the obvious, namely that in his day to day work he did not see living people but he did have cause, however, to describe and interpret injuries suffered by persons who had died, including children. I have little difficulty in accepting that he was well qualified to comment on the findings in this instance. He began by setting out a summary of the injuries as he had deduced them from the various hospital notes and records. He considered the injury to be properly described as a contrecoup brain injury and his evidence was in accord with Dr McKinstry's on that issue. He did not think that if the head was supported in the cot a contrecoup injury could be caused to the child in the manner envisaged by Dr Glasgow. He was clear that the absence of any apparent mark of the laceration or abrasion on the left side of the skull suggested impact had been with a smooth surface. He considered the undercarriage of the bus to be rough and that it was likely it would leave marks at the point of impact if the injury was caused in the way described by Dr Glasgow. He also referred to the petechial bruising found on the child's arm and considered that this to be consistent with the arm being grasped forcibly.

[33] In the course of his cross-examination a mannequin was produced which apparently is used to instruct students in the maternity unit. Counsel then engaged in a detailed demonstration and description of Dr Glasgow's analysis of how the injury occurred. This involved demonstrating the bus hitting on the point of impact, ie the location of the egg shaped swelling on the left parietal region of the skull which then moved towards the front of the

skull and moved across the hand of the child which must have been resting against its temple area, thus causing the hand bruises and then moving around the forehead to cause the two small lacerations and the V shaped laceration on the front of the forehead.

[34] He was unimpressed with this analysis because if it had occurred he would have expected to find abrasions, or similar, at the point of impact, the theory did not explain the patechial bruising on the arm; neither did it explain the absence of any abrasions on the bruised fingers nor how the bus, having impacted on the skull in the parietal region, was then able to move across the fingers without causing any scratches or abrasions and leave only two tiny marks on the side of the forehead.

[35] The proposition was then put to him that this was more akin to a crush type injury because the left hand side was compressed. Professor Crane refused to accept that saying the brain could not have been compressed in that way with the bus coming down onto the head as described. The extent of the injury was such that a much bigger object would have had to meet the head in order to cause sufficient compression of the brain on the opposite side from the impact. A small object such as the toy bus did not contain a sufficient surface area to provide sufficient force to compress the brain to the extent necessary to cause the injury and damage. He rejected the proposition that the movement of the head through a distance of a couple of inches, as might have occurred with the child at rest in the cot, would be likely to cause such damage to the right side of the brain or the diffuse injuries found on the CT and MRI scans.

[36] Although Professor Crane had been involved in experts' meetings and discussions he indicated, when re-examined after the compression/crush thesis had been put to him, that this had never been discussed during any of their meetings or discussions. At a later stage Dr Glasgow accepted that he had only reached this conclusion after the final experts' meeting which was a matter of some 30 minutes before the trial commenced. He had never made it known to any of the experts. Not only did Professor Crane rule out the theory, he also excluded any possibility the injury was caused by excessive slapping or hitting with the hand. He was also clear that the bus could not have caused the injury because for it to have produced the fracture would have required such considerable force that laceration or abrasion would be expected at the point of impact whereas only the swelling, and ultimately bruising, was found there at any stage: neither would it explain the contrecoup. He was satisfied this was a case of non-accidental injury.

Evidence of Dr Elizabeth Anne Black

[37] Dr Black is a consultant paediatrician at the Ulster Hospital, Dundonald and has held that post for approximately ten years. She has a

special interest in child development but practices in both general and acute paediatrics. She was Registrar to Dr Glasgow in an earlier stage of her career and whilst she disagreed with his conclusions, she accepted that he was a very proper and qualified person to carry out work which she had suggested should be done by a forensic pathologist. She was the duty consultant over the New Year period when N was admitted she attended in the light of concerns about the causation of the injuries. It is clear that these were looked upon with grave suspicion from the outset. She was very much "on the scene" from the beginning therefore. She said that when the bruising on the left hand of the child was raised with the mother an attempt was made to explain this on the basis that the doctors had handled her child roughly in the course of the initial emergency and suggested that attempts to set up an intravenous drip might have been the cause. Dr Black followed these suggestions up immediately and was established that a drip had never been put into the left hand, and no attempt had been made to do so. She checked the child and there were no signs of any needles marks on the left hand. At that time the drip was in situ attached to the right hand. She was also able to confirm that the two small oval shaped bruises on the left side of the forehead had not been recorded initially but had been later, and this tended to suggest they were emerging. She thought this made it likely there had been little delay in seeking treatment. This was further reinforced by the fact that the injury on the left side of the skull, which had produced the swelling, was altering by the time of transfer to the Royal Belfast Hospital for Sick Children as the swelling was reducing and bruising was appearing by then.

