Neutral Citation No. [2013] NICty 10 | *Ref:*

*Judgment: approved by the Court for handing down (subject to editorial corrections)** | *Delivered:* **26/11/13**

In the Family Care Centre sitting in Belfast

In the matter of A

Her Honour Judge Smyth

Introduction:

1. This is an application for a care order in respect of A who was born on the 1st June 2012, and is now aged 16 months. The care plan is permanence outside the birth family. The guardian supports the application and the care plan.

2. On the 17th September 2012, the health visitor attended at the family home for a 16 week assessment. The mother told the health visitor that she had noted blood coming out of the baby's mouth a few times over the previous few weeks. On checking the baby's mouth, the health visitor noted a torn upper frenulum, on further examination the health visitor noted a bruise on the baby's lower left abdomen. The mother was unable to offer an explanation as to the cause of either injury. The mother reported that a number of people had cared for the baby in the recent past. The father was reported to be in bed during the assessment; subsequently he suggested that the torn frenulum may have occurred when the baby slipped from the maternal grandmother's hands and banged her mouth on a tap, while she was being bathed in the sink two to three weeks previously.

3. Following admission to hospital, the baby was noted to have extensive injuries including fractures and bruises as well as the torn frenulum. In

relation to the fractures, the baby had sustained a fracture of the acromion (part of the left shoulder), a fracture of the proximal left tibia, a fracture of the distal left ulna, and a fracture of the left proximal humerus. The baby had also sustained bruises to the left and right side of the abdomen, and to her back.

4. Dr Evans, retired Consultant Paediatrician, and Dr Fairhurst Consultant Paediatric Radiologist, concluded that the injuries were non-accidental in nature. Dr Fairhurst expressed the opinion that the fractures could have occurred at the same time, or could have occurred at different times within a range of time frames. Even if the fractures occurred within a short space of time, at least three and probably four separate applications of force would have been necessary to cause the four fractures. The bruising was considered to be probably several days old and the frenulum injury could have been one, two or even several days old.

5. Dr Evans explained that the bleeding from the torn frenulum would have been immediately visible, and the bruising to the abdomen would have been obvious to anyone changing or bathing her. In his opinion, the fractures would have caused significant pain and discomfort during movement of any of the affected bones, and he would have expected any reasonable adult to be alerted to the fact that the child was in significant pain. Dr Fairhurst agreed that the fractures would have been very painful, and that anyone responsible for the acromial fracture in particular, would have been aware that she had suffered a significant injury even if he or she did not appreciate that it was a fracture. Although, in her opinion, someone that was not responsible for the fracture might not be able to identify that she had been injured. Dr Evans described the frenulum injury as extremely painful and said that the baby would have cried immediately and would probably also have cried whenever that part of her mouth was touched in any way. If the injury had been caused by the baby's mouth striking an object such as a tap, he would have expected an injury to the front of the lip, which was not present.

6. In terms of mechanism, Dr Fairhurst explained that the acromial fracture would require significant force and can result either from a pulling or twisting force being applied to the shoulder or the upper arm, for example if the arm is suddenly yanked away from the body. Although such an injury can be caused by a violent shaking episode, she considered this to be a less likely cause because of the absence of intracranial injury. She noted that acromial fractures are very highly specific for non-accidental injury. The fractures to the left proximal tibia and the left distal ulna require a twisting and pulling force to be applied to the limb. This type of fracture is again highly specific for non-accidental causation. The frenulum injury is caused by blunt trauma, and in Dr Evan's opinion the most likely cause is a feeding body thrust into her mouth very forcefully. With regard to the abdominal bruising, the marks are consistent with finger print marks, which suggested that the baby's abdomen had squeezed.

7. Dr Evans expressed the view that the delay in seeking medical attention was unacceptable given the time periods for the fractures and the bruising, and the account given by the parents that the baby's mouth had bled on at least one previous occasion. Blood tests confirmed that the child was not at increased risk of bleeding, so the expert opinion was that the injuries were entirely consistent with a non-accidental cause.

The Assessment of the Parents

8. The father was assessed by Dr Fred Browne Consultant Forensic Psychiatrist. In his opinion, the father is not suffering from major mental illness, or learning disability. He has a history of alcohol dependence syndrome and drug addiction. He also has a history of violence, both to himself and others, and personality deficits. Dr Browne considered that the father tended to minimise or deny problems and tended to attribute responsibility to others.

