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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

OFFICE OF CARE AND PROTECTION

IN THE MATTER OF C, a Child (Care Proceedings)

AND IN THE MATTER OF an Application by a Health and Social Care Trust under Article 50 of the Children (NI) Order 1995

McCLOSKEY J

Anonymity

The relevant Trust, both parents and the child concerned are anonymised throughout this judgment. Nothing should be published concerning either this judgment or the proceedings to which it relates which could identify, directly or indirectly, any of the parties.

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I INTRODUCTION

[1] This is an application by a Northern Ireland Health and Social Care Trust ("*the Trust*") for a care order pursuant to Article 50 of the Children (NI) Order 1995 ("*the 1995 Order*"). The hearing which I have conducted is a combined one, being concerned with issues of fact finding, threshold criteria, welfare and disposal. The protagonists are:

(a) The child concerned ("C"), who was born in August 2008 and is now, therefore, aged two-and-a-half years.

(b) "M", who is now aged 25, the mother of C.

(c) "F", who is now aged twenty-four, the father of C.

(d) The aforementioned Trust.

In circumstances where there exists an interim care order in its favour, the Trust now seeks a care order as a prelude to C being adopted, coupled with the court's approval of its extant care plan in respect of C. Whereas M opposes the Trust's application, F has the more limited aspiration of securing parental contact with C and neither consents nor objects to the Trust's application.

[2] I was informed by the parties that the hearing which I conducted materialised following an appeal to the Court of Appeal and an order for a rehearing. It became apparent, as this fresh hearing progressed, that the evidence now amassed, both factual and expert, has grown exponentially. I would also highlight that the sixteen bundles of evidence prepared for the purpose of this rehearing included a transcript of the original hearing, consisting of almost four hundred pages. There was agreement amongst the parties that this transcript should form part of the evidence to be considered by the court and, in the course of the hearing, some of the parties placed specific reliance on certain of its contents. I should also record that whereas F gave evidence at the first hearing, he did not do so in the rehearing. While he was in attendance during the first couple of days, the court was informed that he was not communicating with his solicitors during the latter stages of the hearing.

[3] In brief compass, it is common case that C was the victim of significant non-accidental injuries during the first two months of her life. As a result, pursuant to an interim care order she has spent most of her two-and-a-half years existence in foster care, with both parents availing of some supervised contact. The admitted fact, nature, extent and frequency of C's non-accidental injuries provide the context within which this court must address, and determine, a range of issues. The decision making framework for the court is further shaped by the position adopted by each of the parents. In summary, both parents:

(a) concede that C's injuries were non-accidental.

(b) accept that they are the only possible perpetrators.

(c) deny inflicting any of the injuries.

(d) deny any knowledge of the circumstances in which the injuries occurred.

(e) assert that they were not alerted subsequently by anything to any relevant traumatic incident or accident.

(f) assert that they had no knowledge, or awareness, which would have required them to seek medical attention or treatment for C, other than on the documented occasions *in Scotland* when they did so.

Bearing in mind that F and M are the only possible perpetrators of C's injuries, the court's primary task is to determine who inflicted the injuries, if possible. In the abstract, there are three possible permutations:

(i) F inflicted all of the injuries.

(ii) M inflicted all of the injuries.

(iii) Both F and M inflicted the injuries, whether jointly or separately or both.

The court may also have to address the question of *parental awareness and knowledge*, particularly in the event of a determination that the injuries were inflicted by one parent exclusively. A finding of this latter kind will prompt consideration of the question of whether the non-perpetrating parent knew or should have become aware of either the precipitating incidents or their consequences.

II THE NON ACCIDENTAL INJURIES

[4] C was born in August 2008. It is agreed that between 11th September and 7th November 2008 (viz. during the first eleven weeks of her life) she suffered non-accidental injuries perpetrated by F or M or both. The parties are also in agreement about the nature of the non-accidental injuries and their vintage. These are as follows:

(a) A metaphyseal fracture of the distal right femur, suffered between 11th and 18th September 2008.

(b) A fracture of the left clavicle, suffered between 12th and 26th September 2008.

(c) A metaphyseal fracture of the right distal humerus suffered between 24th and 31st October 2008.

(d) A metaphyseal fracture of the distal left tibia, suffered between 25th October and 7th November 2008.

(e) A metaphyseal fracture of the left distal humerus, suffered between 28th and 31st October 2008.

(f) A "buckle" fracture of the first metatarsal bone of the left foot, suffered between 28th October and 7th November 2008.

(g) Bilateral subjunctival haemorrhages (bleeding in the whites of the eyes), with some documented symptoms in both Scotland and Northern Ireland.

(h) A periosteal reaction on the proximal and lateral aspects of the right tibia coupled with sub-periosteal bleeding (a non bony injury). There was some debate amongst the medical experts about whether this constituted a discrete injury. Insofar as it did so, there was no challenge to the opinion proffered by Dr. Blumenthal (*infra*) that it post-dated 22nd October 2008.

As the formulation of the list of non-accidental injuries demonstrates, there is, in respect of all of the fractures (viz. the first six injuries) an agreed estimate of the time period during which the individual injury was sustained. This estimate is accepted by all parties' medical experts and reflects a consensual assessment of probability, based particularly on the clinical and radiological information generated in the relevant Scottish and Northern Ireland hospitals.

III <u>CHRONOLOGY</u>

[5] The two most important periods which fall to be considered are:

(a) 25th August to 1st October 2008, during which F, M and C lived together as a family in Scotland, when C suffered the first two of the eight non-accidental injuries.

(b) 2nd October to 7th November 2008, during which they lived together as a family in Northern Ireland, when C suffered the remaining six of the non-accidental injuries.

It is agreed that no other person resided in the family home during either of these periods. Furthermore, there is no dispute amongst the parties about the following material dates and events:

(i) **August 2008**: C was born by Caesarean Section.

(ii) **29th August – 30th August 2008**: M's mother and stepfather visited the family home, briefly, an event characterised by tensions and fraught relations.

(iii) **2nd September 2008**: M was admitted to hospital, for treatment of her abdominal Caesarean Section wound, for twenty-four to forty-eight hours.

(iv) **5th September 2008**: A health visitor attended the family home, for the first time, weighed C and noted no concerns.

(v) **9th September 2008**: M telephoned the health visitor as she was concerned about C's sticky eye.