[38] When she gave evidence it was also clear the V-shaped mark in the central area of the forehead was unlikely to be connected with the present investigation. She confirmed it had been described as healing and, as was shown by later evidence, it is highly probable this was the mark noticed by the health visitor when she attended for her routine visit at about 10.00 am on the day of the injury.

Evidence of Dr Daphne Primrose (medical aspects)

[39] Much of Dr Primrose's evidence was concerned with the interpretation of the account of S together with considerations of whether or not he might have been coached and I shall deal with those issues separately. In medical terms however she gave important supporting evidence on behalf of the Trust. She emphasised that she is a General Paediatrician working for approximately one third of time in the hospital setting and about two thirds in the community. She was asked to deal in particular with the bruising on the baby's fingers, back of hand and the petechiae on the volar aspect of the forearm.

[40] She was sure that the bruising injuries were due to blunt trauma of some kind and accepted that the fingers could have been injured by the bus

but thought it unlikely it could have been caused by the undercarriage, as suggested by Dr Glasgow, due to the absence of any abrasions. She felt that the roof of the bus could have caused it. The petechiae however would not be consistent with an injury in the manner described by Dr Glasgow. She thought there was a possibility that the linear petechiae could have been caused by very tight clothing but thought it was unlikely these injuries were all caused at the one time. In the absence of any suggestion that there was overly tight clothing it appeared unlikely that the petechiae could be so caused. She thought the presence of a contrecoup type injury was as black and white as it could get even if Dr Glasgow was of the opinion that it was a grey area. She was also at pains to emphasis that any bruising on a baby at this age was unusual and called for a proper explanation. Finally she emphasised that any suggestion that the bruising of the fingers and back of the hand were caused due to handling by a hospital doctor was unlikely. In her experience she had never seen that type of injury caused by a doctor even when a child was being handled in the course of an emergency.

Evidence of Professor Ray Bull

[41] Professor Bull holds the degree of DSc in Psychology and is a Professor of Forensic Psychology at the University of Leicester. He has a considerable background in child development but has also taken a particular interest in interviewing techniques of children and has researched and taught widely on the subject. I am satisfied that his expertise is of value to courts in these circumstances. He has given evidence in this court previously and considers issues such as whether or not a child has been coached or prompted and does so, inter alia, by reference to a consideration of the language used by a child in describing behaviour. He was commissioned by the Home Office to write the first working draft of the *Memorandum of Good Practice* and was part of a team that produced the 2002 Government document *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable and Intimidated Witnesses, including Children*. He considered the transcripts of the interviews of S conducted by the police and viewed the video recordings of same. In his opinion the interview did not contain anything to suggest it was problematic in any way. He looked at the videos, and considered the text of the transcript, looking for any signs of possible coaching but made it clear that he did so in the light of research which showed that it is very difficult to decide if a child has been coached. His technique included looking at words, phrases and ideas with a view to considering whether or not they were appropriate to the age and development of the child. He considered whether or not certain words used by S were appropriate, eg. "realised", "accidentally" and similar three or more syllable words. He considered whether or not the interview had been conducted in accordance with the *Memorandum of Good Practice* and did so in the knowledge that it is difficult for persons, unless very highly trained to stick rigidly to it. The Memo requires that open questions should be used wherever possible and the child

should be left with a choice from a number of options when answering – in other words closed or leading questions should be avoided. He considered that the interviews were not very skilled but were not so poor that they should be left out of account. They were good enough to rate the interview as acceptable. He also considered the interviewer spoke very fast and did not always allow a choice from several options. His conclusion was that he could not find any overt signs of coaching and the interview should be considered at face value. He referred to a question which appeared to invite the answer "yes" but in fact S answered "no" thus indicating a degree of independence of thought. He was unaware of any hesitancy or delays in giving answers to crucial questions. When a question and answer from the first interview was put to him where S effectively said that he had no idea how N had got the bump on her head he was not prepared to agree that that was an unvarnished lie. He explained that the mind of a child is very different from that of an adult and whilst it might be a lie, it might equally represent what he believed at the time.

