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(subject to editorial corrections)

Delivered: **18/01/07**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

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IN THE MATTER OF J (THRESHOLD CRITERIA: NON-ACCIDENTAL INJURY)

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GILLEN J

[1] This judgment is being handed down on Thursday 18 January 2007. It consists of 30 pages and has been signed and dated by the Judge. The Judge hereby gives leave for it to be reported. The judgment is being distributed on the strict understanding that no person may reveal by name or location the identity of the children and the adult members of their family in any report. No person other than the advocates or solicitors instructing them (and any other persons identified by name in the judgment) may be identified by name or location and that in particular the anonymity of the children and the adult members of his family must be strictly preserved.

[2] There is before this court an application by a Health and Social Services Trust ("the Trust") for a care order in respect of a child J aged 1. It was agreed between the parties that a split hearing should take place and that I should at this stage determine whether or not the threshold criteria have been established within Article 50(2) of the Children (NI) Order 1995 ("the 1995 Order"). If those criteria are so established, the court will continue at a further hearing to determine whether a care order or some other order or no order should be made. In order to preserve the anonymity of the family members, I shall identify the child as J, the mother as F, and the grandmother as O. The father of the child J is unknown. References to a further deceased child of F's shall name that child as C and the father as W.

[3] The hearing in respect of the threshold criteria was heard on 28/29 September 2006, 2, 3, 4 and 9 October 2006. Thereafter it was adjourned for several weeks to permit the respondents F and O to consider calling further

medical evidence if they so wished. Final submissions in the case were made on 11 December 2006.

[4] Article 50(2) of the 1995 Order provides:

> "A court may only make a care or 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 him or
> >
> > (ii) the child being beyond parental control".

Background facts

[5] Some basic background facts in this case are as follows:

(i) F, who is now 19 years of age, is the single mother of J who is now one year of age. The father of C was another child("W") at the time C was conceived. The father of J is unknown. O is the mother of F.

(ii) Social services had first been engaged with this family in January 2001 due to problematic behaviour on the part of F, then 13 years of age. An underage pregnancy report was completed on F when she was 12 years of age.

(iii) F gave birth to C on 19 June 2003. By October 2003 F had presented at psychiatric services and problems with schooling had emerged. She was a child with learning disabilities.

(iv) In January 2004 C died. The post mortem was unable to determine the cause of C's death but it did identify evidence that C had sustained non-accidental injuries prior to death namely a bucket handle fracture of the lower end of the right tibia. It subsequently emerged that there also had been a fracture of the right ulna. An investigation was carried out by the PSNI but no prosecution was forthcoming.

(v) It is the Trust's case that to date no explanation has been provided for these fractures.

(vi) Evidence emerged that W and F had been living and engaging in sexual intercourse together whilst children in O's household. That relationship terminated after the death of C.

(vii) Subsequent to C's death F engaged in concerning behaviour including sexual intercourse with a number of different men leading to the birth of J on 30 July 2005. On 5 August 2005 the Trust lodged an application for a care order in respect of J. On 18 August 2005 a guardian ad litem ("the guardian ") was appointed.

Witnesses

Dr Jennifer Galbraith

[6] This witness was a consultant clinical psychologist who had been asked to provide a clinical psychology report on and assessment of both F and O on behalf of the guardian , the Trust and F and O. In the course of her two reports of 18 May 2006, supplemented by a letter of 14 June 2006, her evidence-in-chief and cross-examination, the following matters emerged.

(1) On an intellectual assessment, overall F attained a full scale IQ of 67, which falls just inside the learning disability range of functioning. The witness emphasised, and I take this opportunity also to assert, that below average level of intellectual functioning alone does not preclude an individual from being a competent parent. F's intellectual ability falls around the overlap between the mild learning disability and borderline ranges. There are parents whose ability level is lower and who have managed to raise their children with success. Parenting capacity incorporates a number of important factors and intellectual ability is only one. An individual's own experience of being parented is of significant influence as are her general childhood experiences. How one was parented will constitute an individual's greatest understanding of what a parent is, whether this is a largely positive or negative experience.

(2) The witness made clear that having a "significant other" to share the parenting responsibility is often the most significant factor in a "family" unit where one parent has a learning disability. This other person is usually of higher intellectual ability, can bring additional skills to the parenting task and hopefully will compensate for difficulties which the learning disabled parent experiences.

(3) The witness had obtained a full history from F as follows:-

Inter alia, F had explained in detail her experience of using and abusing alcohol and drugs for a period of eight months from shortly after C's death in the wake of the distress which had been occasioned to both F and O. F admitted that she was knowingly harming herself because she wanted to die, so great was the grief she was feeling after losing her baby . She would have been drinking or taking drugs every night of the week. When she discovered she was pregnant with J, she immediately stopped all alcohol and drugs. She admitted to Dr Galbraith that she wanted to be pregnant and had sexual relations with four different men with the intention of becoming pregnant but without knowledge of the father's identity. So far as the father of C is concerned, she started the relationship with W when she was 14 years old. Their sexual relationship was consensual on both sides she said. She explained that W stayed over in her house before C was born. After C's birth, W was living full time with her family. F described the difficulties of that relationship in the family home and it ended a few weeks after C's death. On the subject of the post mortem findings of C, she refused to accept that C had sustained a broken leg indicating that if the child had had such a fracture C would have been in pain and F and O would have observed the distress. She asserted that at no time did C cry without any obvious explanation.

(4) Dr Galbraith was clear in her opinion that this young woman could not bring up a child on her own at present. Intellectual capacity does come into her decision but in conjunction with other variables. By her own admission F does very little for herself in terms of household tasks according to the witness. She does not budget her own money, her mother keeps her benefit money and she asks her mother for money whenever she needs it. She does not cook for herself or contribute to household management unless specifically asked by her mother. This seldom happens because her mother thinks that she has enough to do in attending contact visits with J. This young woman is therefore not self-sufficient in practical ways and Dr Galbraith does not believe she can look after a baby on her own. It was noteworthy that F has not expressed a wish to raise J on her own and wants J to be returned to the care of both her mother and herself. Dr Galbraith goes on to indicate that F does not demonstrate an ability to look after herself in other aspects of life for example physically, emotionally and sexually. She abused drugs and alcohol for a period of time, intentionally slept with a number of men in order to become pregnant. This all reflects immature thinking and lack of forethought as well as serious risk taking behaviour. This behaviour demonstrated to Dr Galbraith how vulnerable this young woman is and her need for guidance and protection. She may have a propensity to return to such behaviour in a time of crisis or loss in the future.

(5) The witness described the relationship between F and O as a somewhat co-dependent one – the adult needing to placate the child in order to feel that she is a good mother and have some control and the child needing the adult for help in all aspects of every day life. Dr Galbraith described this

young woman as struggling to meet her own needs and therefore could not be responsible for a baby, certainly at this stage in her life. Her report adds:

> "It may be that skills, training and education on many aspects of parenting and independent living could add to her repertoire, but such input would need to be tailored to her individual need and level of ability and would also take some considerable time to complete. Unfortunately the more complex aspects of parenting, which involve understanding the emotional needs of a developing child are difficult to teach and indeed a real appreciation of the vulnerability of a child may not be fully understood by some adults."