(vi) **15th September 2008**: The health visitor attended the family home again. It was recorded "*using Infacol for colic*" [Infacol being a non-prescription pharmaceutical medicament commonly used to treat symptoms of colic]. C's eye had settled and no concerns were noted. The family's plan to move to Northern Ireland was recorded.

(vii) **17th September 2008**: In the morning, M telephoned the health visitor, reporting that C had been crying all night. An immediate appointment with the general practitioner (Dr. "N") materialised and a referral to "Y" Hospital in Scotland was made. The history given was that C had been unsettled throughout the night, with F and M noticing "*increased secretions and swelling around the neck*". The documented diagnosis was "*feeding problems*".

(viii) **24th September 2008**: A further routine visit by the health visitor occurred. No concerns were noted. Later that day, both parents brought C to the "VI" Hospital in Scotland. C was examined between 16.46 and 17.40 hours. It was recorded:

> "*Dad collapsed whilst holding her. Fell to ground.*
> *No obvious injury. No sign head injury.*"

C was discharged accordingly.

(ix) **25th September 2008**: M brought C to the "RHSC" Hospital in Scotland. Admission occurred at 12.50 hours. The history given was

that F had fainted the previous day while holding C. It was reported that C was not moving her right leg, was in pain when the leg was moved and had a limp right leg. Radiological examination disclosed a fractured right femur and C was admitted for treatment by traction. On the same date, F attended a general medical practitioner, giving a history of having a "*blackout*" whilst holding his baby daughter and falling. The record also states "*... says has happened before never investigated ...*". No abnormality is recorded and F was advised to pursue further investigation with his new general practitioner in Northern Ireland.

(x) **1st October 2008**: F moved to Northern Ireland.

(xi) **2nd October 2008**: C was discharged from the RHSC Hospital. M and C were driven directly to the airport and flew to Northern Ireland, where F, M and C lived together as a family unit (until 7th November 2008), spending the first three nights in a local hotel.

(xii) **10th October 2008**: Each member of the family was registered at "M" Family Surgery, a local health centre in Northern Ireland.

(xiii) **20th October 2008**: A health visitor [Ms Connolly] was appointed and contacted the family by telephone.

(xiv) **21st October 2008**: M returned the phone call and a home visit was arranged.

(xv) **22nd October 2008**: The health visitor attended the family home. A family needs assessment was initiated. No concerns were noted.

(xvi) **24th October 2008**: There was an incident of domestic violence perpetrated by F against M.

(xvii) **28th October 2008**: All three family members attended "M" Family Surgery, where C received two immunisation injections, in her left and right thighs. It was noted by Dr. "D" (C's general practitioner) that M had facial injuries, while C had a bloodshot eye.

(xix) **3rd November 2008**: The health visitor left a message by telephone.

(xx) **4th November 2008**: M telephoned the health visitor twice, regarding the issue of C's eye, which she felt was improving.

(xxi) **5th November 2008**: F visited his doctor at the M Family Surgery (Dr. "P") and reported the alleged "blackout fall" incident in Scotland,

preceding the hospital examination of C on 24th September and her admission to hospital from 25th September to 2nd October 2008.

(xxii) **6th November 2008**: Both the health visitor and Dr. D visited the family home, as a result of which it was arranged that C would be brought to "D" Hospital the following day.

(xxiii) **7th November 2008**: C was brought by her M to 'D' Hospital. Various injuries were diagnosed and she was admitted. An Emergency Protection Order was secured. The matter was reported to the police.

(xxiv) On the same date, F and M were arrested by the police and interviewed.

(xxv) **11th November 2008**: Renewal of Emergency Protection Order. First interview of F and M by social workers. [The appointed Social Worker was Ms Harte, while the Senior Social Worker was Ms O'Conboirne].

(xxvi) **12th November 2008**: C was placed in foster care.

(xxvii) **19th November 2008:** First "Looked After Children [LAC] Review of Arrangements".

(xxviii) **Early January 2009**: F and M separated and have not cohabited subsequently.

(xxix) **15th January 2009:** Second "LAC" report.

(xxx) **26th January 2009**: Non-molestation order in favour of M against F.

(xxxi) **24th February 2009**: The second round of police interviews of both parents.

(xxxii) **26th February 2009**: F was convicted of having committed ten breaches of the non-molestation order and one offence of sexual assault on M, all belonging to the period 10th – 17th February 2009, on his plea of guilty, giving rise to a commensurate sentence of five months imprisonment.

(xxxiii) **From April 2009 onwards:** Quarterly "LAC" reports.

(xxxiv) **April 2010:** Public Prosecution Service ("PPS") decision that there would be no prosecution.

(xxxv) **5th July 2010**: Notification of PPS review decision, affirming the original no prosecution determination, intimating that "*There can be no*

doubt that the child has been seriously assaulted (without doubt by one of [the parents]) *but there is insufficient evidence to establish beyond doubt which one committed the assaults and also insufficient evidence to establish criminal neglect on the part of either suspect*".

C has remained in foster care since 12th November 2008, with F and M availing of some limited supervised contact.

[6] Whereas the second of the two crucial periods ended on 7th November 2008, the court has received evidence (of not insubstantial volume) relating to various subsequent events. As appears from the résumé which follows, parts of this evidence are of some importance.

IV SCOTTISH HEALTH VISITOR AND MEDICAL RECORDS

[7] As appears from the above, C was born in Scotland and lived there with F and M until the family moved to Northern Ireland in early October 2008. The first assessment of C by a Scottish health visitor occurred on 5th September 2008, when nothing abnormal was noted. On 9th September 2008, a "*sticky eye*" was noted and advice was given. On 15th September 2008, it was recorded that C was "*using Imfacol for colic*" [Infacol is a non-prescription remedy sold in pharmacies]. It was noted that C's eye was no longer sticky. The health visitor also recorded

> "*Good family support available – partner is [employed] – usually only home one weekend out of four.* [M] *not working at present … tired but coping well with help. Family moving to Ireland on 1st October.*"

On 17th September 2008, M reported by telephone that C had been crying all night, was not feeding, was unresponsive to colic relief and had a puffy face. An immediate appointment with the family doctor ensued. The doctor referred C to "Y" Hospital in Scotland. The child was brought there by both parents on the same date. It was recorded:

> "*Baby girl who has been irritable, crying overnight and has been off feeds since last night, swelling to face at cheeks and neck. Settled on arrival …*".

