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Judgment: approved by the Court for handing down | *Delivered:* **13/12/05**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

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IN THE MATTER OF THE CHILDREN (NORTHERN IRELAND) ORDER 1995

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BETWEEN:

A HEALTH AND SOCIAL SERVICES TRUST

Applicant;

and

M and P

Respondents.

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McLAUGHLIN J

Introduction

[1] In order to protect the identities of the children in this case I shall refer to the parties as follows:

M - mother of the children who are subject to the application.

P - father of the children.

K - first child of the above who was born in February 2002.

S - the second child of the above born in May 2003.

[2] This is an application by the Trust for a Care Order pursuant to Article 50 of the Children (Northern Ireland) Order 1995 which provides in its relevant portions as follows:

"50.-(1) On the application of any authority or authorised person, the court may make an order –

(a) placing the child with respect to whom the application is made in the care of a designated authority; or
(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 –

(a) that the child concerned is suffering, or is likely to suffer, significant harm; and
(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 …

(6) The court may –

(a) on an application for a care order, make a supervision order;
(b) on an application for a supervision order, make a care order."

The Trust seeks the Care Order with a care plan attached which envisages that neither child shall be returned to either parent and that I should approve a plan for permanence for them to be achieved by placing them together in a dual placement suitable for long term foster care or adoption, but with the aim that a freeing order should be obtained and ultimately an adoption order made.

Background

[3] M and P are relatively young people and are now aged 19 and 21 respectively. M first became pregnant when she was 16 and so K was born when she was aged 17. The respondents conducted a relationship over a period of approximately two years but separated about one year ago. During the time they lived together they seemed to have a relatively harmonious relationship.

[4] In the course of a night in November 2003 their younger child S began to exhibit obvious signs of distress. M was sufficiently concerned about her condition that she phoned the duty doctor at the local health centre at about 3.30am. From the description which she gave the doctor he suspected there might be a dislocation of the shoulder and advised M to take her child immediately to the casualty department of the local hospital but S was not presented there until about 2.30pm on the particular date in November, some eleven hours later.

[5] Hospital records show S was assessed by Dr Rosemary Friel, Accident and Emergency Officer, at 14.50 hours. After an initial examination x-rays were directed and they showed a recent fracture of the humerus and an older fracture of the ulna both on the left side. The findings gave rise to immediate cause for concern and were discussed with M in the presence of Staff Nurse McClintock.

[6] S was then admitted to the paediatric department and examined by the Specialist Paediatric Registrar Dr Lynne McFetridge: M was present throughout. The initial concerns were confirmed so later that day S was reviewed by Dr Neil Corrigan, Consultant Paediatrician. The clinical findings at his examination confirmed the original opinions of the A & E Officer and the Paediatric Registrar and also their suspicions that the injuries were, at least potentially, non-accidental in origin. Dr McFetridge noted a history from the mother that S was brought to the hospital because she had noticed S was not moving her left arm. This had been noticed first by M at approximately 11.30pm the previous evening. It was recorded that the mother stated the child had woken from her sleep crying with her arm hanging limp between the bars of her cot and was distressed when her arm was moved.

[7] M said she then contacted the GP, as outlined above, resulting in S being brought to the Accident and Emergency Department. Mother also reported that two months previously S had been reluctant to move her left wrist although she did not seek any medical advice regarding this. She reported also that S bruised easily and was a cross baby who always cried when she was picked up. On examination at the Accident and Emergency Department S was alert and smiling but had a bruise on her right cheek

measuring 2 x 3 centimetres approximately, it was yellow in colour with central clearing. There was also a bruise to the left cheek of approximately 1.5 cm in diameter. A further yellow bruise was noted at the lateral margin of the right orbit. These injuries, individually and in combination in a six month old child, necessitated medical staff alerting social services, particularly in the absence of any satisfactory account of how the diverse injuries had occurred. Dr McFetridge also arranged for S to have various investigations which included a bone profile, full blood count and coagulation profile. A so-called "baby gram" – x-rays to look for other fractures - was also carried out but no other fractures were found.

[8] Having confirmed the original findings and suspicions of the other doctors, Dr Corrigan decided to involve Dr Sandi Hutton, Consultant Community Paediatrician, leader of the local child protection team. Dr Hutton reviewed S on the morning of a date in December 2003 and that afternoon Dr Corrigan spoke to both police and social services and confirmed his concerns about possible non-accidental injury. A strategy planning meeting was arranged for the next morning. S remained in the ward until her discharge 6 days later in December 2003. Because the original suspicions had not been allayed she, together with her brother K were then placed with short term foster carers with the consent of her parents. Dr Corrigan indicated in his evidence that he had a number of concerns following upon his original assessment of S, namely:

> "(i) There was delay between mum's initial recognition of a problem at 11.30 pm the previous evening and presenting to casualty the following day at 1424 hours.
>
> (ii) There was no good history to explain the fractures she presented with and at six months self-injury is extremely unlikely because of the limited range of mobility at that age.
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> (iii) The finding of a second healed fracture on the x-ray was also concerning, particularly as this did not attract any medical attention at the time and was likely to have been painful and distressing for the child.
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> (iv) There was no evidence of blue sclera or other medical illness that would explain a predisposition to fractures (such as osteogenesis imperfecta) and skeletal survey after admission showed no evidence of other fractures.