(6) In cross-examination this witness accepted that J was well cared for by F and O during the three months or thereabouts that the child was with them. There are copious references in the contact sheets to the effect that F and O fed and provided well for the child. However Dr Galbraith made the point that the examples from the contact sheets are in a restricted setting which is time limited, supervised by social service staff and where there is no opportunity for conflict between mother and daughter. This does not reflect the wider family life where there is a different relationship in terms of who is in charge, and who will provide stability within the family setting.

(7) Having carried out an intellectual assessment of O, Dr Galbraith found that she attained a full scale IQ of 74 which falls at the lower end of the borderline range of intellectual functioning when compared with standardised norms for the general population. One can expect 4% of individuals to achieve an equal or lower full scale IQ score. The fact that she functions intellectually at a below average level does not mean that she could not parent a child effectively and indeed has raised two children of her own with only recent input from social services in respect of F's behaviour. Her intellectual ability is not that much greater than her daughter's and yet their ability to function as independent adults differs dramatically.

(8) O recorded that during her childhood F had gone through periods of self-harming, cutting her arms and sniffing aerosols, running away from school and from home on a number of occasions. She has a very close relationship with her daughter and they have grown closer in the aftermath of C's death. She described her daughter as having "gone off the rails all together" after C's death. She recalled that F had engaged in a number of incidents involving the police and had become involved with a drug dealer who had smashed the windows of the family home. Dr Galbraith recorded her concern that no formal intervention had been taken at this stage to ensure the safety of F given her level of learning disability. O also informed Dr

Galbraith that she believed F had intentionally had sexual encounters with a number of men which served to further fuel Dr Galbraith's concerns about the vulnerability of this young woman. Disturbingly Dr Galbraith described the situation where F's boyfriend W, himself a child, was given a position of power living and sleeping with F within the family home even though F was only 15 years of age. O explained that since F was already pregnant, she did not see any problem with this. Soon the arrangement changed from staying a few nights per week to staying there constantly. W had gained a position of importance and influence in the home and seemed to dominate the domestic set up. Dr Galbraith states:

> "I find it alarming that this woman allowed a 15 year old boy to, in my opinion, 'take over' her family life. I understand that the circumstances were unusual and that she felt a greater sense of control over F if she kept both these young people in the home but I would suggest that this was an unacceptable and inappropriate arrangement."

In evidence before me Dr Galbraith indicated that she discerned no indication from either F or O that even now they consider this to have been an iniquitous situation. It is unfathomable why, as the only adult in this situation, O did not set boundaries and make rules which would ultimately have protected all concerned.

(9) O had recorded the practice of F to go to C's grave at least once per day. O is concerned that if F is left alone, she may try to dig up C's coffin, O having reported that F had often reminded her that the coffin is only three feet under the ground and that it could be dug up. O is convinced that F would attempt to do this.

(10) Dr Galbraith found it alarming that O had passively allowed this 15 year old boy not only to take over the life of the household, but that she thought it acceptable that F and W, themselves still children, be the main decision-makers in respect of C's care. In the witness's opinion O struggles in a relationship with her daughter, always wanting to please her and being fearful of the consequences of any disagreements or fall outs. She concluded that a family system which lacked clear, consistent leadership and boundaries constituted an environment with an increased potential for risk to vulnerable children. It was Dr Galbraith's view that O would need to be more assertive and less passive in her responsibilities as mother and grandmother. She needs to be more firm and confident in her decision-making and less fearful of F's reaction to this. There seems to be an unpredictability factor in F's presentation and it was the witness's impression that her mother worries about her potential reaction to situations which do not please her or are difficult for her to handle. Whilst it might be worthwhile thinking about

some therapy for O to ascertain if she was motivated to change and that thereafter some family therapy might be utilised nonetheless this would only be a starting point for change and would take a long time. Dr Galbraith indicated that she would be very concerned at the prospect of both F and O jointly caring for J even if there was social work input on a regular basis. The nature of the relationship between F and O is such that much input would be needed by way of therapeutic work to help O look at her parental role and to be a family leader in charge of F and J. At the moment there is no family system which has a clear consistent leadership in the setting of appropriate boundaries. It was her clear view therefore that currently it would not be safe to return the child to their joint care.

Dr Bentovim

[7] Dr Bentovim, a Consultant Psychiatrist, provided a written report of 22 February 2006 augmented by a letter of 18 July 2006. In the course of that report, his evidence in chief and cross-examination he made the following points :

(1) His instructions essentially were to consider the risks of J being returned to F and O and to advise the court in relation to the management of J's future care plan. In particular he was to consider what were the risks of any to J returned to the care F and O and whether these could be managed to ensure J's safety and protection. He was also asked to consider any further interventions required before rehabilitation could safely be pursued and whether the J's physical safety could be guaranteed to an acceptable extent.

(2) On separate occasions he met with

(a) the foster carers of J supported by a social worker.

(b) F and J.

(c) F, O and J and the social worker.

(3) Whilst the witness accepted that a grandparent can support a daughter and a child, in his opinion that was not the situation in this instance. O had failed to set appropriate boundaries, limits and care for her daughter particularly in light of the agreement to allow W to live with them. Her capacity to care for F and J had to be seen in the context of F having an intellectual disability which should have been a cause for increased concern on O's part. On the contrary O seemed powerless to deal with the situation where two children, namely F and W, were looking after C and was unable to exert appropriate authority. It was Dr Bentovim's view that it would be a matter of grave concern for J to be returned to this situation and he

questioned whether it was either viable or safe. There would have to be evidence of dramatic improvement before such a move could be contemplated. Whilst he recognised that F wished to care for J her skills and capacity to relate to J were limited by her emotional and intellectual disabilities. In the context of a suggestion that J be returned to the joint care of F and O, he expressed grave concern that no explanation was forthcoming as to how C had been harmed. They have both had to acknowledge that harm was caused to C but they are unable to take any responsibility or to give an explanation.

(4) The birth of J had occurred in the context of the death of C shortly before. Between the death of C and the birth of J he doubted whether F realised how irresponsibly she had acted. Whilst he did not doubt that F had a warmth of feeling for J and a desire to be a good parent, the fact of the matter is that children become uniquely aware of intellectual and emotional difficulties with a parent and pick up an avoidant way of coping. That avoidance emerges when there is a limited capacity on the part of a parent to be responsive. There is more to parenting that simply caring, feeding, washing a child in the first few months of his life. Parenting requires capacity to cope with the endless needs of children and requires maturation and ability to exert a loving response at all times. When a parent is emotionally tuned a child will develop secure attachment observed through direct eye contact, and response. His experience of observing F with J was that these responses were not present and there was an avoidance way of coping on the part of J.