The clinical notes recorded:

> "*Comfortable in Mum's arms. Crying when moved. Able to be consoled by lifting easily …*".

It was noted, *inter alia*, that both femoral pulses were present (cf. Mr. Cowie's evidence, paragraph [], *infra*). A swollen neck and chin were noted, these duly

settled and the child was discharged some five hours later. The diagnosis was "*feeding problems*".

[8] The health visitor next visited the family home on 24th September 2008. This was a routine visit, conducted at 11.30am. The corresponding record contains nothing of note, with the exception of "*… going to try* [?] *for colic*". Later that day, C was brought to the VI Hospital, the arrival time being recorded as 16.46 hours. The clinical notes record:

> "*Dad collapsed whilst holding baby. Fell to floor …*
>
> *On examination crying appropriately. No obvious bruising/ bony injury …*
>
> *Moving all limbs.*"

There is no record of who accompanied C to hospital. Later records suggest that F, but not M, did so. C was discharged at 17.40 hours. The next entry in the health visitor's records is dated 25th September 208 and the time is recorded as 4.30pm. This documents a telephone call from a social worker –

> "*…reporting that* [C] *had been admitted to* [RHSC] *Hospital today with fractured right femur.* [F] *and* [C] *presented at* [VI Hospital] *yesterday - dad stated that he had been having blackouts and had one whilst caring for* [C] *– he either fell or rolled onto baby …*
>
> *Mum noticed* [C] *unable to move her leg – taken to* [hospital] *today …*
>
> *Seen by Dr. Scott Henry A & E Consultant and Dr. Alison Rennie, on call child protection consultant – advised SWD Department that injury consistent with history. SWD investigating further.*
>
> *Dad … also advised that Dr. Notman* [the family doctor] *knew he was having blackouts and planned to admit him. Dad seen at surgery 12.10pm today by Dr. Flett stated had blackout yesterday while holding baby – unwitnessed – partner came home to find him on floor and baby crying … Says has happened before – not investigated …*".

The next of the health visitor's records, dated 26th September 2008, appears to have been generated by an enquiry made of the family doctor, stating:

> "*No history of seeing GP prior to this blackout. Investigations continue meantime*".

I shall comment on the significance of these records in due course.

[9] The RHSC records document that on 25th September 2008 C attended hospital at 10.11 hours and a history was recorded within approximately one hour. The clinical notes were compiled at 10.40 hours and, following x-ray and diagnosis of the fractured right femur, the child was admitted at 12.25 hours. At around this time, a further event of some significance unfolded. In the health visitor's record of 25th September 2008, it is documented that at 12.10pm F was "*seen at surgery*", reporting his "blackout" the previous day. At the RHSC Hospital, the presenting complaint regarding C was documented thus:

> "*Dad fainted while holding* [C] *yesterday – woke up with her beside him – was checked at* [VI Hospital]. *Mum feels her right leg is limp and painful when moving.*"

According to one of the clinical notes:

> "*Baby now not moving right leg, cries when moved. Doesn't seem overly distressed according to mum …*
>
> *On examination … cries when moved …* ***right leg not moving at all*** *(Mum says she's seen toes moving) …*".

The highlighted words reflect a clinical finding. The clinical notes further document:

> "*Mum's partner has had four 'blackout' episodes recently, currently being investigated. Mum was out yesterday. Partner said he 'fainted', woke up on the floor with baby lying crying beside him. Partner thinks he fell back and baby landed on him …*".

Another of the hospital records states:

> "*Attended Emergency Department today as* [C's] *dad fainted yesterday while holding her. Seen at* [VI Hospital] *then but not x-rayed.* [C] *is not now moving her right leg. X-ray taken and shows fractured right femur.*"

The radiological report was as follows:

> "*Transverse fracture through the metaphysis of the right distal femur with slight distraction and angulation*".

The "Scottish Social Services" record states:

> "*History given by mum and dad* ***not consistent ...***
>
> *Prior to incident no HV concerns – appeared to be a caring couple who provided well for their baby. Social Work Department initially following up and will contact services in Northern Ireland*".

While I have highlighted the words "*not consistent*", the precise nature of the perceived inconsistency in the histories provided by F and M respectively is not entirely clear: the Scottish Social Services' records do not form part of the evidence presented to the court. The period of C's admission to hospital was 25th September to 2nd October 2008. The records note that she was in receipt of "Infacol" on account of "*colic*" daily, during her admission.

[10] It is clear from the RHSC records that the Social Work Department was alerted as a result of C's admission to hospital on 25th September 2005 and an investigation of uncertain scope ensued. In one of the hospital records it is noted "*Ongoing police and SW investigation*". C was discharged from hospital on 2nd October 2008 and was brought to Northern Ireland by M that day, F having travelled there the previous day. The discharge note records:

> "*Seen by Mr. Wilson, deemed fit for discharge home. For follow up with own GP. Advised if any concerns to seek medical advice.* [C] *discharged home in care of mum. No concerns to note.*"

There is no indication in this record that the hospital personnel were aware that M was on the point of travelling *immediately* to Northern Ireland with C, with all the consequences this would entail. On 8th October 2008, the consultant orthopaedic surgeon responsible for C's care during her RHSC admission, wrote to the family doctor in Scotland. This letter records the circumstances of the admission, the history of trauma given, the diagnosis and C's full recovery. It continues:

> "*The events of the fall seemed clear cut. The father was investigated for what was thought to have been a fit or possible cardiac event by the adult service and the local child protection team here and the Social Work Department were happy with the explanation of the circumstances. I believe they are in the throes of moving to Northern Ireland …*".

At this juncture, it is appropriate to highlight three particular considerations. The first is the concern which was subsequently generated by the initial, and repeated, failure of F and M to alert anyone in Northern Ireland to the episode involving C's fractured femur and admission to hospital in Scotland. The second is M's later suggestion to a Northern Ireland health visitor that she had been given a hospital discharge letter which she was unable to locate and her inability to account for this

missing letter in her evidence to the court. The third notable factor is the evidence given by F at the first hearing that he knowingly burned the discharge letter.