> (v) The pattern of bruising on the baby's face and cheeks was relatively unusual. Falls by babies of six months are not common as the babies have little or no independent mobility but where they do occur they tend to be associated with injuries to the forehead to side or back of the head, rather than the cheeks which tend to be relatively protected."

He was also concerned about the apparent difference in age between the two bruises and the pattern of them.

[9] When Dr Hutton gave evidence before me she confirmed all of the findings of the other doctors and gave her opinion that their suspicions were entirely justified. She was particularly concerned at the absence of any plausible explanation for any of the injuries.

[10] Dr Hutton also noted that the father appeared to be the main carer of their son K and that mother took a more "hands off" approach to him. She noted that P interacted with the boy much more than mother and helped prepare him for the medical examination. Mother on the other hand was said to be the only one who could look after S. She said that whilst it is not uncommon for one parent to gravitate naturally towards one child she thought the polarisation in this case was considerably more than the norm observed by her in her practice. This was particularly marked during the period when S was absent as the mother still stood back whilst the father took the lead in looking after K.

[11] Given her expertise in child protection Dr Hutton emphasised the importance of considering the wider picture in such cases. She thus obtained details of the social backgrounds of the parents and concluded that both had difficult upbringings which she realised could impact on their parenting skills. She had access to various records and these heightened her concerns, in particular there was evidence of:-

- poor family support
- a marked failure to attend at the baby clinic at the request of the health visitor with many missed appointments
- numerous house moves (seven in a period of two years).
- a report by mother that S bruised easily – which was not confirmed by the medical examinations.

These background factors confirmed Dr Hutton's anxieties about the origins of the injuries noted on S's body.

Search for an explanation for the injuries

[12] Despite the best efforts of the medical staff at the hospital, and the various Social Services personnel who came into contact with the parents, no explanation of any kind was forthcoming to account for any of these injuries. That remained the case until mother and father attended with Dr Ian Bownes, Consultant Forensic Psychiatrist, who was conducting various investigations on behalf of the Trust. In the course of his first examination in April 2004 P made significant admissions. When interviewing the father, Dr Bownes sought to emphasise the importance of having a proper history of how the injuries had occurred so that he could focus his own investigations and recommendations properly. The father of S then stated "I done it – she was crying – I was annoyed – I pulled her up by the arm – I didn't mean to harm her – does that I mean I won't get the kids back?" This came as a surprise to Dr Bownes and he immediately terminated the interview and reported to the relevant authorities. He did not see the father again until two dates in June 2004 following which he prepared his first report dated July 2004. In the course of those interviews the father gave Dr Bownes a further account stating "I pulled her by the arm – I just cracked up – I was annoyed – her crying was wild loud – it just got to me".

After some time for reflection the father made further disclosures saying:-

> "I hadn't had a row with M or anything – she was out in the hall at the time talking to the landlord – I was grand before the baby started crying – she just annoyed me cause she wouldn't settle – she had settled for me quite easily before when she was crying – I got up and walked away after I tried to settle her then I got more and more annoyed and pulled her straight up off the bed towards me by her arm – I put her down again and M came in".

This appeared on the face of if to be a plain admission that he acknowledged his responsibility for causing the fracture of the humerus during the evening immediately preceding her admission to hospital. This was confirmed by both the context in which it was said and by the content. After making the above disclosures the father continued that he did not tell M because she had managed to settle S who stopped screaming. He told Dr Bownes that he was sorry it happened that he didn't mean to do it – ie to hurt her.

[13] P was re-interviewed on a number of occasions about the matter, and asked to repeat his account. Essentially that version remained unchanged although it is possible to nit-pick over some of the wording or detail used in

subsequent accounts. I am satisfied that nothing turned on any of the differences in later explanations of what had happened.

Further expert medical opinion

[14] The Trust and the parents took the somewhat unusual step of seeking opinions from consultants in England about the nature of the fractures, their possible age and the likely manner in which they were sustained. For this purpose Mr John M H Paterson, FRCS, Consultant Orthopaedic Surgeon, London Independent Hospital, provided a report, which is dated 31 January 2005. All parties jointly engaged Dr Karl Johnston, Consultant Paediatric Radiologist, Birmingham Children's Hospital, to advise further. They both gave evidenced before me by video link.

[15] Dr Johnston's findings confirm that the x-rays taken in November 2003 demonstrated a transverse fracture (a fracture at right angles to the length of the bone) of the left humerus. There was no periosteal new bone formation around the fracture but there was some soft tissue swelling. He explained that periosteal new bone is x-ray evidence of bone healing which typically starts to appear on x-ray after about one week. The absence of same indicates that fracture was less than about a week old at the date of the x-ray. The presence of the soft tissue swelling suggested that the fracture was probably less than a few days old. He noted there was a healing fracture at the mid-shaft of the left ulna. There was marked periosteal new bone at the site of this injury and x-ray evidence of bone healing. From the amount of healing he estimated the ulnar fracture was in the region of 5-8 weeks old at the time of the x-ray. No other fracture was noted. He stated that both fractures required a significant amount of force to cause them and they could not occur from simple domestic accidents, over exuberant play or rough inexperienced parenting and that S would not have had the strength or level of development to self-inflict these injuries.