9. The father was also assessed by Dr Christine Lavery, Consultant Clinical Psychologist, she described the father as having cognitive difficulties but no

evidence of a general learning disability. In her opinion, his communication style is strongly suggestive of autism. She described his rigid, egocentric thinking and repetitive behaviours, lack of empathy, poor social understanding and social communication deficits. The deficits in his empathy result in a limited ability to understand the impact of his depression and other mental health difficulties, rigid thinking and a controlling manner in respect of his partner.

10. While the existence of Autism, would not in itself be an impediment to his ability to parent his child, his difficulties may impact on his ability to demonstrate change, by effectively engaging in therapeutic intervention, parenting assessments and support. Dr Lavery noted that despite the seriousness of his daughter's injuries and the distress this has caused him, he has not engaged with community mental health services or community addiction services. He does not accept that he has an addiction and he lacks insight into his need for on-going intervention with mental health services. Dr Lavery concluded that unless the father effectively engages with professionals and services offered to him, 'his outlook is poor and does not bode well with his ability to effect and maintain change within a timescale that would meet his child's developmental needs.'

11. The mother was also assessed by Dr Lavery. She described the mother as demonstrating a basic understanding of her child's developmental needs, but as having clear deficits in her ability to recognise and meet her child's needs in terms of safety and protection. The mother did not appear to have a understanding of the emotional impact the father's autism, mental health and other relationship difficulties might have on both herself and the child. She demonstrated difficulties in terms of prioritising her own needs over her partners and Dr Lavery concluded that it would not be unreasonable to predict that she would also have difficulty placing the child's needs before the father's needs.

12. Dr Lavery expressed the view that 'considering the seriousness of A's injuries, the mother's lack of appropriate responses to a number of issues regarding protection and safety of herself and her daughter, this young mother clearly needs ongoing advice, counsel and direction in order to reduce the risks for herself and the child. She raised significant issues of concern around the mother's ability to work effectively and openly with professionals involved with A. Dr Lavery also noted that the mother does not consider that there is a need for change in either her thinking or behaviour, in terms of her relationship with the father. Since the mother cannot identify the need for change, Dr Lavery concluded that it is highly unlikely that her engagement in the recommended work will result in positive outcomes.

The Evidence of the Parents

13. The father filed two statements of evidence, dated the 8th November 2012 and a further statement of evidence dated the 9th August 2013. In his first statement he gave an account of bleeding from A's mouth approximately two-three weeks before her injuries were discovered. He said that he and the mother looked in A's mouth and couldn't see any reason for the bleeding. They cleaned her mouth and she 'settled fine'. On the night before her injuries were discovered he said that he noticed quite a lot of blood in A's mouth when he was placing her in the crib for the night. He said there was more blood on this occasion and she actually seemed to be bleeding. He said that he and A's mother had looked in A's mouth and saw what he described as 'a wee red thing' at the top of her mouth', which he now understood to be the frenulum. He said that A was not unsettled and slept normally. He said this had occurred in the middle of the night, and since the health visitor was due the following day, they would tell her about it in the morning.

14. The father said that after A was admitted to hospital, the paternal grandmother revealed that A had fallen forward and banged her mouth in the sink, 2-3 weeks previously when she was being bathed. He said that his mother had not told him or A's mother because she 'felt guilty and

embarrassed'. He also said that the paternal grandmother had told him that she had been playing a 'dancing game' with A, where she was 'holding A up on her feet on her lap, and was moving her up and down.' She said she was holding her tight and that this may have caused the bruising.

15. In his statement of evidence, the father also described two incidents where A had fallen whilst in his care, and which he believed may provide an accidental explanation for the injuries. The first occurred when A was eight weeks old. He said that he had wrapped A in a blanket and was walking A to her crib, when the blanket unravelled and A fell to the ground. The second incident was alleged to have occurred around the end of August 2012, when A was between two and three months old. He said that he had been lying watching T.V on the sofa and was cradling A on his chest, and he said he must have dosed off for a brief moment because he was woken by the mother shouting his name and A was on the floor crying. The mother's statement of evidence corroborates the father's account. Both parents strenuously denied any deliberate injuries to A and named a number of family members who had cared for A in the weeks prior to her injuries being discovered.