V THE NORTHERN IRELAND PHASE: 2nd OCTOBER TO 6th NOVEMBER 2008

[11] The records belonging to this discrete period have three sources: the health visitor, the local Social Services and the family's local medical practice (the "M" Family Surgery). It appears from the records that the family was registered with this practice on 10th October 2008 and they attended for the first time, on 20th October 2008. This seems to have been a routine first appointment at their new medical practice. This was followed by the first contact from the health visitor (Ms Connolly), who first attended the family home in Northern Ireland on 22nd October 2008, when a "Family Health Needs Assessment" was completed. It is clear from all the evidence, particularly that of Ms Connolly and M, that this was no casual conversation. Rather, the exercise consisted of Ms Connolly posing a series of prescribed, pro-forma questions and recording the answers. It was noted, *inter alia*, that F was looking for work, while M was planning to be a full time mother. One of the most significant aspects of this exercise is recorded in Ms Connolly's later statement to the police in the following terms:

> "*As part of my assessment I asked* [M] *about the family which included any medical or social concerns. No medical conditions were disclosed in relation to any of the family*".

Evidence was given by Ms Connolly that, in completing this assessment, she specifically asked the parents whether there were any medical concerns relating to C, eliciting a negative response. Nothing was said about C's fractured femur or her one week admission to hospital in Scotland. Nor was any mention made of the discharge letter entrusted to M, for transmission to the family doctor, upon C's release from the Scottish hospital just three weeks previously.

[12] Ms Connolly further testified that during this visit, C was undressed and closely examined by the health visitor. She appeared a well cared for baby, living in a warm, comfortable home. Next, on 28th October 2008, C was given immunisations at the M Family Surgery. All three family members were in attendance. There they had dealings with both the health visitor and Dr. D. The immunisations entailed injections of both the left and right thighs. The evidence was that this entailed simply exposing C's legs: she was not undressed. On the same date, the following health visitor's record was compiled:

> "[M] *attended clinic with* [F] *and* [C]. *Green/yellow bruise on left cheek and under right eye. Seen by Dr. D.* [M] *stated that she had fallen in the shower*".

The health visitor's evidence was that this information emerged when both parents were seen by Dr. D in his consulting room, before the injections were administered. Some two weeks later, after they had been arrested and interviewed by the police, both parents admitted that this account of how M had sustained her injuries was untrue.

[13] There is a Social Services record which confirms that, coincidentally, on the same date (viz. 28th October 2008) the Northern Ireland Social Services received information from their Scottish counterpart. This was to the effect that whereas at the time of diagnosis of C's fractured femur no concerns were raised –

> "*Dad had suffered a blackout …*
>
> *Subsequently concerns were raised as Dad had disclosed information re his medical history and specifically blackouts…*"

The remainder of this record suggests that investigations were being made about F's history, the possibility of alcohol misuse and F's involvement in a previous relationship with a child assigned to the Child Protection Register, but were terminated when the family moved to Northern Ireland. In a subsequent record dated 5th November 2008, it is suggested that this incomplete investigation included social worker interviews with F and M in the family home, which were dominated by F. Moreover, per the record, F had a "*previous head injury*", he was "*previously known to substance misuse team*", had *possibly* been involved in "*alcohol misuse*", had been reared in care and, further:

> "*SS previously involved with his former partner and child* [who] *had bruise under the eye – sustained whilst in* [F's] *care. SS accepted* [F's] *explanation of events. However child's name was placed on CP register due to neglect issues*".

It was also suggested that F and M had proffered inconsistent explanations for C's fractured femur. (See my earlier comment in paragraph [9]).

[14] Ms Connolly testified that on 3rd November 2008 she telephoned M and left a voicemail message. M responded on 4th November 2008, when she telephoned the health visitor, reported that C's eye was improving and suggested that no medical attention was required. The health visitor's response was to arrange to visit two days later. On the following day, 5th November 2008, there was an event of some significance. F attended his general practitioner, Dr. "P" who, in consequence, made immediate contact with the social services. The relevant Contact Sheet records, in material part:

> "*… Dr.* [P] *saw* [F] *about one hour ago at his surgery …*

> [F] *told him **a story** this morning about his long history of illness. He then told GP that baby daughter … had recently sustained a broken femur as a result of her father having a blackout. GP was very concerned about this and said he did not believe* [F's] ***story***. *GP very suspicious and wanting to make a referral to social services."*

[My emphasis]

It was further recorded that F -

> *"… reported he had 'blacked out' and dropped* [C] *resulting in fractured femur."*

This concise record repays careful reflection. Especially striking is the immediate reaction of the medical practitioner concerned: he disbelieved what F was telling him in its entirety. Moreover, it would appear that F was not reporting any current symptoms relating to blackouts and Dr. P, apparently, did not take steps to arrange any medical tests or investigations. It is clear that Dr. P contacted Ms Connolly immediately following F's visit to the Health Centre and recounted what had occurred. According to the records, the concerns of social services were aroused by a combination of a failure to disclose this incident earlier and M's facial bruising. On the same date, the Health Visitor reported that neither parent had disclosed the history of C's fractured femur to her**.** The alarm bells had clearly begun to ring.

[15] On 6th November 2008, the health visitor attended the family home, as arranged. All three members were present. F stated that he had attended the hospital the previous day on account of his "*symptoms*" (which are unparticularised). C was noted to be settled and smiling. The record continues:

> "[F] *left. I spoke with* [M] *re her facial bruising last week.* [M] *stated she fell in the shower and would not put up with anything like that. I gave her Women's Aid (local number for PSNI etc) information …*
>
> *I then asked* [M] *about* [C's] *fractured femur.* [M] *stated she didn't tell me or GP about it because we would get the records …*
>
> *She had been at the hairdressers and returned and* [F and C] *had fallen following his 'blackout'."*

M then recounted the events involving the two Scotland hospitals on successive dates. M pointed out to the health visitor that both of C's eyes were bloodshot, although she felt this was improving. The health visitor telephoned Dr. D from the family home. He attended quickly thereafter and made essentially the same observations. Meantime, Dr. D had arranged for the admission of C to D Hospital

under the care of Dr. Hughes, consultant paediatrician. The upshot was that C was taken by M to D Hospital the following day. The records compiled on 6th November 2008 highlight the twin recurring themes of (a) the non-disclosure of C's medical history by her parents to Northern Ireland health care professionals during a period of approximately five weeks and (b) the corresponding failure to provide these professionals with the Scotland hospital letter of discharge – or even to mention its existence.