(5) In his opinion F will find it very difficult indeed to take a back seat with J and accordingly it will be extremely difficult for O to take control in a way that does not present itself as challenging to F. The risks to J will therefore not be managed in a way that is compatible with the chid's safety and protection if returned to F and O.

(6) Dr Bentovim recognised that there are guidelines for dealing with parents under a disability. He accepted the IQ level of F in itself should not prevent her caring adequately for a child. Equally there was a history of incapacity to care appropriately for C. Whilst he acknowledge the evidence that F had given birth to J during a period when she was undergoing a grieving process for C, (see the reports of Dr McCartney), Dr Bentovim felt that this was a much more complex situation than purely one of a grieving process. Her history of bullying at school, use of tranquilisers, antidepressants, needing support and concerns about self-harm coupled with behaviour involving excessive drinking and drug abuse all complicated her ability or capacity to care for J. Even now the exact nature of the domestic violence that had occurred when W was living with her and O was not clear.

(7) Although the witness accepted that a perusal of a number of contact sheets for example between January and March 2006, revealed F interacting

well with J. Dr Bentovim noted that this might only superficially look well to a social worker. Other experts had observed the avoidant response on the part of J which he had noted. His observation was over a period of an hour and he noted in the parenting assessments similar concerns about such matters. It was not inconsistent that some contact sheets gave a positive assessment at times because avoidance is not a wooden response all the time. Dr Bentovim observed the avoidance response gradually emerging. Attachment is an area for an expert to make a judgment in his view.

(8) It was Dr Bentovim's conclusion that F had been difficult to manage. She was a forceful young person whom O found difficulty controlling. Many parents do have difficulties with children growing up but when there is a baby present, these difficulties often take on greater concern. F did not display the kind of mature understanding of the situation with Dr Bentovim that was required if there was going to be major change. Both F and O were trying to put responsibility on W for the harm to C and he was not at all convinced that they acknowledged or understood their frailties. F had become pregnant in the shadow of the death of C and her difficulty was to parent at a point when she was so close to the death. It was Dr Bentovim's view that nothing would be gained by putting F into a residential setting in the absence of some explanation of the death . He opined that F and O had not yet worked through the degree of maturation of the relationship which J would need to ensure good quality care. This child requires a period of involvement in a secure relationship which F and O could not offer. He criticised any suggestion that J could be experimented with. There needs to be certainty about the capacity to care for J before any return could be contemplated.

Evidence of J Mark H Paterson FRCS, Orthopaedic Surgeon and Dr G D Thornbury, Consultant Paediatric Consultant

[8] Although these two consultants gave evidence on separate days, the former being called by Mr O'Hara QC on behalf of the guardian ad litem and the latter on behalf of the Trust by Mr Toner QC, the conclusions of the two of them in the course of their reports, examinations-in-chief and cross-examinations can be conveniently conflated;

The x-rays

(1) Both of these witnesses gave evidence concerning two fractures to the deceased child C who died on 2 January 2004.

(2) Both now unequivocally agreed that there had been evidence of a fracture of the distal tibial metaphysis (the lower flared end of the right tibia) which was of a type known as a bucket handle or classic metaphyseal lesion (hereinafter referred to as "the tibial fracture") and a fracture of the right ulna which constituted a metaphyseal corner fracture affecting the distil right ulna (hereinafter called "the ulna fracture").

(3) There had been initial confusion concerning the diagnosis of these fractures by both of these experts. Skeletal x-rays of the deceased child had been taken both at the post mortem at Causeway Hospital, Coleraine on 2 January 2004 ("the Coleraine x-rays") and subsequently at the Royal Victoria Hospital ("the Belfast x-rays"). Dr Thornbury belatedly discovered that there were two sets of x-rays one having been carried out in Coleraine and the other having been carried out in Belfast. Relying on the Belfast x-rays she had observed only the tibial fracture. She had not observed any fracture of the ulna on the Belfast x-rays. However upon being shown the Coleraine x-rays she was in complete agreement that these revealed a distal fracture of the right ulna. Mr Paterson had seen only the Coleraine x-rays which had diagnosed a fracture of the right ulna. On being shown the Belfast x-rays, he found that they confirmed the presence of a medial tibial metaphyseal fracture of the distal right tibia with well formed periosteal reaction extending up to the medial shaft of the tibia. The two of them took part in an experts meeting on 7 June 2006 at a meeting chaired by Kelly and Corr solicitors acting on behalf of the guardian ad litem and engaged in further correspondence. Both are in total agreement that there were unequivocally two fractures at the sites described. The reason for the confusion was because, as Dr Thornbury described, views and x-rays can vary depending on the angle of the body, and the angle of the x-ray. So far as the Belfast film was concerned, it did not show the ulna fracture because it was a very small subtle fracture and difficult to see. Any minor variation of the x-ray could have made it invisible. Similarly so far as the tibial fracture is concerned, a change in angle due to the position of the body of the x-ray would have rendered it difficult to spot as well. I am satisfied that there is a good explanation for the initial difference in view on these x-rays and I am now convinced that both parties are satisfied that the two fractures were present.

Non-accidental injury

(1) Dr Thornbury was of the view that the fracture of the right tibia at the bottom of the bone was a classic example of a non-accidental injury. She considered that such a fracture is associated with non-accidental injury and not with clumsy handling. There needs to be a twisting or torsional force. In her opinion it is beyond what could be caused by normal or clumsy handling of a baby and a violent force was required to cause it. She indicated that if a bystander witnessed what was happening that bystander would understand that harm was being done to a child and would attempt to interfere. Mr

Paterson said that such a fracture in his opinion was associated with violence in the form of rotational, twisting or angular stress to the area around the joint. Ligaments might pull bone away in a child with open growth plates as would be the situation with this child. He also did not believe that this was caused by clumsy handling such as putting a baby into a baby grow. He concluded it was more difficult to fracture this bone in a child than in an adult because a child's bone is more pliable. He could not think of any explanation consistent with the injury being accidental because of the degree of force required to cause such a fracture. In the case of a child only six months old, he could not think of an act which would generate these forces on the basis of clumsy handling or negligence albeit in cross-examination he conceded that there was remote possibility that the fractures were caused by clumsy handling. However this was no more than a 10% chance. Such fractures are almost always associated with non-accidental injury. Moreover he had never in his career come across two fractures at different times caused by clumsy handling.

(2) So far as the fracture of the right ulna was concerned it was Dr Thornbury's evidence that this again was a fracture specific to non-accidental injury and in her opinion could not be caused by clumsy handling. Classically it was caused by twisting or tortional force eg. roughly lifted by a limb or shaken. A violent act of this kind would be evident to a bystander. The baby would have screamed, been irritable for a period and tender over the region for several days. Mr Paterson expressed similar views to those I have already outlined in relation to the tibia in terms of cause. In short he again said he could not think of an explanation consistent with the injury being accidental although he conceded the remote possibility that it was caused by clumsy handling. Clearly the risk of both fractures being caused by clumsy handling became even more remote in combination and, as earlier indicated, he had never come across two fractures at different times by clumsy handling.