[42] The parents and MGM all were insistent that they had made no efforts to coach S. Indeed it is clear that E left the house within a short period after 31 December and set up her own household. It would appear there was little direct contact between her and S, although there was clearly some, and there was no contact of any consequence between S and C: it was said therefore there was no opportunity for E or C to coach S let alone enforce it sufficiently.

The evidence of mother, father and grandmother

[43] As is apparent already, neither mother, nor father nor grandmother could throw any light on how such a dreadful injury was sustained by N. Their versions of events of that day was essentially consistent, with some possible exceptions. The grandmother struck me as someone who was trying to assist the court and I have no cause to think that she was withholding crucial information. She said that she had babysat for N on the night of 30/31 January and that at about 10.00 am the health visitor rang to say she would call later. The child was apparently normal at that stage apart from a small mark on the forehead. This appears to be an innocent mark and not in any way related to the events later in the day. The domestic routine appears to have been entirely unremarkable. At about 1.00 pm MGF went to work. At 2.30 pm MGM attended her GP, Dr McCombe, by appointment. At that stage E, N, another daughter and that daughter's boyfriend were in the house. MGM returned at 4.00 pm with another daughter. She intended to prepare dinner and on finding C and E were upstairs in the bedroom with N, she enquired if C intended staying for dinner and then prepared the family meal. When C and E came down for dinner all appeared normal. S finished dinner first and went upstairs. He soon shouted down that N was crying and E shouted upstairs to him "don't lift her". S had been upstairs for about 5-10 minutes at that stage and on learning that N was crying her father, C, went to

attend to her. There was then a larger than normal cry after he had gone upstairs. E was still eating at the table and at that point got up and went upstairs. It seems that at about the same time S came downstairs and asked her to come up, clearly indicating that there was something wrong. She said that when she went upstairs E was on the bed and C was standing beside it with S. The baby was crying heavily and could not be comforted. It then appeared to stop breathing and she was given the baby by E. She asked for a cold compress and blew on the child's face and it started breathing again. She was in a state of heightened panic at that point realising there was something significantly wrong with the baby and decided to get her to hospital. She never thought of sending for an ambulance and left immediately to drive to the Ulster Hospital which was about 10 minutes drive away. She remained at the hospital until about 12.15-12.30 am next morning. She acknowledged that during the time in hospital Dr Black had made clear to them that the circumstances of the injury were suspicious and there was much discussion about what could have happened.

[44] I believe that MGM was straightforward in the way in which she gave her evidence and I have no reason to doubt any of it, particularly the evidence relating to the circumstances in the house whilst she was there. There has never been any serious suggestion that she was in any way responsible for the injury caused to N and I exclude her as a possible perpetrator without hesitation. The same considerations apply to her two daughters and the boyfriend of one of them who were nowhere near N at any stage in circumstances where they might have been able to inflict injury and they shall also be excluded from the pool of possible perpetrators.

[45] E, mother of N, gave evidence which agreed essentially with that of her own mother. When she realised that the baby was crying, during the time she was eating her meal, she asked C to go to attend to N so that she could finish dinner and then sterilise a bottle. When she went upstairs N was lying in the middle of her double bed and C was standing at the side of it. N's face was really red and she was crying. She described it as sore crying and tears were falling down her face. She changed the baby's nappy and tried to settle her but she did not comfort. When she was trying to put her down S came in and noticed the lump on the side of E's head: she then asked S to go and get MGM. They then went straight to the hospital. She denied doing anything that could have injured N.

[46] In the course of cross-examination E agreed that during interview by the police she had described N as "starting to squeal like a banshee" and this was just after C had gone upstairs. She also agreed that S had only gone halfway upstairs when he shouted down that N was crying and it was at that point that she asked C to go upstairs to attend to her. She also stated she did not think S would have been able to lift N from her cot, drop her and put her back in the cot. She confirmed that N had been with her throughout the

period before dinner and had fallen asleep just before going downstairs to eat.

[47] The father also gave evidence and stated that he had arrived at the house at about 3.00 pm at which stage E and S were at home. E was in a chair downstairs and had the baby asleep in her arms: S was watching TV. C said he took a turn at holding N for a period of about 10 minutes and then she was taken upstairs by E to be put into her basket. He remained upstairs with E until it was time to eat. When he went upstairs after S had indicated the baby was crying he found her in her Moses basket and crying very heavily. He lifted her to "give her a wee nurse" and tried to feed her but she rejected the feed. He said he then put N in the middle of the bed and started to change her nappy. At that point E came upstairs and took over: N was still crying very heavily. Within a short period S pointed out the lump on N's head; panic then started and N stopped breathing. MGM came up the stairs and tried placing a cold cloth on the lump and within a short time they headed to hospital in the family car. He denied doing anything that might have injured N.