VI THE EMERGENCY PROTECTION ORDER

[16] The Emergency Protection Order relating to C was made by a District Judge (Magistrates' Courts) on 7th November 2008. It was stimulated by events on that date, following the assessment of C at "D" Hospital. According to one of the hospital records, the following diagnosis was made, in summary terms:

> "*Non accidental injuries – multiple long bone fractures …*
>
> *Presented with bilateral subconjunctival haemorrhage – conclusion was as a result of a probable shaking injury …*".

Following the medical investigations and assessments of C, Dr. Hughes, prepared a report containing the following salient passages:

> "*Dr. D had referred her because of concerns about her past medical history. Mum presenting to the GP surgery with bruising to her face (mother, not child) and recently noted spontaneous bleeding around the child's eyes (subconjunctival haemorrhages bilateral…)*
>
> *(c) Had a sticky left eye for the first few weeks after birth but this cleared up spontaneously after a few weeks. Mum then noted a red mark laterally on her left eyeball about ten days ago which then also appeared on the medial side of her left eye after a few days. At the same time it also appeared on the medial side of her right eye …*
>
> *She has no history of cough, constipation or vomiting …*
>
> *Generally the child has been very well and Mum didn't feel that she was irritable …*
>
> ***Skeletal survey shows healing fractures of her right lower femur and left clavicle. However there are more recent fractures of the right and left humeral metaphases (elbows). There is also a small fracture at the base of the left first metatarsal (foot) ...***

> **Conclusions**
>
> ***This child has multiple fractures with no reasonable explanation for this presentation. She has two healing fractures which could possibly have occurred in September when the alleged fall occurred. However she also has more recent fractures which are in areas known to be associated with non-accidental injury. She has bilaterally spontaneous subconjunctival haemorrhages for which there is no apparent medical explanation, excluding a bleeding disorder. This should be ruled out when her haematological investigations are available. ...***
>
> ***It is very likely that this child's injuries are consistent with non accidental injury."***

[Emphasis added].

This assessment and findings were the impetus for the Emergency Protection Order made by the District Judge (Magistrates' Courts) on the same date.

[17] Three days later, on 10th November 2008, C was assessed by Dr. P, a consultant ophthalmic surgeon, who later reported:

> "*My impression at the time was that she had bilateral subconjunctival haemorrhages. In a child of this age this could be caused by repeated coughing or vomiting and in the absence of these occurrences a bleeding disorder or haemorrhagic conjunctivitis could cause subconjunctival haemorrhages …*
>
> ***Therefore if this infant had not suffered from any of these conditions then either direct or indirect trauma would be the other cause."***

[My emphasis].

Dr. Hughes, of course, had already recorded that there was *no* history of cough or vomiting. Furthermore, the medical investigations at D Hospital did not uncover any bleeding disorder. In subsequent reports and in evidence to this court, Dr. Hughes and other medical experts have expressed their views on a range of issues related to C's injuries. I shall consider this evidence in a separate section of this judgment.

[18] On 12th November 2008, C was discharged from hospital into the care of foster parents. On 18th November 2008, an Interim Care Order was made. Notably, Dr. Hughes was prompted to write to the RHSC Hospital in Scotland, by letter dated 27th November 2008, in which he said:

> "*I am writing to you because I would have concerns that this child initially presented to* [RHSC] *and the parents gave a history that the father had fallen while holding the child, sustaining the right femoral fracture. It would appear that this explanation was accepted and that no further investigations were done at this time to look for any other injuries …*
>
> *The initial x-rays taken in* [RHSC] *have been viewed by our paediatric radiologist. She believes that these x-rays (25/09/08) displayed a fracture that was not recent i.e. within the previous forty-eight hours which was the history given by the parents. She suggests that this fracture was at least two weeks old when the x-ray was taken and that this should also have prompted further suspicion…*
>
> *In addition I would have concerns about the way in which the Scottish Social Services Department handled this case given information which was available regarding her father's history.*"

Thus Dr. Hughes was expressing two central complaints. The first was that the RHSC personnel too readily believed the history given that F had fallen suddenly whilst holding C in his arms. The second was the failure to properly evaluate the x-rays and to carry out further medical examination of C. In passing, Dr. Hughes testified that he does not know whether his letter stimulated any investigation. It is noteworthy that Dr. Hughes, who is obviously a highly responsible and conscientious medical practitioner, did *not* write to the VI Hospital in Scotland then and has not done so subsequently.

VII THE MEDICAL EXPERTS' EVIDENCE

[19] The expert medical evidence considered by the court consisted of a mixture of reports and sworn testimony. The latter emanated from the aforementioned Dr. Hughes, Mr. Cowie FRCS (both on behalf of the Trust) and Dr. Blumenthal (on behalf of M). In summary, the expert medical evidence available to the court (in documentary or sworn form, or both) has been provided by the following:

(a) Dr. Hughes, consultant paediatrician.

(b) Mr. Cowie, FRCS, consultant orthopaedic surgeon.

(c) Dr. Page, consultant ophthalmic surgeon.

(d) Dr. Flynn, consultant neuroradiologist.

(e) Dr. Paterson, consultant paediatric radiologist.

(f) Dr. Arthur, consultant paediatric radiologist.

(g) Dr. D, the family doctor in Northern Ireland.

(h) Dr. Blumenthal, consultant paediatrician.

(i) Mr. Byrnes, consultant neurosurgeon.

[20] With reference to the above list, those medical experts who had direct and personal involvement in the assessment, investigation and care of C's injuries on 7th November 2008 and in the immediate aftermath are Dr. Hughes, Dr. Page, Dr. Paterson, Dr. Flynn and Mr. Cowie, FRCS. In contrast, Dr. Blumenthal, Dr. Arthur and Mr. Byrnes were engaged to provide opinion evidence in a litigation context viz. for so-called "medico-legal" purposes. I shall consider the report of Mr. Byrnes in a separate section of this judgment (see, Chapter X). Prior to the hearing, several of these experts, together with Ms Connolly (the health visitor concerned), met and deliberated upon a range of issues raised by a set of agreed questions. The issues on which opinions were expressed related essentially to the degree of pain and distress probably suffered by C as a result of each injury; how evident any distress would have been; the likely duration of ensuing symptoms; possible alerting mechanisms – in particular, the kind of baby care activities likely to expose pain or distress or other symptoms; the likely state of knowledge of both F and M concerning each injury; and the relevance, if any, of colic. The product of this exercise was a fairly substantial measure of agreement amongst the experts. Furthermore, as already noted (in paragraph [5]), there is no dispute about the estimated period during which most of C's injuries was sustained. The limited residual areas of disagreement amongst the experts emerge in the following paragraphs hereof.