[16] He commented further that the fracture of the humerus would result from an impact, blow, or snapping/bending action applied to it and the amount of force required would be significant. He considered S would have been in pain and would have shown signs of distress such as crying and screaming and anyone witnessing S at this time would have realised she was upset. The initial distress would last some minutes and then she may have become more settled. Following injury her arm would have remained tender, he would expect it to become swollen and S would have been reluctant to move or lift her arm or grab with it. Any action involving moving or touching her arm such as when she was bathed, or dressed, would exacerbate the tenderness and cause distress. He considered that any reasonable carer with day to day contact would realise there was a problem with the arm. He further considered it reasonable to assume that any carer would remember an

event that caused this fracture as it would have been traumatic and frightening.

[17] He then went on to consider the description of the event given by the father which was by then assumed to be when the injury was sustained. He concluded:

> "This action would not be the type of action any reasonable carer would use in looking after the child. The amount of force and actions would be excessive and inappropriate. Anyone witnessing those actions would realise it was a totally inappropriate way to handle a child. The net result was that the outcome was highly suspicious of being the result of an inflicted non-accidental injury and would result from either a severe snapping/bending action or a severe blow/impact to the arm."

[18] He considered next the amount of force required to cause the fracture of the ulna and stated it would also have been significant. He thought it was either the result of the impact of a blow or bending/snapping action applied to the ulna. He would have expected S to have been in pain at the time and that she would cry out and show distress. In his opinion anyone witnessing S at that time would realise that she was upset and in pain. Again the initial distress would last for a few minutes. Following the initial distress he would expect S's arm to be tender to touch so that moving or bending it, such as when bathed or when her clothes were changed, would exacerbate the tenderness and cause distress. She would have been reluctant to move or grab with her left arm and any reasonable carer would realise there was a problem with the arm and seek appropriate attention. The symptoms would last some days. The fracture was not old enough to have been present in July 2005 when it was known that S was taken to the GP's surgery, apparently with some kind of cold or sniffles. Again this would have been a traumatic and frightening episode for the child. The fact that the injury was not detected until some weeks later suggested neglect on the part of the carers.

[19] Mr Paterson confirmed that in advance of the hearing he had discussed the case with Dr Johnston and they were ad idem about the nature and extent of the injuries, their age and the degree of force required to inflict them. In evidence by video he confirmed these injuries could not have resulted from simple domestic accidents, over exuberant play or rough or inexperienced parenting. He considered that any distress on the part of the child would have been obvious to the carers. The swelling present at the site of the fracture of the humerus would be consistent with a recent injury where the swelling was increasing or a somewhat older injury which was waning.

[20] Dr Johnston and Mr Paterson reported their opinions in writing, including their beliefs that the description by P of the way he had handled S was not a sufficient account to explain the fracture of the humerus. It then became a feature of the case that having apparently admitted to causing the injury the father then resiled from that. He asserted that since both Mr Paterson and Dr Johnson were of the opinion that his description of the way in which he had lifted the child was not sufficient to account for the injury then he could not be responsible. This led to him maintaining a denial of responsibility for the injuries thereafter although he was prepared to accept he may have caused the humeral fracture.

The course of the proceedings

[21] At the outset of the case counsel for each parent presented a document to the court prepared jointly by them. As it was intended as a statement of threshold findings to which they were prepared to consent. This is of considerable importance I shall set out the core of it verbatim:

> "At the time the Applicant intervened the parents accept the following threshold criteria were met:
>
> 1. A fracture of the humerus on S's left arm. Medical evidence indicates that this occurred when both parents were in charge of her. The father accepts that he mishandled the child which may have caused the said fracture. The parents should have detected the injury and sought medical assistance. There was a delay of ten hours before presenting S to Casualty despite medical advice which both parents concede was unacceptable.
>
> 2. An old fracture to S's left wrist and no medical attention was sought for this by the parents or explanation given. The parents failed to detect this fracture, and it is accepted that a reasonable parent should have detected it and sought medical assistance. The parents were the primary carers of the child and therefore are in a pool of uncertain perpetrators.
>
> 3. Bruising to S's face. The parents' explanation for same is not accepted by medical professionals.
>
> 4. The parents acknowledge responsibility for their failure to protect S from suffering significant

> harm. They also accept the potential risks to K given the injuries inflicted on his sister."

[22] The effect of this document was that the parents conceded the threshold test was satisfied in respect of both children. Further, mother was prepared to concede that the Trust plan, which envisaged permanence without the return of the children to her care, was inevitable in light of the medical evidence. Father however maintained his position that the children should be returned to his care and he should be permitted to look after them with the help of his mother and other family members.

[23] The Trust was prepared to accept paragraphs 2, 3 and 4 as a sufficient statement in respect of the matters referred to therein. It was not however prepared to accept the adequacy of the statement contained in paragraph 1. In particular, it asserted that the use of the expression "which may have caused the said fracture" left open the possibility that some other person, including M, had been responsible. In view of the apparent admission made by P to Dr Bownes and others this was regarded as unacceptable and unsatisfactory. In those circumstances a full hearing was conducted with a view to establishing whether it was possible to identify the perpetrator.