16. At the outset of the threshold hearing on 30th April 2013, his counsel indicated that the father now remembered a significant piece of evidence which was not contained in his earlier statement nor made known to the PSNI. The new evidence was that on the evening of 15th September into 16th September had stayed overnight with the paternal grandmother Ms R and her partner Mr H. The parents account was that the bleeding to A's mouth had occurred in the earlier hours of 17th the day the Health Visitor arrived.

17. In evidence, the father alleged for the first time that he had received a phone call from the paternal grandmother on the evening of the 15th to tell him that she had noticed some bleeding in A's mouth. She said that she didn't know what had caused it. She said that she had looked underneath the lip and "poked" something, causing blood to flow. Her partner, Mr H who is a nurse had checked her mouth and wasn't concerned. The father said he trusted his

mother and although he mentioned it to A's mother they didn't think it necessary to telephone the doctor. When the mother gave evidence to the court, she also purported to remember for the first time that the child had stayed overnight with the paternal grandmother on the 15th, and that a phonecall had been received to say that the child's mouth was bleeding. She said she wasn't concerned, even though this had happened previously because the child was settled when she arrived home and the Health Visitor was coming on 17th.

18. In light of this development the Court directed that a transcript of the father's evidence should be sent to the paternal grandmother Ms R and her partner Mr H and that they should be put on notice that they may be within the pool of possible perpetrators for the torn frenulum. They were invited to take legal advice and to intervene in the proceedings. In light of the evidence, the Court also directed that other family members named by the parents as having care of the child within the relevant period should also be invited to intervene. Ms R and Mr H were subsequently joined to the proceedings, made statements of evidence and gave oral evidence. The maternal great grandparents Mr and Mrs M were also joined and made statements of evidence but declined to give oral evidence.

19. Ms R and Mr H denied that A had stayed overnight on the evening of the 15th into the 16th September and insisted that they had only looked after her for a few hours on the 16th. At the outset of her evidence Ms R made an application to amend her statement of evidence to change the date on which she had allegedly injured the child accidentally on the tap from the 6th September to 13th September. However, in oral evidence she insisted this incident had actually happened on 16th and said she didn't know why she had sought to amend her statement of evidence. It was put to Ms R that in fact she had told police that the alleged incident with the tap had occurred *nine days* prior to the injuries being discovered which would have dated the incident on or about 6th or 7th September. Ms R alleged that she was unfit to be interviewed

by the PSNI because of ongoing health difficulties but that the police had threatened to arrest her. It should also be noted that there is a record to the effect that this incident occurred "two-three weeks" previously.

20. Mr H also denied that A had been in his care along with the paternal grandmother overnight on the 15th through to the 16th as the father had alleged. In oral evidence he said that he was not sure whether the incident with the tap had occurred on 16th September but agreed that he had made that assertion in his statement of evidence. He also said that he had not actually been present when the incident occurred although he said he was in the house. Mr H described to Police how he came into the room to find Ms R with a cloth with "dark blood on it , drips of blood as though it ... and she said it came out of A's mouth ". It was put to Mr H that although he had initially told Police that this occurred on 19th September he later clarified that it was 16th. He had also told police about a "little bump" A had received " a week or a couple of weeks" earlier whilst in Ms R's care - but in oral evidence he denied that anything had happened previously which could have caused the injuries.

21. Evidence was adduced by the Trust regarding threatening and concerning behaviour by the father during the course of these proceedings which had resulted in contact being suspended pending a risk assessment by Dr Browne. The father, who has previous convictions for violence and possession of offensive weapons had posted a Facebook entry in which he was seen brandishing a machete and on another occasion he self-inflicted a serious injury with a knife.

The Law

22. In accordance with Article 50 of the Children (NI) Order 1995, it is open to the court to make a care order only if satisfied of two matters. The first is that A is suffering, or is likely to suffer significant harm. The second is that the

harm, or likelihood of harm, is attributable to the care given to the child, or likely to be given, if the order were not made, such care not being what it would be reasonable to expect a parent to give to the child. This constitutes the statutory threshold for intervention by the court. This must be considered in the context of the "threshold criteria" in this particular case. If satisfied that the statutory threshold is met, the court will then consider whether it is appropriate to make an order, giving effect to the welfare and non-intervention principles enshrined in Article 3 of the 1995 Order. In making its determination, the court must be alert to its duty as a public authority under section 6 of the Human Rights Act 1998 and, in this context, the right to family life, guaranteed by Article 8 ECHR. At the heart of the legislation is a determination of what is in the child's best interests, which must be the court's paramount consideration.