<u>The age of the fractures</u>

(3) Both doctors considered that the fracture of the ulna was more recent than the fracture of the tibia. They were both satisfied the fractures had not occurred at the same time. Mr Paterson conceded that he was not an expert in dating fractures and would defer to a radiologist. In his opinion the ulna had occurred a few days from C's death. He was prepared to say up to five days before death as there was no sign of healing, sharp edges or blunting. In his opinion the fracture of the tibia was a few days older being 7-14 days old given the appearance of the periostial area which was quite marked indicating that some healing had commenced. Dr Thornbury considered that the injury to the tibia had occurred 10-14 days before death because the healing that was evident was not only consistent with that length of time but no healing would have taken place if it had occurred after death.

So far as the fracture to the ulna is concerned she could not say if it occurred before or after death. There was no visible healing on the ulna. She did find the ulna lesion difficult to date. However given the lack of healing on the ulna and the presence of healing on the tibia, it was probable in her view that the fractures had occurred on separate occasions. While she could not tell whether the fracture to the ulna had occurred before or after death, she had never seen in her experience a fractured ulna arising out of something that occurred after death in a child of this age.

Signs of distress

(4) Dr Thornbury indicated that so far as the right tibia is concerned, the effect on the child would have been that C would have screamed and been irritable for 1 to 2 days. Over the ensuing 5-7 days C would have been tender over the region during dressing or handling. The witness stated that she would have expected a reasonably careful mother to have been aware that that region was causing a problem over the ensuing 5-7 days subsequent to the fracture. So far as the fracture to the ulna was concerned, she recorded that the baby would have screamed at the time, have been irritable for a period and tender over the region for several days. Again in her opinion a competent carer who had not witnessed the fracture, would have noted that the child was unusually irritable and pulling her arm away when being dressed. Although there would be nothing visible of either fracture with no visual clue, the main clue to the fracture would have been the pain response when handled eg. when bathing, putting the child's hand or leg into a baby grow, putting on socks or boots etc. Mr Paterson broadly adopted the same approach. He said that in the aftermath of the fractures any attempt to move the areas of fracture would have caused discomfort, the child would have moved away and any pressure over the wrist or ankle would have caused a similar reaction. He also mentioned that the putting on of a babygrow or shoes which would have involved moving the limb would have caused obvious discomfort. He also would have expected a competent carer to be alert to these signs.

Bruising to the left foot

(5) The standard of note taking concerning the bruising referred to in the post mortem report was so poor that Mr Paterson was unable to make any definitive statement about the presence or cause. I have therefore not taken that into account in any respect in this case.

Photographs of C over the period of Christmas 2001

(6) A number of photographs taken of the child on Christmas Day (Exhibit P1) were introduced in evidence. They seemed to show the child happy and smiling. Mr Paterson however indicated that whilst the child did

not appear to be in distress, it was unlikely that the child was weight bearing in any of the photographs.

(7) It was Mr Paterson's view that in light of the fact that these two injuries had gone unnoticed he entertained serious doubts about the ability of those in charge of the child to be able to care in the future for a child.

Dr Thornton

[9] This witness was a Consultant Paediatric Radiologist from the Children's Hospital at the Royal Victoria Hospital Belfast. In the course of four documents namely a post-mortem dated 2nd January 2004, an autopsy which was a neuropathological report, two reports drafted by her on 17 May 2006 and 23 June 2006, her examination-in-chief and her cross-examination, the following matters emerged:

(1) C had died on 2 January 2004. The child had been brought to the Accident and Emergency Hospital in Causeway Hospital Coleraine and had been declared dead at 10.10am. On 2 January 2004 C was then brought to the Royal Victoria Hospital from Causeway by the undertakers.

(2) This witness had carried out a post-mortem. In the course of her findings she referred to iron in the air spaces in the lungs which were observed by microscope. She indicated that iron deposits of this kind take place at least 5-7 days after bleeding in the lung area and perhaps even considerably longer. She had attempted to discount any natural causes and whilst the usual natural causes had been excluded, she could not exclude every possibility of a natural cause. In terms she could not be specific where the blood had come from. Usually such conditions derive from for example a hand being held over the mouth of the child but in this case she could not exclude the possibility of a natural cause. Having read her reports I raised the matter with Mr Toner QC on behalf of the Trust before the commencement of her evidence and he conceded that given the standard of proof required, the Trust was not making the case that there had been a non accidental injury to C leading to the iron deposits found. The conclusion of Dr Thornton was that this was an unexplained death.

(3) This witness readily conceded that she was not a radiologist and had not observed the fractures herself with the use of the microscope. She indicated that she can pick up through observation obvious matters such as fractures of ribs but not fractures of this type. The body from Causeway Hospital had not been accompanied by the skeletal x-rays and she therefore arranged for x-rays to be taken in Belfast on 2 January 2004 prior to her post-mortem. These were taken by Dr Thornbury, a previous witness, and she relied on her in this regard.

(4) Cross-examined by Ms McGrenera QC on behalf of F about the possibility of the fracture to the ulna having occurred after death (Dr Thornbury had indicated she was unable to say whether the fracture had occurred before or after death), Dr Thornton indicated that she could not envisage the normal resuscitation steps leading to such fractures. She had seen ribs fractured, commonly due to resuscitation but never a fracture to the right wrist or leg. The limbs had to be twisted very vigorously in opinion to sustain such a fracture and it simply would not occur during transport from one hospital to another or in resuscitation.

[10] Dominic Drumm and Darlene Lyons

(1) The former is a Social Worker with the Trust. He became involved in this case in 2005 and was engaged in a programme of work commissioned by the Trust for the purposes of assessing F and O's practical abilities to parent J and to explore with F what meaning C and J had for them. Essentially therefore his work covered the period between July 2005 and the present date. The latter witness, Ms Lyons, was also a Social Worker with the Trust. Her role was to illustrate to the court how past and current concerns in relation to J should satisfy the threshold criteria. She outlined the circumstances that lead to social services intervention together with the related risk that it is alleged constitutes the potential for significant harm should a care order not be made. The two witnesses complemented each other in terms of their evidence. It is therefore possible for me to summarise and conflate the gravamen of their reports and their evidence before me by outlining the following salient matters that emerged:

(i) I preface my remarks by indicating that I harbour grave concerns about the manner in which this Trust conducted the approach to this family both prior to the death of C and thereafter. Mr Toner QC in his closing submissions cautioned the court that the PSNI have re-investigated the matter of C's death following the confirmation that they were non-accidental injuries and are currently gathering witness statements for the Coroner's Court. Trust staff have been interviewed and others remain to be interviewed. Moreover in late 2005 the Senior Management Team in Children's Services have referred this case and the death of C to the Area Child Protection Committee to be considered for case management review and that review is also being currently conducted. Finally the Social Services Inspectorate of the Department of Health has through the period 2005/2006 been conducting a large scale audit of child protection services throughout Northern Ireland. Several Trusts including this Trust have been closely monitored and inspected. As a result significant changes in management structure and personnel within the child care programme of this Trust have been introduced and it is anticipated that a formal report in respect of these changes will be published. I am anxious that nothing that I say should interfere with the hearing of this matter before the Coroner's Court

particularly since the PSNI are still gathering witness statements. Nonetheless I consider myself duty bound to outline as a background to these two witnesses the concerns which have gathered momentum in my mind during the course of the evidence before me and in particular that of these witnesses;

(ii) This family had been referred to Social Services as early as January 2001. A referral was received from the family's GP requesting support for the family as F was thought to be sniffing substances and was running away from home. The child was 13 years at this stage. It was suggested that O did not respond to correspondence from Social Services at this stage although her evidence, if she had been called, was to the effect that correspondence may not have been received. In any event no further action was taken by the Trust.

(iii) In April 2001 F was attending the Child and Adolescent Mental Health Service who were very concerned that she was sexually active and had a negative pregnancy test at the age of 12. She was no longer attending school at this stage and was receiving home tuition whilst a more appropriate educational placement was sought.

(iv) In December 2001 O contacted Social Services regarding support in regard to the behaviour of F. She was getting into trouble at school and O spoke of being worried that she would harm her daughter as a response to her negative behaviour. A referral was made to the Education and Welfare Department at that stage.

(v) Nothing else seems to have happened until June 2003 but it became known that F was having a relationship with W and subsequently became pregnant with C who was born on 19 June 2003. An underage pregnancy report was completed by Betty Christie (Social Worker Intake and Assessment Team) which concluded that F had adequate support from her mother. Although there were healthcare visits and midwife services provided, there was no further social services input for this child despite the clear moral danger to which she had been exposed.

(vi) By October 2003 F had enrolled in school but was presenting at the Psychiatric Services with low mood and hallucinations of a man in black, whom she believed was going to harm C. In November 2003 she was seen by Dr McCartney and presented with low mood and irritability. F had decided not to continue attending the school and had requested home tuition. Although she was referred to the Children's Disability Team, subsequent offers of related services were refused by F. In cross-examination Ms Lyons indicated that she could not discern at this stage if anyone from Social Services had communicated with the family although the health visiting records apparently reveal nothing of concern.

I consider that the lack of Social Service input during these months is something that does require careful investigation at an appropriate level.

(vii) In January 2004 C died. Geraldine Cunning (Community Nurse Learning Disability Team) visited F following C's death and offered support. This service has continued. The health visitor also visited on several occasions and offered bereavement counselling. In February 2004 F was exhibiting disturbing behaviour and running away from home. She was referred to the Intake and Assessment Team in the Childcare Office by the PSNI because she was running away from home.

(viii) In August 2004 a professionals meeting was held regarding F and she was subsequently referred to the Children's Learning Disability Team who were recommended to complete relevant risk assessments.

(ix) On 17 September 2004 an initial Child Protection case conference was held with reference to F. It identified a number of risk factors including that she was at times beyond parental control, that she had no insight into her responsibilities and consequences, that she had an IQ of 55 (an unaccurate assessment at that time) that she had been engaging in high risk activities and had low moods and suicidal thoughts. A number of recommendations were made in order to minimise the risks for F including the appointment of two social workers to liaise with her to complete work around self protection. The social worker for that meeting had recorded that O had contacted the Children's Disability Team in August 2004 and O had admitted to physically hitting and kicking F. As later emerged it is clear that both F and O were less than frank with the social services about the nature of the physical violence that had been going on in the household involving W, F and O both prior to the child's death and subsequently. It was the evidence of both of these social workers that they only became aware of other incidents of violence in the home in September 2005.

(x) Ms Lyons admitted that having read the police interviews with F of 8 February 2005, only then did she become aware that W had been staying overnight in the family home with her up to four nights per week. I observe at this stage that I found this an extraordinary state of affairs given the knowledge of this Trust about this girl's sexual activities in the past and the regular visits being made by health visitors and midwifery services that had been going on. Ms Lyons went on to say that in the pre-birth assessment which was made when it discovered that F was now pregnant with J, it was confirmed that W had stayed overnight. Although it was a three bedroom house she became aware that both children were sexually active. Ms Lyons indicated that she understood W's parents had been agreeable to this. O had expressed the view that F would do what she wanted and it was better to allow it to occur in her household where she could keep an eye on it. O had

not spoken about the risk of F becoming pregnant again. It is interesting to note that the records of social services made at this time ie April/June O5, made no reference whatsoever to this being a criminal offence, a consideration which I would have thought the social services ought to have been taking into account very seriously.

(xi) Ms Lyons then carried out a pre-birth assessment which was dated 3 October 2005 although it was completed on 26 June 2005. This matter was discussed at a Child Protection Conference on 29 June 2005. At that conference it was unanimously agreed that the baby's name should be placed on the Child Protection Register at birth under the category of "potential physical abuse". The case conference members agreed that the baby should go home with O and F on condition that a stringent monitoring regime was in place and that the necessary assessments were undertaken and completed. Due to the unexplained injuries of C, it was unanimously agreed that the decision from the last case conference to place the baby's name on the Child Protection Register should remain. Ms Lyons went on to record that professionals were visiting the house every day of the week except Sunday and that a midwife would visit on Saturday. A series of assessments were planned to ensure that the interim plan would remain as they had decided. The witness gave evidence that at this stage there was a high level of cooperation from the family, apparently they were being honest with the Trust (although this later turned out to be incorrect), and F presented as properly able to provide a suitable home environment. The Trust did have concerns which included the non accidental injuries identified at the post-mortem to C, the fact that two children aged 15 years of age had been allowed to live and sleep together in that household and that F had a disability with an IQ of 55.

(xii) I pause to observe that I find this approach to be very difficult to explain. Whatever else this Trust did not know, it was aware that this girl had allegedly been engaged in sexual activities since the age of 12, that she had become pregnant at 14, that the father of the child was 15, that C had died when F was 16 in circumstances which were highly questionable and where the cause of death was unexplained. Moreover the child became pregnant again at the age of 17 in 2004 in circumstances where the father was unknown, it being suggested that she had had sexual intercourse with four different males. O had permitted W and F to openly engage in sexual activities in the household despite the fact that they were both children. The decision to leave J in the household at this stage with F and O where at the very least there was no social work supervision at all over the weekend (other than the visit of a midwife) is a risk assessment process which requires to be revisited.