The evidence of the parents

[24] In the course of the hearing both parents gave evidence on oath. I consider it accurate to say that nothing surprising emerged in the course of same which was essentially in line with the evidence already available from other sources. Both parents confirmed that S had been looked after by the maternal grandmother in the two days prior to the date her distress became evident in November. This had been necessary because their older child, K, had suffered convulsions and was in hospital for about 48 hours. Upon K's discharge they collected S and returned to their home on the evening prior to this. Apart from crying at times there was nothing untoward about S's presentation.

[25] In respect of the older fracture mother said she had never observed any distress on the part of the child although at one stage she did notice that its wrist appeared to be a little floppy. This was particularly evident when she was playing an affectionate game with the child where she held its arms and slapped its hands against its own cheeks. She said that caused the child to laugh. She was mystified by the presence of this fracture.

[26] As to the second fracture M said that she first noticed something was wrong when the child's arm was hanging outside the bars of the cot, which was during the course of the night preceding her attendance at the hospital in November. She said that she had changed the child for bed when they returned home from her mother's house and the child was still awake when

the landlord of their house arrived to attempt to fix their heating which had broken down. She spoke to him and spent some time outside on the landing whilst he worked at the boiler. At that stage she heard a loud cry from S, who was then in the care of P. She went to S and tried to comfort her. She was able to get S to settle after a few minutes by placing her against her shoulder and was able to continue her dealings with the landlord. She did however say that the crying which had drawn her attention was "very very different from her usual cry." She was adamant that she had never pulled or applied pressure to the child's arm in any way that might have caused injury. She was happy to suggest on the one hand that the child was apparently normal when they arrived home, no one else was in contact with the child except its parents and there had been a very unusual cry from it when alone with her father. Following that she had noticed the arm floppy and ultimately had to attend to the child during the course of the night culminating in a phone call to her GP. She confirmed the history which was given at the time of arrival at the hospital as to the events at home that evening. She then said that about six weeks after the injury had been sustained P had confessed that he had "pulled her up by the left arm." By that stage she was aware S had sustained two fractures but she never thought to ask if he had been responsible for the first one. She also agreed she never told anyone about this confession, even though she was in danger of losing her children to permanent care at that stage. She claims she was frightened and she wanted P to take the responsibility upon himself and to tell the authorities what he had done. Therefore, although he told her in January that he had done something which was clearly wrong, and which was entirely consistent with having caused the injury to their child, she did nothing. She had no explanation to give for the bruising on the child's cheeks, or close to the orbit, other than it had been caused by kissing or cuddling of some kind. Even though she was sufficiently realistic to acknowledge that it was unlikely the children could be returned to her care she made the rather unusual statement that she had no particular concerns about the children being returned to the care of P. She thought that "as long as someone gets them back instead of being adopted" she did not mind. She said he seemed to be very good with the children and that she would have no big worry. She accepted she was anxious to keep their relationship going when P had told her what he had done. I am satisfied that she preferred to remain quiet about his apparent confession in order to preserve their relationship rather than act in the best interests of S by telling social services personnel what P had told her.

[27] P also gave evidence on oath. Despite having had a relatively lengthy relationship with M he did not see them having a future together although they were still friends. He agreed he was much closer to K than to S and looked after him on a day to day, basis including getting him up in the mornings, washing, dressing and feeding him. He frequently took K to his own family home whilst M looked after S. He could give no explanation for

the bruising on Ss face and head other than kissing and equally was unable to explain the fracture of the ulna: he agreed he should have noticed it. He also accepted that he had hurt S by pulling her by the arm towards him on the morning of the date in November she attended hospital. He acknowledged that she was crying and that it got to him so that he felt very bad. He also acknowledged he did not own up to what he had done for six weeks and had not told anyone else until his disclosures to Dr Bownes in April.

[28] In cross-examination he said that when he pulled S by the arm he was very tense and angry as she was crying so hard. He said he was angry because he felt he had to stay in the relationship with M, which was breaking down at that time. He agreed his emotions were pent up and that he was fed up in general and felt trapped in the relationship. It was clear from his evidence that nothing suspicious had happened that night in the house save for the incident involving S when he had pulled her up by her arm. He confirmed the description in his statement that he had lifted her "a bit roughly" and claimed he was scared to tell social services what had happened as he thought that if he remained silent they would get the children back.

[29] Throughout the course of his evidence P was unable to give any explanation as to how S might have come by any of her injuries save for the possibility it happened when he pulled on S's arm. He acknowledged that after they returned from grandmother's house S was moving her arm normally and that M had never been left alone with her. He also acknowledged that M was very close to S and had never done anything to hurt her.

Conclusion

[30] Despite the fact that I heard a welter of evidence over a period of more than 7 days I am satisfied this matter can be resolved quite simply. There has never been any explanation given for any of these injuries, save for the possibility that P damaged S's humerus when he lifted her by the arm on the evening in November. The child then normal prior to that apart from some crying which appears to have been nothing out of the ordinary since both parents described her as being "crabby" at times. M was never alone with her. The only person who was alone with her throughout that evening was P. It is clear that he did an act in anger which was capable of causing the injury. He sought comfort and refuge in the fact that Mr Paterson and Dr Johnston were of the opinion that the injury would not have been caused in the way in which he described pulling or lifting her. I am satisfied however that he gave a superficial and self-serving account of the incident and that is probably an index of interior feelings of guilt and perhaps his own inarticulate manner of speech. He was quite unable to see that if he pulled the child by the left arm towards him the child might swing to its right and thus impose a bending or

snapping force on the baby's arm. That seems to me to be the most obvious point where the injury occurred. It would also explain how sufficient leverage was applied to the humerus to break it. Both Mr Paterson and Dr Johnston referred to the necessity for some bending force and I am satisfied the injury was caused by his action in lifting the child in anger in what was clearly a most dangerous and reckless manner. I am also satisfied that he, together with the mother, has understated the reaction of the child since the suggestion that the child was settled within a couple of minutes without any later distress was inconsistent with the overall evidence.