C's Injuries: Summary

[21] At the outset, bearing in mind that the family's move from Scotland to Northern Ireland was completed on 2nd October 2008, it is appropriate to recall the following agreed classification, as regards the various fractures suffered by C:

(a) The fractures of the right femur and left clavicle occurred during the period 11th to 26th September 2008 viz. in Scotland.

(b) The fractures of the right distal humerus, left tibia, left distal humerus and first left metatarsal, together with the bilateral sub-conjunctival haemorrhages and the non-bony injury of the right tibia, occurred

between 24th October and 7th November 2008 (viz. in Northern Ireland), thereby placing the spotlight very firmly on the family's interaction with health care professionals during this discrete period.

As regards the two "Scottish" injuries, only the first was diagnosed and treated there. The second was not the subject of either diagnosis or treatment in Scotland and was first discovered on 7th November 2008, in Northern Ireland. Similarly none of the injuries sustained in Northern Ireland was the subject of any reporting by either parent or any immediate medical investigation or treatment at the instigation of either parent. While the family had certain contact with medical and health professionals in Northern Ireland during the critical period of 24th October to 7th November 2008, none of this was stimulated by any of C's injuries or the consequences thereof, with the exception of the sub-conjunctival haemorrhages.

Dr. Hughes

[22] I have already detailed the direct involvement of Dr. Hughes on one of the critical dates, 7th November 2008, in paragraph [17] above. In his sworn evidence, Dr. Hughes testified that he and Dr. Blumenthal are agreed that the likely cause of C's sub-conjunctival haemorrhages was squeezing of the baby's chest. As regards the other issues debated by the experts and addressed in their written and/or sworn evidence, Dr. Hughes agreed with the court that there are, unavoidably, certain variables and imponderables in play. In particular, there is general agreement that while all of the injuries would have produced some pain and distress, it is difficult, in retrospect, to measure the extent, intensity, frequency and duration of any exhibited symptoms. All experts are agreed that the fractured femur would have been the most painful of C's injuries. This is illustrated by the following statement extracted from the transcript of the meeting of medical experts, attributed to Dr. Hughes:

> "*My view is that there would be pain at the time of the injury and with all these injuries but obviously with the femoral injury there would be more significant pain and there would be pain and discomfort at the times of manipulation, bathing and changing clothes …That child would have been in considerable pain for a period…*".

Dr. Hughes explained that the metaphyseal fractures were caused by someone gripping or squeezing C, using their hands. Such injuries can be inflicted within a time span as short as one or two seconds. He opined that as M claimed to be C's primary carer, if she was not a perpetrator she should have become aware of the injuries.

[23] Dr. Hughes was asked to comment on the assertion made by M during police interviews that, in the immediate aftermath of the alleged F/C "fall", on 24th September 2008 –

> *"… I actually noticed that there was something wrong with* [C's] *right leg, she wasn't moving it when she was crying … She was only moving her left leg and her right leg was just kind of hanging there …*
>
> *I said this to the doctor … can you have a look … cos she's not moving it and the doctor had a look at it and said she thought it was fine but she would get the senior doctor down to have a look at it …*
>
> *He grabbed both her legs and he was like moving them up and down … he said no, no her legs are fine and he was tapping her knee and he said her leg was fine, she's maybe just bruised it and that's why she's not moving it so we went home … The next morning she still wasn't moving her leg so I took her straight up to* [RHSC Hospital] *… and straight away they done an x-ray and said she had a fractured thigh bone …".*

It is agreed by everyone that this fracture was sustained between 11th and 18th September 2008. Dr. Hughes testified that if the assertions attributed to M in the above passages relating to the medical assessment of C at the VI Hospital on 24th September 2008 are correct, there is no apparent reason why the fractured femur was not detected on this occasion. Dr. Hughes also highlighted, in this context, the history given by M on the second of these occasions, 25th September 2008, that C's right leg was limp, was not moving and was painful on movement. According to Dr. Hughes, these symptoms must have been present the previous day, bearing in mind particularly the vintage of the fracture. Dr. Hughes was prepared to acknowledge the possibility that neither parent noticed these symptoms until after discharge from the first of the two hospitals involved. This possibility must, of course be evaluated by the court in the context of all other available evidence, including the agreed assessment that this fracture was sustained by C between 11th and 18th September 2008. Furthermore, this possibility is contradicted by M's assertions to the police in the interview passage quoted above. The truth of these assertions is one of a myriad of factors bearing on the credibility and reliability of F and M which the court will have to consider.

[24] The issues of irritability and colic were explored at some length in the questioning of Dr. Hughes. This discrete topic is conveniently exposed by the following statement in the transcript of the experts' meeting, attributed to Dr. Hughes:

> *"For those five days of admission, my impression was that she was a fractious, irritable child. This was the impression of the nursing staff and other medical staff on the ward and it is clearly documented in the medical notes and in the*

nursing notes that she was a fractious, irritable child who disliked handling and required analgesic on numerous occasions during those first few days of admission …

So if she was like that at that time she must have been like that for a period of time prior to her present admission."

Dr. Hughes acknowledged the documented references to both colic and the medicament "Infacol" in both the Scottish and the Northern Irish hospital records. He maintained his view that C was not suffering from colic. However, he agreed that M could reasonably have believed this. He suggested that as C was plainly more irritable when physically handled this *could* have suggested some physical injury to a parent, particularly a primary carer. Dr. Hughes further highlighted the passage in his report of 7th November 2008:

"*Generally the child has been very well and mum didn't feel that she was irritable*".

[I interpose here, for convenience, my finding that this was not an accurate representation by M].

Dr. Hughes contrasted this description with C's presentation throughout her period of admission to D Hospital, conveying the impression that he questioned its accuracy. Finally, Dr. Hughes emphasized his direct and personal involvement in the assessment and care of C between 7th and 12th November 2008. On this account, he suggested that he is better equipped than Dr. Blumenthal, whose opinion is detached and *ex post facto* in nature, to evaluate this discrete issue. [In the event, this issue did not feature in Dr. Blumenthal's sworn evidence].