(xiii) This background has to be coupled with the patently poor procedures which had been adopted in the wake of C's death. A report from Dr Barson, Pathologist of 22 March 2006 summarises the position well:

> "At the time of C's post-mortem examination it was known that she had a recently fractured leg and a history of a possible non accidental injury to her feet. Preliminary gross examination of the body had not revealed a cause of death. At an early stage after C's death it should have been obvious that detailed questioning of relatives was going to be important. In these circumstances I find it extraordinary that the examination of the brain was not completed until 18 May 2004, the pathologist's report was not signed out until 9 November 2004, police interviews were conducted between 8 February 2005 and 15 February 2005 and a statement from W was not signed until 25 March 2005. Information about the circumstances of C's death was therefore still being gathered 14 months after death. My impression from the transcripts of the police interviews is that the memories of witnesses were being taxed by this delay. Moreover bearing in mind that C's fractured leg could not be the cause of death, I am surprised that more questions were not directed to elucidating the pathologist's suspicion that C had been repeatedly suffocated. If there was a suspicion that C was being suffocated it was crucial to establish who was witness to the unexplained episodes of distress. In particular it is important to know not just who saw C in a state of distress, but who was present immediately before or at the onset of these episodes."

I find the delay outlined by Dr Barson to be inexplicable and I trust that the investigations into this matter will encompass his concerns.

(xiv) The Trust were well aware, as evidenced by the professional meeting of 9 August 2004 in relation to C, of a great number of these concerns even though they did not yet have the report from Dr Barson. At the professionals' planning meeting of 4 April 2005 the concerns about the circumstances leading up to C's death and the injuries were raised. Dr Walsh, Consultant Paediatrician, had actually questioned as to whether or not the baby had been murdered. The chairperson of that meeting also raised similar worries.

(2) It came as no surprise to me whatsoever in the course of this case to discover that very soon after her appointment on 18 August 2005 the guardian wrote specifically to the Trust Social Services outlining her concern

about the circumstances of this case and the factors that were being considered in the current risk assessment. This guardian followed this up on 10 November 2005 with a further letter to the Trust repeating her ongoing concerns about J's placement. She specifically drew attention to the publication of the Department of Health, Social Services and Public Safety in May 2003 of "Cooperating to Safeguard Children" which laid down guidelines for case management reviews. In the context of these Trust witnesses, it is important that I quote precisely from this case management review document:

> "Introduction
>
> 10.1 When a child dies, and abuse or neglect are known or suspected to be a factor in the death, HSS Trusts need to take steps to ensure that all other children who may be at risk of harm are safeguarded eg other children of an alleged perpetrator or other children in an institution where abuse is alleged. This should be done in accordance with ACPC procedures.
>
> 10.2 The Trust must immediately inform the Director of Social Services in the HSS Board and the chair of the ACPC who in turn will inform the Department.
>
> 10.3 Any agency, professional or the Department/SSI may refer a case to the chair of the ACPC if it is believed that there are important lessons for interagency working to be learned from a particular case.
>
> 10.4 It is important that Case Management Reviews are completed as soon as is practicable and that each agency involved with a case gives the review process the priority it deserves.
>
> When should an ACPC undertake a case management review?
>
> 10.5 An ACPC should always undertake a Case Management Review when:
>
> - A child dies, including death by suicide and abuse or neglect is known or suspected to be a factor in the child's death."

(3) The delay in invoking this procedure on the part of this Trust is a matter that requires explanation. Ms Lyons was unable to provide any answer as to why this delay had occurred and Mr Drumm similarly gave no explanation. In the closing submissions on behalf of the Trust by counsel, the following appears at paragraph 6:

> "The Trust does not seek to deflect legitimate criticism and recognises that practice in relation to events surrounding the assessment and support of the respondents during 2003 requires further examination. In late 2005 the Senior Management Team in Children's Services referred the matter of C to the Area Child Protection Committee to be considered for Case Management Review which is currently being conducted by that organisation."

(4) I have no doubt, that irrespective of the outcome of that inquiry explanations must be sought from the appropriate personnel as to the cause of this prima facie unconscionable delay in triggering a review in a matter as serious as this.

(5) Mr Drumm has led a Family Centre Review of O and F between July 2005 up to March 2006. A Specific Issues Looked After Children Review was held in September 2005 and again on 14 November 2005. O and F had attended all sessions with him. Both had engaged well and shown motivation and commitment to the assessment programme. The work was to assess F and O's practical abilities to parent J, explore with F and O what meaning C and J had for them, to assess F and O's emotional responses to J's needs and to assess F and O's ability to care and protect J. Information emerged however which revealed that the degree of domestic violence had been greater than had hitherto been admitted. In particular the Trust now became aware that:

(a) O's violence to W was not an isolated incident as had hitherto been thought but that there were two incidents when O was violent towards F.

(b) The Trust were unable to understand why O was unaware that domestic violence existed in W and F's relationship with a frequency of incidents. In a session on 11 November 2005 F indicated that she had been slapped and punched by W on a regular basis. She said she had kept this domestic violence from her mother with the exception of the incident when W had thrown a bottle at her. Given the closeness of the relationship between O and F, the Trust found this difficult to accept.

(c) Notwithstanding the level of violence that F was subjected to by W, O still described him as a likeable person who was generally good to C. It appeared to the Trust that neither F nor O could make the connection between the violence and the impact on C's safety and developmental needs.

(d) The Trust was worried that O and F did not recognise any distress in C given that the child had sustained a bucket handle fracture.

(e) O indicated that one slap could be acceptable and this not only questioned her attitude to violence but it could introduce an element of premeditation in her impulsive behaviour. The Trust was now concerned that the information about the domestic violence had not been provided in the early stages of the assessment and only emerged when F and O were pressed on the subject. Given the background injuries to C which were as yet unexplained, the Trust now felt they had to be sure that there was openness and transparency in their exchanges with F and O. At this stage of course the Trust were only aware of one fracture to C. I am bound to note however that I found it another inexplicable aspect of the Trust approach to the matter that the report of Mr Drumm on these matters of November 2005 failed to highlight the importance of the sexual impropriety that had operated in this household prior to the death of C or the general lack of parental control exercised by O over F.

(6) Referring to the LAC Review of 14 November 2005, it was clear that the new revelations of domestic violence now played an important part. Ms Lyons commented that until an assessment of F as sole carer of J was complete, and O's violent past considered, the Trust could not sustain J at home. Whilst it was felt that the preferred option would be for a mother and baby unit, no places were available at that stage and the suggestion was made that J be placed in foster care. A decision was taken that the Trust wished to change the care plan of J to note that J would go to a foster care placement until a mother and baby placement could be found.

(7) There was a further LAC on 6 December 2005 where the Trust indicated that whilst they were not ruling out a mother and baby placement, they had to be cautious. The outcome of the assessments was stressed.

(8) A further LAC was held on 15 December 2005 arising out of an incident when F had been involved in minding two children and had left them alone which gave cause for concern to professional staff involved. At a LAC on 23 February 2006, Ms Lyons advised that a referral had been made for a PACT assessment and that F and J were on the waiting list for admission. The witness said in evidence that this was done solely as a precaution to ensure the Trust was prepared for all possibilities which might arise out of the assessments.