[31] Whilst Mr Paterson was willing to concede that it would be possible to comfort a child and settle it within a few minutes this was in the context that any disturbance of the arm would cause significant discomfort and upset. I accept the evidence of Mr Paterson and Dr Johnson that this child could not have been handled in normal domestic situations without it being obvious that there was a significant problem with the upper left arm. Any reasonable carer would have been conscious of that and could not possibly have failed to notice demonstrations of its distress if its arm was moved about during the ensuing hours before it arrived at hospital. I believe it was obvious also to mother the injury had been caused during the course of the evening and that it must have been caused by P since he was the only one who had exclusive access to the child at that time. Knowing that the child had cried out in a most unusual manner meant it was inevitable that anyone, including mother, considering the situation, would come to the conclusion that the child had been injured by the father at that time.

[32] In those circumstances therefore I have no hesitation in concluding that the perpetrator should be identified as P, father of S, on the following basis:

> (a) P admitted to an action which was capable of explaining the injury and which no reasonable carer would use.
> (b) He admitted carrying out the act at a time which was consistent with the medical evidence as to when it was likely the injury was caused.
> (c) He admitted that at the time he lifted the child he was angry and that he did so in a rough manner. As the threshold statement proposed by him puts it, "he mishandled the child which may have caused the said fracture."
> (d) There was no one else who had exclusive contact with the child at the time or for some hours before.
> (e) The father was conscious of the fact that he was the probable perpetrator from the outset and

> he consciously withheld disclosing relevant information for a period of six weeks. He did not disclose his actions to anyone else until a period of four months post injury elapsed.

[33] It was accepted from the beginning by the Trust and the Guardian ad Litem that it was now too late to be able to establish the perpetrator of the older fracture to the left ulna. It is also impossible to establish a definitive pool of possible perpetrators but it is certain, on the evidence which I have heard, that both mother and father must be included within any such group. The same conclusion must be drawn as to the bruising on S's face as the parents have admitted their explanation is not accepted by medical professionals and they are unable to give any other explanation at all let alone a convincing one. They have also acknowledged responsibility for their failure to protect S from suffering significant harm and the potential risks to K due to the injuries inflicted on his sister. Given their acknowledgement that the fracture of the humerus ought to have been sufficient to alert them to the possibility of injury and the need for early medical attention, the delay of some 11 hours before presenting S to the casualty department, despite medical advice to the contrary, was clearly unacceptable. The unchallenged expert medical evidence, which I accept, also shows that whenever, or by whomsoever, the fracture of the ulna was caused, it was not the result of a simple domestic accident, over exuberant play or rough or inexperienced parenting. Any reasonable carer would have sensed the distress of S and I find the failure of the parents to detect the injury, or having detected it to have ignored the need for medical attention, is proof of prolonged gross neglect on the part of both as S was in their joint care in the weeks following the injury. On the balance of probabilities the fracture of the ulna, like that of the humerus, was not accidental in origin.

[34] My conclusion is that the presence of both fractures and the other injuries indicate that S was abused and then neglected in a most serious way which gave rise to very considerable pain, discomfort and distress on her part. The family dynamics, which I shall consider in more detail in the next portion of this judgment which deals with care planning, are such that K was also at very significant risk of harm whilst in the care of both parents. This is so even with the acknowledgement that P and K had a particularly close relationship as evidenced by the various welfare reports. Neither parent can be absolved from responsibility for the serious neglect of S and therefore there is a real possibility that if either child was returned to the care of either parent, or that one parent should have both children, there is an ongoing risk of serious harm to both of them. K could not be considered safe in their care (jointly or separately) given their prolonged neglect of S.

[35] Having concluded the threshold criteria have been met it does not follow necessarily that a Care Order, Supervision Order or any order should

follow. It is evident in this case however that these very young children are in need of continuing care of a high order. Fortunately that is being provided in their current foster placement although should I approve the care plan an early move is likely. At the hearing Miss Margaret Walsh QC, on behalf of the mother, made it clear M now accepted that rehabilitation of the children to her care was not feasible and her main focus was upon the post care contact arrangements. P on the other hand has stoutly resisted any suggestion other than that the children should be returned to his care immediately so that he could look after them with the help of his mother, with whom he resided. There was a marked change in his position however by the time he gave evidence towards the end of the case. When asked about this by Miss McGrenera QC, in examination in chief, he indicated he accepted that before any return to him could take place more work needed to be done such as that outlined by Dr Bownes. In answer to his counsel he agreed that he would undertake such work as advised. If on the other hand a return to his care was not an option he wished to keep as much contact as possible with both children. He said he would take on board what the court said.