Can the perpetrator be identified?

[48] C made the positive case that S was responsible for the injuries. He said there was a period of at least five minutes when S was upstairs alone and that he must have injured N at that stage. He was adamant that neither he nor E could have caused the injury. When he said that S was upstairs alone for about 5-10 minutes before he responded to the baby's cries, he recognised that his version was somewhat different from that of E who had said S was barely upstairs when he called down that the baby was crying. He acknowledged he had raised the possibility of S being responsible for the injuries from the beginning.

[49] It is a matter of very great concern when a distinguished doctor such as Dr Glasgow should stand out against his colleagues for either he has misinterpreted some of the facts and circumstances, or they have. A divergence of medical opinion, even where the experts are of high standing does not mean however that the court cannot resolve the dispute. It is for the court to analyse the facts in light of its own experience of life and consider if it is possible to come to a decision on the balance of probabilities. Sheer weight of numbers of experts on one side is not determinative but it means extra vigilance is require din evaluating the opinion of each expert.

[50] After very much reflection and analysis of the evidence which was placed before me I have concluded that I have to reject the evidence of causation given by Dr Glasgow. When he said there was injury to both the right and left sides of the brain he was correct but to a point and I consider he

has failed to take sufficient account of the uncontradicted evidence of Dr McKinstry that 75-80% of the damage was to the right hand side. The crush/compression thesis advanced by Dr Glasgow at the trial was, as accepted by him, formulated in the 30 minutes before the trial commenced and had never been advanced before the meetings of his expert colleagues at any of their pre-trial meetings which were convened as a result of the promptings of Gillen J, who had conducted the pre-trial reviews in the case. These were intended to allow free discussion between the experts of their opinions with a view to narrowing any disputes or finding common ground. In so far as the mechanism of the injury is concerned I am satisfied that the evidence of Drs McKinstry and Primrose together with that of Professor Crane is by far the more likely explanation for this injury. Much of Dr Glasgow's thesis is based on his analysis of the second PSNI interview of S. It is clear from reading the transcript however that at no point does S ever say that he fell on top of the child whilst holding the bus in the way postulated by Dr Glasgow. It was accepted by all the experts that the injury could not have been caused if the bus had simply passed through the air when released from S's hand. S's account could only have been considered as a possible explanation if he was holding the bus at the moment of impact. I am unable to find any support for such a proposition in the statements made by S. It appeared to me that Dr Glasgow may have been of the same view, but was forced to interpret what S was actually saying to fit his theory so as to conclude he was holding the bus at the material point. I consider that that is unjustified in the circumstances and undermines fatally the thesis which he advanced.

[51] I must go further however because I am satisfied on the preponderance of the medical evidence, particularly that of Dr McKinstry and Professor Crane, that this was a contrecoup injury properly so called. The effect of that conclusion is that the injury was caused non-accidentilly when the head of the child was moving towards a stationary blunt object. I was unconvinced by Dr Glasgow's thesis that a crush/compression type injury had occurred on the area of the left parietal bone causing the brain to be pushed to the right hand side. In my opinion the pattern and extent of the damage, as demonstrated particularly in the CT and MRI scans, is simply too clearly biased towards the right side of the brain to permit acceptance of Dr Glasgow's view. The fact that it was formulated by him in the thirty minutes before the commencement of the trial, and after all of the experts meetings had concluded, does not necessarily show that the theory is wrong but it does demonstrate in my opinion that Dr Glasgow is straining to find an innocent explanation for the injuries in the face of powerful evidence to the contrary. I am completely satisfied that he has done this in exercise of his obligation to consider all possibilities and not to rush to a conclusion that the injury was non-accidental but in bending over backwards to be fair to the possible perpetrators I feel he has fallen into error.

[52] I have also come to the conclusion that this injury was not caused by S, either in the manner which he described in the course of the second police interview, and to his mother, ie. whilst he was holding or attempting to show the toy bus to his niece. Having concluded that this is a contrecoup injury, and having set out above the mechanism by which I believe it was inflicted, I am satisfied on the balance of probabilities that he did not cause the injury. To have done so would mean that S had gone upstairs for a relatively short period during which he was alone, had taken N out of her cot, thrust her head against a hard object, put her back into the cot and made up her bedding into its proper order. He would also have done so in circumstances where he did not reveal any guilty conscience for many weeks in the aftermath of what he clearly understood to be a serious injury. I consider that it is so inherently unlikely that a seven year old boy, such as S, would have behaved in that way that I can exclude it.