(9) Ms Lyons concluded her evidence by indicating that at this stage the Trust was aware that Dr Galbraith had mentioned the possibility of a number of sessions for F and O to consider whether or not their position could be moved forward. The witness indicated that this would be considered in the case planning process in the future.

Apart from the admission of the police interviews to which I have already referred, this completed the Trust case.

[11] **The Respondent F**

This witness was only 19 years of age and gave evidence before me. F insisted that she and C had been close and that she had never done anything to harm the child. She indicated that W had been violent towards her personally and that she knew this was wrong. The relationship with him had ended shortly after the death of C. She was adamant that if anyone struck her again she would go to the police. F insisted she knew nothing about the fractures to C's right wrist or leg and said that she found it hard to accept the evidence of the medical witnesses. I was shown photographs of the child C over the Christmas period prior to her death which she suggested indicated the child was in no pain. F was clear that she and her mother had a close relationship and that she wished her mother and herself to look after J if there was a return home . She expressed regrets about the past but emphasised that all she wanted now was a residential assessment in order to get J back. The witness recognised that work needed to be done with both her and her mother. She was adamant however that she never saw C in distress or upset at any time.

It was very clear that this young woman laboured under a learning disability and I recognised fully that her evidence could at best touch perfunctorily on the key issues in this case. Responsibly neither Mr Toner QC on behalf of the Trust nor Mr O'Hara QC on behalf of the Guardian ad Litem cross-examined her.

The second respondent O did not give evidence.

[12] **The Guardian ad Litem Teresa Fallon**

Ms Fallon had made two reports in this matter on 24 October 2005 and 23 May 2006 respectively. In addition she had written the letters to the Trust to which I have already adverted at page 18 of this judgment. In the course of her reports, her evidence in chief and her cross-examination, the following matter emerged:

(1) The guardian said she became concerned at a very early stage after her appointment about the path that this case was taking. She indicated that it was unusual in her experience for her to bring questions about the interim care plan to the court's attention at such an early stage. In particular she questioned the relationship between F and O, especially as the Trust had advised her that if O was not living with F, they would not have placed J there. In her view there was uncertainty as to O's ability to exercise authority and give F advice and guidance together with F's capacity to behave consistently and accept advice and guidance. She was thus concerned about the interim care plan that J should be placed with O and F following his birth in light of the various factors arising out of the death of C and the injuries leading up to the death. She considered that the decision had been made without a proper assessment of the impact of F's learning disability upon her capacity to provide consistency of parenting as well as O's cognitive capacity and her understanding of F's learning disability. She did not consider that the current level of assessment/monitoring was intensive and the Trust appeared to have placed the majority of responsibility for the baby's care with F and O. As early as October 2005 therefore the guardian was indicating she could not be satisfied that this child's safety was guaranteed in that placement. She continued to raise her concerns with the Trust including a letter of 10 November 2005 when she drew attention to the document "Co-operating to Safeguard Children" and the need for a case management review. The witness wrote again on 6 December 2005 to the Trust repeating her concerns about the proposal that J be placed on an interim basis in a foster placement with F in the absence of an assessment to the risk to a child being parented by F which would include an assessment of her level of cognitive/social functioning and her capacity to provide long term care throughout the child's life. She drew attention also to the absence of outstanding assessments in respect of O particularly as C was in the joint care of F and O at the time of death. That letter concluded:

> "I am also concerned that Trust documentation before the court highlights concerns about F's ability to care for herself independently or to provide independent care for a child which lead to the initial Trust decision to place J with the mother and grandmother. The eventual role of O in such a mother and baby placement is unclear and I am aware of recent Trust worries about O's level of co-operation. I was keen to bring my own concerns to your attention as it seemed there was some disparity between my own view and the Trust's view on those matters which are at the core of the case."

(2) The guardian made the point that the reports of Mr Patterson and Drs Thornbury and Galbraith all seemed to confirm her concerns. Similarly the

report of Dr Bentovim reinforced her views. Dr Bentovim had indicated that in his opinion there was limited awareness by O and F that there is a need for J to be protected as a result of conflict between them or that there are a number of factors which make the situation inherently unstable eg F's functioning, the difficulty O has in managing F, and the degree of closeness between F, O and the extended family and the fact that as a family they are both prone to conflict. It was his view that O struggled in a relationship where she always wanted to please F and was fearful of the consequences of any disagreements or fallouts. Both Dr Galbraith and Dr Bentovim had described F as vulnerable. This vulnerability was increased by her not being amenable to advice, guidance and boundary setting which in turn increased the vulnerability of a child in her care.

(3) In her second report of 23 May 2006, the guardian repeated her reliance on those reports and considered that if J were to be returned to the care of F and O, the inability of O to assert herself as a responsible adult would continue to place J at risk of significant harm. She set out a detailed analysis of the respects in which she considered the threshold criteria had been satisfied not only because she considered that in the care of F, J would be at risk of significant harm because of the impact of the quality of care giving he would receive but also because in the care of O, J would similarly be at risk for the reasons she therein set out.

(4) In cross-examination the witness accepted that whilst in the care of F, C had been taken to hospital regularly for various immunisations, and that within limits it was a question to be considered as to whether the Trust had failed with regard to F's own needs. Much depended upon the amenities at their disposal. However it is right to say that the Trust had invoked the assistance of disability services, the children's learning disability team, the childcare team to deal with underage pregnancy and mental health experts. At least three teams were involved at any one time during parts of the period under consideration. She recognised that Mr Drumm and Ms Lyons had been regularly in the house weekly for long periods and found that the relationship between J and F was a warm one. On the other hand she did point out that Dr Bentovim thought that J had developed an avoidant attachment. The guardian's own observations at contact were that whilst F did feed and change J, the child approached her, the guardian, and gave affection to her as well. However the guardian did acknowledge that F clearly loves to see J but asserted that her experience was the same as that of Dr Bentovim.

(5) It was therefore the guardian's view, unequivocally stated, that there was ample evidence in this case to justify the court coming to a conclusion that the threshold criteria had been met. I found the guardian to be extremely impressive and insightful. Her concerns in my view were well-founded and I am satisfied that they played an appropriate role in galvanising the Trust to reassess the issues in this case.

[13] **Conclusions**

A. Legal principles

(1) I have come to the conclusion that the threshold criteria have been established within the ambit of Article 50(2) of the 1995 Order in this case. In order for the threshold conditions for the making of a care order to be satisfied on evidence or material in respect of a child who had suffered significant harm, (in this case C), it is not necessary to identify a particular individual as being responsible for the harm. It is sufficient that the harm was attributable to an absence of proper care being given to the child (see Lancashire County Council and Another v B (a child) and Same v W (a child) TLR 21 September 1999.However the focus must be the subject of the application ,namely J.The fact that another child-C- in the same household has been mistreated is not the deciding factor although it may be relevant in considering whether there is a likelihood of harm to the child under consideration .I have been careful to adhere to this principle in this case in considering the relevance of the injuries to C .