[36] Given the evidence as summarised above and after detailed consideration of all of the matters detailed in the welfare checklist, I have no hesitation in concluding that a Care Order must be made in this case. Firstly a Supervision Order will not be sufficient for either child simply because it is essential that the Trust should enjoy parental responsibility to ensure their welfare for the foreseeable future. A Supervision Order would not provide that. A "No Order" order for similar reasons is not an option. A Care Order is essential in this case to enable the Trust to protect these children and to plan properly for their future lives. I shall therefore be prepared to make a Care Order subject of course to approval of the Trust care plan.

Care planning proposals

[37] After all of the internal and statutory processes have been completed by the Trust it concluded that the future planning for the children must provide for permanence away from their parents. For various reasons, including their age, they propose the children be placed with new carers with a view to adoption. Initially there was some difference of opinion between the Trust and the guardian ad litem as to the contact arrangements that should be available to the parents in the post Care Order phase. By the end of the evidence however they were able to reach an agreed position. An amended care plan was therefore put before me in respect of each child, although the arrangements are in fact identical for both and in respect of both parents. It is now proposed that should a Care Order be made contact will be reduced to once per week initially and then during the process of placement transfer it shall reduce to once per fortnight. It is envisaged that the contact arrangements will be reconsidered at a LAC review due to take place in January 2006. The decision about contact thereafter will take into account all

the relevant circumstances, including the rights of the parents, their views and their responses to ongoing work. The responses of each child will also be taken into account. In view of the fact that difficulties might arise the Trust has also indicated that if the children should become distressed or upset, or if there is significant disagreement with the parents as to the frequency of contact, then a specific issue LAC review will be convened or alternatively the matter will be referred to the court for resolution. Ongoing contact will take place at a Trust child-centred facility within the Trust area. A final farewell visit is also envisaged for appropriate members of the extended family of the children. I must now decide whether I should approve the care plan.

[38] The Trust has devoted considerable resources to the assessment of both parents over an extended period of time during which the children have been kept in foster care. Ms M has been the Field Social Worker since December 2003 and together with her colleagues and predecessors has had carriage of day to day responsibility for the case. Expert assistance has also been recruited however and the assistance of Dr Ian Bownes, Consultant Forensic Psychiatrist, Katherine (Kitty) Loughery, NSPCC, who carried out a six week parenting assessment and Ms Sally Wassell, Consultant and Trainer in childcare, have all prepared detailed reports. Dr Bownes saw each parent more than once. In fact Dr Bownes examined P in April, two dates in June 2004 and provided a supplementary report following an assessment in December 2004. I shall consider his evidence first.

Dr Bownes' assessment of the personal and social background of P

Dr Bownes thought P had an unfortunate and difficult early life where he was subject to physical and emotional abuse, possibly to sexual abuse also. He considered P to be of limited intellectual ability with a poor school record and limited learning. He had followed a typical pattern of mitching school and leaving eventually with no formal qualifications. There was also a history of cannabis use and of substantial excessive social drinking at times. I did not get the impression however that the cannabis abuse had reached a stage of becoming a significant problem and was perhaps more of the order of teenage experimentation. His pattern of consuming alcohol was of more concern particularly as it appeared to be a regular feature of his growing up. The combination of alcohol and cannabis abuse however does have considerable implications given that he was responsible for two young children at the time. In the course of the first interview P made disclosures to Dr Bownes about the manner in which he had manhandled S and it was assumed at that stage, as explained already, that he had caused the injury. This had led to a suspension of the assessment. He concluded however that it was:

> "Clear that in certain circumstances, such as recently demonstrated in the domestic context, the cumulative

> and interactional effects of his intellectual deficits and other factors …. has lead to expressions of anger and frustration and without the appropriate therapeutic interventions a recurrence of acting out behaviours in response to stressful and demanding events would be inevitable."

Dr Bownes went on to say:

> "I feel that it is highly probable that he still retains intrusive memories regarding his childhood relating in particular to his relationship with his mother, the quality of her (sic) emotional attachment to her, the intrusive nature of Mr C. role in the household, alleged abusive behaviour towards him by Mr C that presently lay unresolved and are likely at present to influence his emotional repertoire, empathic capacity and the nature of his interpersonal relationship functioning…. I would be concerned that P is likely to have deficits and deficiencies with respect to the aforementioned practical and emotional domains and which become evidence when he is exposed to stressful or emotionally demanding situations – particularly in the domestic context. I would thus feel that further work is required in this area before a definitive opinion regarding Mr B's capacity to be in touch with his own and demonstrate appropriate empathic capacity towards any children in his care could proffered."

[39] Dr Bownes had some difficulty at that stage in deciding what he should recommend by way of future assistance and therapy because it was unclear to him whether the couple intended to remain together. In the event they had lived apart by then for about one year and his concerns in that respect have been justified. He felt that for therapeutic work to progress it was essential that P should acknowledge what had happened, its effects on the child, the importance of excluding any risk of repetition and a recognition by him of his own role. Since it has taken a full hearing to achieve a situation where P has been identified as the perpetrator it is little wonder that Dr Bownes was unable to come to a more optimistic or positive conclusion. He felt that any programme of work would involve progressing from the earlier and simpler stages to more complex and difficult ones. These procedures could take many months, perhaps years to fully address. Whilst some of the work could be done in parallel other work could only be done sequentially so that he envisaged a minimum period of 24 months before one could feel able to assess whether he could cope with stressful situations so as to accept a

child into his care with safety. Rehabilitation of either child or both children to his care at this stage, even with help from his mother, would not be realistic within a timescale appropriate to the needs of the children.