23. I have taken into account the following authorities relating to medical evidence in non-accidental injury cases; Re M (children) (fact finding hearing: injuries to skull) [2012] EWCA Civ 1710 and Re R (a child) [2011] EWHC 1715 (Fam). These cases are, however, fact-specific and merely serve to emphasise the importance of correctly analysing the expert medical evidence before reaching findings of fact. I have also taken into account the observation of Dame Elizabeth Butler-Sloss in Re T [2004] EWCA Civ 558 that "*evidence cannot be evaluated and assessed in separate compartments. A Judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof*".

24. I have also taken into account Re J (Children) [2012] EWCA Civ 380 which concerned the approach to be taken to "possible perpetrators". At paragraph 18 LJ McFarlane said:

> "18. *Where a court is in the position…..of finding that significant harm has been occasioned to a child, but being unable to identify on the balance of*

probabilities which of a number of individuals perpetrated the harm, the most the court can do is to identify a pool of possible perpetrators. As will be seen, the case law establishes that an individual will be considered as a "possible perpetrator" where the evidence establishes that there is "a real possibility" that that is indeed the case. As the concept of the "pool of possible perpetrators" only arises where the evidence is insufficient to identify one or other possible perpetrator as being "the" perpetrator on the balance of probabilities, a name goes into the pool of possible perpetrators only where the evidence falls short of the balance of probabilities but is sufficient to establish "a real possibility" that a particular individual caused a particular injury."

25. LJ McFarlane also referred to the judgment of the Supreme Court in Re S-B (Children) (Care Proceedings: Standard of Proof) [2009] UKSC 17; [2010] 1 AC 678 which confirmed that the simple balance of probability test, following the House of Lords decision in RE B (Children) (Care Proceedings: Standard of Proof) [2008] UKHL 35 should be applied in finding that a person was the perpetrator of an injury. The Supreme Court also confirmed in Re S-B that where the evidence falls short of that standard, an individual will be found to be *a possible* perpetrator if the evidence establishes "a real possibility" that they caused the injury.

26. Baroness Hale, giving the judgment of the Court in Re S-B identified the case as being:

"…about the proper approach to deciding who has been responsible for harming a child in proceedings taken to protect that child, and others in the family, from harm. It raises profound issues: on the one hand, children need to be protected from harm; but on the other hand, both they and their families need to be protected from the injustice and potential damage to their whole futures done by removing children from a parent who is not, in fact, responsible for causing any harm at all." (paragraph2)

27. The parties reached agreement that threshold is met, apart from the Trust assertion that only the parents are within the possible perpetrators for the

injury to the frenulum. The parents accept that they, along with other family members are, in the pool of perpetrators for the other injuries. The Trust case is that the parents changed their evidence at the outset of the threshold hearing, in order to place the paternal grandmother and her partner within the pool of possible perpetrators for the frenulum injury.

Conclusion on threshold and pool of possible perpetrators

28. There is no question that the extensive injuries sustained by this young baby were non-accidental in nature. I am also satisfied that the accounts provided by both the parents and the paternal grandmother Ms R and her partner Mr H do not explain any of these injuries. With regard to the other family members named by the parents, the court is satisfied that there is no evidence to justify a conclusion that the maternal great grandparents, Mr and Mrs M, are within the pool of possible perpetrators. Although they chose not to give evidence, they did intervene in the proceedings and provide statements of evidence. No evidence whatsoever was relied upon by the parents which would enable the Court to find that there is a 'real possibility' that they were responsible for any of A's injuries. Nor was there any evidence to suggest that the baby may have suffered any injury in the care of the other family members named apart from Ms R and Mr H.

29. The court is satisfied that both the parents, Ms R and Mr H are within the pool of possible perpetrators for all of the injuries, including the torn frenulum. Clearly, the finger of suspicion must point to the father as the perpetrator because he has a history of violence, substance misuse and mental health issues. However, the court found the evidence of all four witnesses, unsatisfactory and untruthful. The inconsistencies between the parents' evidence on the one hand and the evidence of Ms R and Mr H on the other, along with the inconsistencies in the accounts given by those witnesses to the court and to the PSNI, have led the court to conclude that it cannot be satisfied on a balance of probabilities where the truth lies.