(2) It is for the applicant Trust in this case to establish all the preconditions and other facts entitling it to the order sought. This was reaffirmed by Lord Nichols in Re H and R (child sex abuse: standard of proof) [1996] 1 FLR 80 ("Re H and R") at p. 95E where 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 condition 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 1995 Order are in identical terms.

(3) Lord Nicholls of Birkenhead, dealing with the standard of proof in Re H and R stated the following at pages 95H – 97C:

"The Standard of Proof

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. ….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. …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 underage 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 in 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."

(4) Lord Nicholls made it 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 fact." 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; …… 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.

(5) I recognise that the threshold set out by Article 50(2) and (3) is a jurisdictional gateway which provides protection to individuals, both adults and children and thus to families from interference in their lives by public authorities through the making of public law orders. I am satisfied that this accords with the essential object of Article 8 of the European Convention of Human Rights and Fundamental Freedoms in the protection of the individual against arbitrary interference by public authorities. I recognise that the connection between the cause of harm or likelihood of harm on the one hand and the care or likely care given need not be a direct cause and effect, and that a contributory casual connection will do. The care given or likely to be given must fall below an objectively acceptable level. That care is the care a reasonable parent would provide for the child concerned.

(6) I have had the benefit of a number of experts in this case whose evidence I have already set out in some detail. I am satisfied that their evidence was relevant to the threshold issues.

B. Factual Conclusions

Adopting the approach set out in these principles, I have determined that the threshold criteria as contained in Article 50(2) of 1995 Order are satisfied by reason of the following facts:

(i) I am satisfied that C suffered two fractures which were inflicted at different times prior to death. I accept the submission of the Trust that there is no legitimate or innocent explanation for either of these such as clumsy handling. I am satisfied on the basis of the evidence given by Drs Patterson Thornbury and Thorton that the initial confusion over the x-rays should not deflect me from accepting the gravamen of their evidence. I am therefore satisfied that both fractures occurred at different times and that in each instance the fracture would have been sufficient to cause the child to scream, to be irritable for a period of days and thereafter tender for several days.

(ii) I am satisfied that an attentive parent or carer would have noticed the upset and distress which followed upon such fractures especially when the child was being changed, nursed, bathed, cleaned, lifted or carried. At the conclusion of this case Ms McGrenera, on behalf of the first and second respondents drew my attention to an article entitled "Avoidable Pitfalls When Writing Medical Reports for Court Proceedings in Cases of Suspected Child Abuse" by Professor T. David ("the article"). I adjourned this case to permit Ms McGrenera to consider calling Professor David or any further evidence in this matter. Having adjourned this matter for some weeks to permit this, counsel then informed me that no further evidence was to be called. In the meantime I allowed written responses to the article by Mr Patterson, Dr Thornbury and Dr Thornton. Mr Patterson made it clear that he did not wish to revise his original position in light of the article and indeed in an additional medical report on 14 November 2006 asserted that a reasonable carer should have been aware that something was amiss during the first 7 to 10 days. Dr Thornbury similarly did not wish to revise her earlier position. She was of the view that the type of tibual fracture sustained by C placed this fracture outside the group referred to by Professor David in his article. Accordingly I am persuaded that the position remains that in my view F and O, had they been appropriately attentive in their parental duties, would have noticed the upset and distress occasioned to this child. I make no finding that they inflicted these injuries – I simply do not know who was the perpetrator – but they had a great deal of contact with this child and I do not accept that they were unaware of the pain and irritation that this child must have suffered. Notwithstanding this they chose not to refer the child to an appropriate GP or health visitor. Given therefore that this child was subjected to non-accidental injury,

there was at very least a failure on the part of both F and O to protect C or to provide care for her by getting treatment at an appropriate stage. That finding persuades me that J, if returned to the care of the respondents, would be likely to suffer significant harm. This child would not be afforded appropriate care or protection.Whilst therefore I am conscious of the principle that the focus of this case must be on J and not C, nonetheless I am satisfied that the lack of care exhibited to C by F and O is highly relevant in considering the likelihood of harm to J in the future.

(iii) I am also persuaded to the requisite level that the guardian is right in concluding that in the care of F, J would be at risk of significant harm because of the impact upon the quality of care giving the child would receive as a consequence of the cumulative effect upon her capacity to parent of the family for the following reasons adumbrated by the guardian.

(a) Her level of cognitive functioning and the impact upon this of her understanding of the needs of the child (I emphasise however as I have said earlier in this judgment that that alone would not be sufficient to prevent her being an appropriately caring parent.)

(b) Her own vulnerability to exploitation as an adult.

(c) Her history of engaging in reckless behaviour within the community.

(d) Her inability to assess risk to herself or others.

(e) Her inability to provide safe, consistent and attuned care giving.

(f) Her lack of understanding of the impact upon a child of anger and conflict.

(g) Her mental health vulnerability.

(h) Her inability to prioritise the needs of a child over her own issues.

(i) The nature of the conflict between herself and her mother and the risk to an infant of the care giving environment this would create.

(j) The volatile and uncertain relationship between F and O.

(iv) Similarly I am satisfied that the guardian is correct in asserting that the child would be at risk of significant harm even if O and F were jointly conducting the care giving because of the frailties of O in the following respects:

(a) O's inability to provide a safe and nurturing care giving environment where the needs of an infant are prioritised over the pattern of placating her daughter.

(b) O's inability to assert herself as a responsible adult or acknowledge conflict within the home.

(c) O's inability to act assertively, be in control and protect a child in her care.

(d) O's capacity to assess risk to a child in her care. The very fact that she allowed W and F, mere children, to openly engage in sexual relationships in the family home is a clear instance of this.

(e) O's understanding as to the impact upon J of F's limitations on her capacity to assume primary responsibility for the child's care.

(f) O's inability to set appropriate boundaries for the behaviour of young people in her care and act authoritatively in respect of such boundaries.

(g) O's own capacity to be taken advantage of by others. I believe that she allowed herself taken advantage of by both F and W.

Whilst I have laid criticism at the door of the Trust for the delay that has been occasioned in this matter, I am satisfied that such delay has not deprived either of these respondents of the opportunity of putting their case before this court or of clearing their name in respect of the injuries to C. I have made no finding that they were the perpetrators but I am satisfied that there is plenty of evidence, none of which has been tainted by delay, to justify the conclusions that I have arrived at. I have taken into account the statements of MMcD a friend of the family whose statement to the PSNI has been drawn to my attention by the first and second named respondents counsel. Sadly that does not dissuade me from the notion that J is likely to suffer significant harm given the factual findings that I have made. Similarly, whilst I do consider that the Trust has been spurred into action by the commendable concerns of the guardian, nonetheless I am satisfied that the role of domestic violence was a wholly appropriate consideration for the Trust also to take into account and which played a significant factor in their decision to take this child into care albeit somewhat belatedly.