[40] The assessment of M was also negative. In part the difficulty for Dr Bownes in making proposals for the future was the uncertainty over whether the couple would remain together. In assessing the requirements of M it was also a problem that the perpetrator(s) had not been identified and as there was a possibility that P was the sole perpetrator different outcomes were possible. Even if it had been established by then that P was solely responsible the second fracture however it was clearly appreciated by Dr Bownes that an explanation was called for in respect of the first fracture, the facial/head bruising and the obvious neglect by M during the period between the two fractures being sustained. He considered that being relieved of the responsibility of caring for the children had resulted in an improvement in M's general level of well being and that she improved substantially in her presentation, both physically and emotionally, within a few weeks. He thought there was little to suggest that she was equipped with the skills to meet the changing needs of young children placed in her care. Again the therapy suggested by him in his report is considered to be long term work: she had "a long journey ahead". A timescale of approximately 24 months for completion of therapies was unlikely to meet a timetable conducive to the welfare of the children. The reservations expressed by Dr Bownes have been justified since by M's recognition that a return of the children to her care is not viable.

[41] In light of the stance now taken by M to the future care arrangements of the children I do not propose to analyse in detail the parenting assessment carried out by Ms Kitty Loughery. Suffice it to say she concluded that M "would not be able to safeguard and promote the welfare of her children or meet their needs appropriately".

[42] A similar assessment was carried out by Ms Loughery in respect of P. Her ultimate conclusion was to the same effect as that in respect of M. The assessments in respect of both parents had been conducted over a six week period. Her report shows that she obtained a detailed history of P's family background and it was clear that he had many angry feelings towards his stepfather although not to his birth father. He had been admitted to care with his siblings when he was 15 for three months and said he enjoyed his time in care. He had sufficient insight to consider that he had "messed up his education" but didn't think his upbringing had impacted on his school life - which showed a serious lack of insight even for someone in late teens. She considered his difficult background had left him with a distorted view of parenthood and he perceived himself to be a patient rather than an angry person, which did not fit with his own description of the events which occurred on the night S was injured. He acknowledged that he was angry

and his mood had clearly contributed to his behaviour and the infliction of injury. His lack of insight into the demands of parenthood was well illustrated when he said parenting was easy and that he enjoyed it. Despite his difficult upbringing he did nonetheless have positive views of family life and thought that he would like to have a car, a nice home, get his weans back and look after them. He appeared however to be fully content with himself and felt that he did not need to change anything. The assessment also showed he was not devoid of skills with children and he was much more imaginative in play situations with his children, and demonstrated more natural skills in organising play, than their mother. He was also much more aware of safety issues in general play, such as the dangers of a child slipping through splashing water on the floor. There were emotional deficits in his personality however which were demonstrated when he failed to pick up on cues to lift or hug the children when they were clearly seeking warmth of that kind. He admitted he had some difficulties in managing children, which were evident during contact and stated he would welcome advice about that. It was also evident that he had a strong bond with K, his son, but was much less spontaneous with S. In fact S placed very few demands on him and Ms Loughery felt this seemed to suit P. She felt he lacked good secure attachments with the children.

[43] The strength of the bond between P and K was remarked upon by all of those who assessed it. This impression was also confirmed by Ms Wassell. A comprehensive assessment which had been carried out on behalf of the Trust, and reported on by Ms M, Social Worker, was to similar effect. Indeed it was extremely positive about many aspects of P in particular. She thought he had taken an active role in K's care from birth and had begun recently to acknowledge his own negative experience of parenting in childhood had impacted on him as an adult and he wanted to seek help and support with this.

[44] The main focus of the evidence of Ms Wassell during the hearing (which was given by video link) was upon the issue of long term foster care or adoption as the preferred route for future care of the children. What emerged very clearly in the course of her evidence was the necessity for permanency to be achieved urgently for each of the children. She was of the opinion they should not be returned to either parent and that the search for adoptive parents must begin forthwith. This involved preparing the children for a move from their current foster placement. She thought the placement should not be delayed and any work with the parents should be in parallel, not before or instead of such a move to an alternative placement. She was adamant when she spoke of work with the parents this was in no way a reference to the context of placement or care planning. She felt the parents needed to know that the court has approved adoption to enable them to focus on this work and such work should help the parents to give permission to the children to move on. She repeated that finding a suitable placement ought to

be the primary focus. Help from the parents to achieve that is always desirable but if it is not forthcoming the move must proceed. If the parents have the potential to assist then help should be provided for them to give such help, but if they are not able or willing to do so then they must be left behind.

[45] As a result of hearing the very detailed expert evidence over a considerable number of days I have reached the conclusion that a return of either child to either parent within any timescale conducive to their welfare is impossible. I consider the mother has realistically accepted that proposition and that P came close to that point ultimately. I have no hesitation in accepting the overall thrust of the evidence from each of the experts, but most acutely summed up by Ms Wassell, that time is off the essence for each of these children and the first priority must now be to achieve permanence for them. She was unambiguous that given the age of the children, the need for permanence, security and to avoid any risk of breakdown in any future placement, adoption was the preferred option. I have no hesitation in accepting that advice, which accords with the opinions of many experts in other cases of a similar kind.