Mr. Cowie FRCS

[25] Mr. Cowie FRCS, a consultant orthopaedic surgeon, became involved at an early stage following C's admission to D Hospital, in November 2008. In consequence, Mr. Cowie compiled a total of three reports, all of which have been considered by the court. Furthermore, Mr. Cowie gave sworn evidence at the hearing. He confirmed that he did not examine C at any time. In his evidence, he expressed his professional opinion on a range of issues and this may be summarised as follows:

(a) He subscribes to the estimated vintage of each of the fractures rehearsed in paragraph [5] above.

(b) All of the meteaphyseal fractures were caused by squeezing or twisting or shaking. The fracture of the first left metatarsal bone of the left foot was not caused in this way. The mechanism of the fracture of the left clavicle was difficult to assess: while squeezing or wrenching

was a possibility, this would be a difficult force to apply to this bone. Direct trauma of some kind was also a possibility.

(c) There is a slim possibility that the fractured left clavicle occurred when C was born.

(d) Some of the fractures could have been caused in combination: this applies to the bilateral fractures of the humerus (upper arm) and the fractures of the left tibia and left first metatarsal.

(e) Of all the injuries, the fractured right femur would have been the most painful, followed by the fractured left clavicle.

(f) The femoral fracture probably resulted in some swelling. An inexperienced mother might not have noticed this.

(g) It would have been impossible to change C's nappies without manipulating her legs to some extent.

(h) The fracture of the left foot bone was caused by gripping *or* crushing with some degree of twisting and is a particularly unusual injury, given C's age.

(i) The non-bony injury to the left tibia was caused by severe gripping or twisting and could have generated a visible bruise.

(j) The presentation of C at the two hospitals on 24th and 25th September 2008 was separated in time by only some eighteen hours and would not have been different on either occasion.

(k) The testing for the bilateral femoral pulses which occurred on 24th September 2008 would not have required removal of all of the child's clothing and would have entailed relatively mild palpation of the area between the groin and the thigh at the *upper* end of both femurs – the fracture of the right femur having occurred at the *bottom* of the bone. In short, Mr. Cowie attributed minimal importance to the recorded finding that both femoral pulses were present. In thus testifying, he emphasized that the two sites are separated by a distance of approximately six inches.

[26] In addition to the above, Mr. Cowie addressed two discrete issues of some importance. The first of these is based on the premise that one of the parents was entirely "innocent" viz. did not perpetrate any of C's injuries and had no knowledge of any injury having been sustained by C. This prompts the question: is it reasonable that such a parent would not have become aware of *any* of the child's injuries? Mr. Cowie, was prepared to acknowledge that this was a possibility.

Elaborating, he testified that while C's injuries, particularly the femoral fracture, would have been the subject of pain and discomfort during periods of varying duration – in broad terms, ranging from a couple of days to seven days or more – it is possible that an "innocent" parent divested of any "guilty" knowledge could have interpreted such signs as indicative of a young baby who was simply irritable and unsettled. However, the strength of this possibility was illuminated by Mr. Cowie's evidence that *most parents* would have noticed something abnormal about C's right upper leg. Dr. Blumenthal agreed with this.

[27] The second discrete issue addressed particularly by Mr. Cowie concerned the history given when C attended the RHSC Hospital, on 25th September 2008 and, specifically, the assertions attributed to M that, overnight, C had become unable to move her right leg and cried when it was moved. Mr. Cowie highlighted that, as of 25th September 2008, the fracture of the femur was of seven to fourteen days' vintage. The most acute symptoms would have been evident during the initial phase of this period. He would have expected the signs and symptoms described by M on 25th September 2008 to be noticeable during the first seven days, viz. at some stage between 11th and 25th September and before the night of 24th/25th September. He opined that it was unlikely that these signs/symptoms were first manifest overnight on 24th/25th September 2008. He rejected the suggestion that the injured right upper leg had been aggravated between the two hospital attendances on 24th and 25th September 2008. In short, he did not accept the accuracy of the history given by M on 25th September 2008 that the signs/symptoms of "*cries when moved*" and "*right leg not moving at all*" [per the clinical notes] were first manifest overnight on 24th/25th September 2008. Dr. Blumenthal agreed with this also.

<u>Dr. Blumenthal</u>

[28] At the outset, it is appropriate to highlight the following passage in Dr. Blumenthal's report:

> "[C] *had sustained metaphyseal fractures in all her limbs. The first occurred well before she was admitted to hospital in Scotland …*
>
> *All of those injuries were inflicted. Metaphyseal fractures are caused by the limbs being wrenched and twisted …*
>
> ***Metaphyseal fractures are caused by wholly inappropriate handling of the child. A person causing such injuries would know that their actions were inappropriate ...***

> ***Since the first weeks of life,* [C] *has been manhandled in a most cruel and inappropriate manner. In the process she has sustained multiple fractures."***

[My emphasis].

During the trial, the court was provided with the following "Joint Statement" signed by Dr. Blumenthal and Mr. Cowie FRCS:

> *"After the fracture of the right femur, we consider that the fractured left clavicle (collar bone) was probably the most painful injury. A fractured clavicle after a Caesarean Section is an unusual injury, but has been documented. Any discomfort resulting from such an injury would probably last a few days. A parent, not inflicting the injury or seeing the injury being inflicted, might not attribute signs of discomfort to the child having been injured."*

This prompted the following enquiry by the court: were Mr. Cowie and Dr. Blumenthal in disagreement about any of the issues raised by the agreed set of questions debated by the medical experts? The initial response to this question was one of some uncertainty. In the event, Dr. Blumenthal gave sworn evidence. He concentrated particularly on the fractured femur. In doing so, he testified unequivocally that this could not have been caused by a fall, due to the characterisation of the fracture (viz. metaphyseal) and the nature of the force required to cause it. He accepted that this injury could have generated exhibited symptoms of pain or distress or discomfort enduring for a period of five days or slightly longer. This evidence qualified his broad proposition that most metaphyseal fractures generate no symptoms.