[53] I have reached the above conclusion in the knowledge that S is a strong little boy who is capable of lifting N, as was conceded by his mother. That is a different proposition from saying that he lifted the child and was able to strike its head against a hard object. Had he wished to harm the child, or even in some misguided way tried to stop it crying, then it would have been just as open to him to punch, slap or shake the child but there is no obvious reason why he should lift it and do what was necessary to inflict this type of injury and then to move immediately to cover it up and do so effectively.

[54] It may be that S did something with the bus, perhaps dropping it or even tripping and letting it fall from his hand onto the child: he certainly gave a sufficiently graphic account of that for it to be a real possibility. The fact that he removed the bus from the Moses basket may further support the view that something unusual did happen. I can also imagine that on such circumstance he might believe he had done something which might be considered "wrong" and that he could thereby be in big trouble. This may well have led him to delay "confessing" what had happened and to have given a misleading interview to the police initially. As matters became more serious, and as more and more questions were being asked by and of the family as to how this injury could have happened, and in the absence of any other explanation, it may well be that S decided in his own mind that he was responsible. An increasing concern or awareness of that possibility might also account for his bedwetting and other disturbed behaviour in the lead up to his revelation to his mother. I do not see that the string of events, culminating in his behaviour at school on the day he made the revelation to his mother, must necessarily be seen as a manifestation of actual guilt for it is equally consistent with a belief, in a childlike way, that he had injured N. I consider also the fact that something may have happened involving the bus would have enabled S to give a relatively detailed account of events and to have been able to demonstrate a lack of any obvious coaching even under the scrutiny of a professional psychologist.

[55] Finally I must consider whether or not I can identify the perpetrator from the remaining pool of possible candidates. For the reasons which I have already stated I believe that the only other remaining possible perpetrators are the mother and father. They were alone with the child together for a large part of the afternoon right up until MGM indicated their evening meal was prepared. It is clear that the time taken to eat it before persons started to go back upstairs was short, perhaps 10-15 minutes. From the evidence it would appear that C was potentially alone with N for up to 10 minutes. He admits that he had removed the child from the cot and indeed N was on the bed adjacent when the mother entered the room. What I am certain about is that either this injury occurred when both parents were present and they are both engaged in a cover up, or the injury was inflicted by one of them in circumstances where the other must know perfectly well of the guilt of the other.

[56] On the basis of the evidence presented to me the finger of suspicion points heavily to C but the precise timing of the injury is impossible to establish. It is clear that when the parents went downstairs to eat N was disturbed for a part of that time. It is also clear that some emergency developed very quickly during the time they were downstairs or perhaps immediately they came back up. I do not think it is now possible to establish within a time frame of perhaps thirty minutes or so when the injury occurred so as to decide if the injury occurred before or after the meal was taken. Certainly the father would seem to have had the most obvious opportunity in the period after they had left the bedroom together to go downstairs to eat. It could be that he was annoyed at the child crying and at his being left to cope with it whilst the others remained downstairs but the picture remains unclear, essentially by reason of the failure of both mother and father to be completely frank about their state of knowledge.

I am left unable to reach a decision about the identity of the actual perpetrator. I consider both parents are culpable however and have withheld information which would have enabled the court to reach a proper conclusion. At the material time N was in the joint care of E and C and they were in such close proximity that it would not have been possible for one to injure her without it being known to the other expressly. By failing to reveal what they clearly know, they demonstrate that they put their relationship and self interests ahead of their child. In doing so they have acted in a manner wholly adverse to the best interests of their child. They are both therefore possible perpetrators and both are withholders of vital information which in my opinion leads to the inevitable conclusion that the threshold test in Article 50 has been satisfied. I find therefore that N has suffered significant harm and that the harm, and likelihood of future harm, is attributable to the care given to the child by each of them or is likely to be given by either of them in the future should they have responsibility for the care and upbringing of N. To

return the child to the care of either of them when the effect is to return her to the care of a possible perpetrator and a parent who is unwilling to provide information essential for the future protection of the child gives rise to major issues of long term care planning and the Trust must now progress that issue as an urgent necessity. It follows that the child must remain in care for the present.