[46] Whilst adoption is frequently portrayed as the severance of relationships with parents that is mistaken. With proper procedures in place there is no reason to think that the children will in any way be deprived of knowledge about the history of their family and the welfare of their parents. In my opinion the case for approving a care plan which envisages placing these children for adoption is overwhelming. I realise that P in particular will be very disappointed but the prospect of returning either, or both, children to his care, to be helped by his mother in the household where he had so many unhappy experiences, is just not to be contemplated. The delay in trying to bring him to the point where it might be possible for him to parent either or both children is unacceptable and in any events the outcome is uncertain. Given the length of time these children have been in foster care, and the urgent need to move them to a permanent placement, (as emphasised by Ms Wassell) the timescale is simply not conducive and the welfare of the children demands that they should be permitted to move on now.

[47] I have set out the detailed plan of the Trust to deal with contact arrangements in the post care period. I approve these plans. They came about as a result of a meeting between the Guardian and Trust representatives following upon the evidence given by Ms Wassell. She had expressed a preference for the approach indicated by the Guardian ad litem. She thought weekly contact was a high level of contact for children who were to be moved to a permanent placement. The meeting between the Guardian and Trust representatives was the revised care plan to which I have referred earlier. The priority at this stage is to ensure that the next move for these children will be their last. They will need a considerable settling in period

and a significant level of contact is unlikely to be conducive to their best interests. The proposals for contact until the next LAC review are sensible in all the circumstances. There is already provision built in for a review of the arrangements once the LAC review has taken place and the Trust ha undertaken to be sensitive to the wishes of the parents wherever possible. If there is any continuing rancour or dispute then the matter can be referred back to court in due course. Clearly the extent to which either parent is able to accept the ruling of the court and make preparations for the future will impact upon the shape of contact both in the post care and subsequent stages.

The Human Rights Dimension

[48] This issue was raised at an early stage in the proceedings when a notice was served on the Trust by solicitors on behalf of M. Reference was made to this in the course of the hearing and the notice sets out a detailed list of complaints about the decision making process and the decisions reached by the Trust. A detailed response to the document was filed by the Trust and is dated 6 October 2005. Many of these issues are no longer relevant because the mother has altered her approach substantially. It is nevertheless important that one should comment on some aspects of it. At one point the Trust had sought to commission Mr Damien McCullough, Consultant Psychologist to conduct a psychometric test of each respondent to ascertain their respective levels of functioning. This was requested by letter dated 13 December 2004 with a view to the assessments being carried out on 15 December. A LAC review occurred on 14 December however and at that stage it was decided that reunification of each of the children to either respondent should be ruled out; accordingly the psychological assessment was cancelled. I am satisfied this was a proper decision given the state of proceedings at that time and the delay which had already occurred. At that point Dr Bownes had made preliminary assessments of the parents from the perspective of the psychiatrist. The view taken at the LAC review was that the evidence already available showed the risks to the children of rehabilitation to either parent were too high, particularly given the serious non-accidental origin of the injuries to S and the surrounding failure of her parents to protect her. Deciding that it was unnecessary to delay further whilst assessments were carried out by a psychologist. In any event the further assessments which had been carried out by Ms Wassell, Ms Loughrey and the ongoing assessments by social workers shows that the decision was well justified.

[49] Making a Care Order has been acknowledged by these courts to be a draconian measure, particularly where the care plan rules out rehabilitation with either parent. Interference with the Article 8 rights of parents is therefore implicit in any such decision. To interfere with private and family life by assuming parental authority, in the form of a Care Order, removing children from the day to day care of their parents, and planning their removal on a permanent basis, is an example par excellence of such a potential breach

of Article 8 rights and clear evidence is necessary to justify it. Article 8(2) states as follows:

> "2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in the democratic society in the interests of national security, public safety, or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others."

The domestic law of Northern Ireland provides that the interests of the children shall be paramount in proceedings such as these. This does not displace parental rights, it simply establishes a hierarchy in which they must be set. It is therefore permissible to allow the interests of the children to override those of the parents, if appropriate, without offending Article 8 as to do so would in such circumstances be "in accordance with the law". It would also in appropriate circumstances be "necessary in a democratic society … for the protection of the rights and freedoms of others" if it was decided a child required permanent removal from as parents to protect it rights and freedoms. The first priority for any society must be to protect its most vulnerable members and children are clearly within that category. Since neither parent is able to provide a safe and secure home for either child within the foreseeable future intervention by the State by making a Care Order and planning for adoption is justified and proportionate.

[50] In the course of this judgment I set out details of the evidence and my reasoning which led me to make a Care Order and approve the care plan. I have done so because I consider it necessary in the interests of the children that they should have a permanent home where their safety and physical and emotional development will be best protected. I have concluded reluctantly that that cannot be achieved by a return to either parent. If the children are to be given the best chance in life I am satisfied that must be done through placing them for adoption. In vindication of their rights and freedoms therefore I have decided that priority must be given to their needs and therefore, with regret, the rights and privileges of the parents enshrined in Article 8(1) must be interfered with to achieve the greater object. Such interference must of course be proportionate. I am satisfied that the consequences of the order which I have made can be mitigated to the greatest extent possible by continuing contact in the meantime and by maintaining a review mechanism for longer term contact. This will at all times be subject to the scrutiny of the court and will give further protection to the parents.