30. It may be the case that Ms R has invented the story about the baby hitting her mouth against the sink in order to protect her son. Certainly, Dr Evans expressed the view that if such an incident had occurred the baby would have been expected to have an injury to the outside of her lip. It may also be the case that the father invented the story that A had stayed overnight with Ms R and Mr H and had been told that A's mouth had bled in order to extend the pool of possible perpetrators for the torn frenulum beyond himself and the mother. Or, it may be the case that A sustained at least some of the injuries in the care of Ms R and Mr H because the experts agreed that the injuries may or may not have been sustained on a single occasion. The mechanism of each of the injuries required deliberate and multiple application of significant force. I do not accept that this baby could have sustained such extensive injuries without a carer being aware that A required medical attention even if he or she was not a perpetrator and was not present when the injuries were inflicted. The failure to seek medical attention within an appropriate timescale demonstrates neglect and at the very least a clear inability on the part of both parents to protect A from harm. I am satisfied that threshold is met on the basis of the statement submitted by the Trust.

Conclusion on care planning

31. Given the extensive nature of this baby's injuries, the degree of force which was required to cause them , the unsatisfactory evidence given by the parents and the expert psychological and psychiatric assessments completed, the court is not satisfied that A could safely be returned to the care of her parents. Despite the father's distress at the removal of his child into foster care , he has failed to engage with addiction and mental health services which are a necessary part of any safe care plan. The mother has been assessed as prioritising the father's complex needs above either her own or in all likelihood those of her child. Despite being aware of the serious nature of the injuries she has not shown any insight into the concerns of professionals.

32. If the mother is not responsible for any of the injuries, not only has she failed to protect her baby but she has failed to seek medical help when she must have known, at the very least, that something was wrong. While Dr Fairhurst expressed the view that a person who was not responsible for the injuries may not have known that the baby was injured and may only have found her to be unsettled and "grizzly" I prefer the evidence of Dr Evans that a carer, and in particular a primary carer, would have recognised that something had happened which necessitated medical attention. Even on the parents' account that the baby bled from the mouth in the early hours of 17th September, and that she had done so previously, I am satisfied that a reasonable parent would have sought urgent medical advice and not waited for the arrival of the Health Visitor.

33. The Court has also considered whether A could safely be placed in the kinship care of either Mr H who lives with the paternal grandmother Ms R, or the maternal great grandparents Mr and Mrs M. Clearly Mr H and Mrs R cannot be considered as appropriate carers since they remain within the pool of possible perpetrators and their evidence to the court was inconsistent with accounts they previously gave to PSNI and with the parents' evidence.

34. In respect of Mr and Mrs M, they were ruled out by the Trust following a viability kinship assessment. As well as health and age issues, the trust was concerned by the couple's inability to accept any blame in respect of their granddaughter, the mother, attributing all responsibility to the father. In addition, the Trust became aware that on 11th July 2013 Mr M made an allegation to the PSNI that when A was four days old, the father held her aloft in the palm of his hand with his arm outstretched. Mr M said that he had told the father to put the baby down. It is recorded in Trust documents that when the parents were questioned about this allegation by Police they denied it and said that they would speak to Mr M. Coincidentally, Mr M withdrew his complaint to Police. Mr M denied that he had been approached by either parent to put pressure on him to retract the allegation but could not offer any

explanation for his conduct other than to say that the PSNI investigation had caused him stress to the point where he required medication and he no longer wished to be involved.

35. The guardian added to the concerns in her evidence regarding her contact with Mr and Mrs M. She recounted two meetings with them in which she concluded that whilst they meant well, they had no insight into the seriousness of the issues. She also expressed the opinion that Mr and Mrs M were not open with her and she formed the impression that Mrs M was motioning to her husband to stay silent as he answered her questions.

36. Mr and Mrs M chose not to give evidence to the Court. Having considered all of the evidence, it is my view that they would be placed under enormous pressure by the parents if they were to care for A and that any such placement is likely to break down. It is also my view that Mr and Mrs M are unlikely to be able to appreciate the risks posed by the mother's prioritisation of the father's needs. I agree that it is not in A's best interests to be placed in their care.

37. Taking into account the welfare checklist, I am satisfied that a care order is necessary and that A's welfare is best met by a permanent placement outside the birth family. Concurrent carers have been identified. I therefore approve the care plan and the proposed contact arrangements.