[29] The second main issue addressed in Dr. Blumenthal's evidence concerned the mechanism of the fractured left clavicle. In summary, he did not dissent from Mr. Cowie's opinion that the possibility of this fracture having occurred at birth is a slim one. He emphasized that this was a "*straight*" fracture of the clavicle, in the middle of the bone. This is a rarely encountered child abuse injury. While it was inflicted non-accidentally, Dr. Blumenthal and Mr. Cowie were agreed that, physically, it was, more difficult to inflict than any of the other fractures. Finally, Dr. Blumenthal responded to Mr. Cowie's evidence that most parents would *probably* have become aware of the fractured femur. Ultimately, he concurred with this opinion. His evidence was that it was *possible* that a caring and responsible parent would not have become aware of this injury. He invoked two factors in support of this possibility. The first is that of misinterpretation of symptoms (*supra*). The second is that the femoral fracture was not detected during either of two hospital attendances, on 17th and 24th September 2008. In this respect, there was no appreciable difference of opinion between Mr. Cowie and Dr. Blumenthal.

[30] Dr. Blumenthal accepted that *all* of C's injuries would have caused some discomfort, for varying periods of time. The fractures of the two humeri would have generated the least discomfort, with an estimated duration ranging from some hours to a couple of days. Finally, Dr. Blumenthal dilated on the nature of metaphyseal fractures. He testified that fractures of this type are caused by a pulling or twisting force, causing a shearing of the metaphysis, which is the weakest part of the bone. Fractures of this kind are often relatively painless. Furthermore, it frequently occurs that metaphyseal fractures are detected only by skeletal survey viz. examination by medically qualified personnel accordingly, with the assistance of the customary tools, including radiological examination. In this respect, Dr. Blumental contrasted non-medically qualified parents, while agreeing with the court that the issue for a caring, attentive parent would be whether there were signs indicating the need for medical advice and/or treatment.

Dr. Arthur

[31] Dr. Arthur is a consultant paediatric radiologist who was engaged to provide a report on behalf of M, for the purpose of these proceedings. In her report, Dr. Arthur expresses the following opinion relating to the history given on 24th/25th September 2008:

> "*A fracture of the femur could occur in this way. However, the fracture showed evidence of healing at presentation and thus the timing is incompatible with the history provided*".

Dr. Arthur also expresses the following general opinion:

> "*These injuries cannot be explained by slightly clumsy handling of the infant by inexperienced parents or by rough play with the baby. **An excessive degree of force has been used to cause these injuries***".

[My emphasis].

Dr. Arthur opines that *all* of the fractures would have caused "*considerable distress*". She continues:

> "*I would have expected the perpetrator of these injuries to be aware that they had injured the baby and had caused the baby to be in pain.*"

She adds, in the following sentence:

> "*I would have expected a carer, not present at the time of the injuries, to have realised that* [C] *was distressed **but may not have known the reason***".

[Emphasis added].

In summary, all of the medical experts acknowledge *as a possibility* that if one the parents did not perpetrate any of C's injuries and did not witness or otherwise learn of their perpetration, the non-perpetrating parent might not have become aware that an injury had been sustained.

VIII SINCE 7th NOVEMBER 2008

[32] C has remained in foster care since 12th November 2008. As a looked after child, she has been the subject of periodic reviews undertaken by the various professionals concerned [so-called "LAC" reviews] which are documented. There is also a series of other related records and reports. Since the bulk of the evidence bearing on the issues to be confronted and determined by the court precedes this particular phase, it is unnecessary to rehearse the evidence belonging to the period mid-November 2008 to date *in extenso*. However, there are certain features of this evidence which must be highlighted, as they provide some illumination and guidance to the court in its primary task, which is to identify who perpetrated the child's admitted non-accidental injuries.

Meeting with Social Services, 11th November 2008

[33] The Senior Social Worker and social worker concerned interviewed both parents for the first time on 11th November 2008. During this encounter:

(a) F asserted that he had a fairly extensive history of "*blackouts*" and "*fainting*".

(b) F asserted that on the relevant date (24th September 2008) he "*must have taken a blackout*" as he was turning a tap, with C "*over his shoulder*" and "*… next thing he knew he was lying on the floor …*".

(c) F disclosed that he had been reared by foster parents since the age of three. He suggested that they "*… were planning on having another baby once this was all cleared up*".

(d) M claimed that "*… there was ten missed calls on her phone from* [F] *while she was in the hairdressers*".

(e) M further suggested that when they attended the hospital on this occasion, C's right leg was "*not moving at all*". A "*senior doctor*" assured them that C had "*some bruising*" and was "*fine*". However, the next morning C was "*not moving her leg*" and they brought her to a different hospital.

(f) M recounted that F had perpetrated an incident of domestic violence against her a couple of weeks previously, pushing her on to the stairs while she was holding C. [See paragraph [6](xxvi) and (xxvii) above]. She had not previously admitted this because she was worried that F "*… would go back into prison, or do something silly …*". Having discussed this following the episode of police arrest and interviews, they both "*saw sense*" and, as a result, had "confessed" to their solicitor earlier that day.

(g) The record of this meeting continues:

> "*The shoulder and leg happened the same time, did not know about the elbow …*
>
> *We didn't know about the fracture to the elbow and foot until the interview. When I fell with her in my arms, it was three stairs up. She didn't appear to be in any pain, smiling at me, gurgling. She was at the doctor on Tuesday for the immunisation, she seemed fine*".

The reference in this passage to "*shoulder and* leg" appears to concern the fracture of the right femur and left clavicle, in the context of an assertion that both injuries were sustained in the incident involving F's "blackout fall". In the next part of this passage, M appears to make the case that, from her perspective, the admitted fall which had occurred on 24th October 2008 (the domestic violence incident) was the only possible precipitating incident and did not precipitate any notable symptoms. M protested that she had not attempted to conceal anything.

(h) It was noted that M "*… did most of the talking* [and] *… spoke with very little emotion, she cried at one point*".

LAC Review, November 2008

[34] This was attended by all protagonists and was based on, *inter alia,* a social work report prepared in connection with the court proceedings. I have already highlighted above the reports of the health visitor and Dr. Hughes, which were also in existence at this stage. The social work report documents some of the information already noted in this judgment. The pattern of this report and its various successors evidences the progressively increasing information available to the Trust's health and social care professionals, the product of enquiries directed to a range of sources. Thus, while this report evidently followed more detailed discussions with both parents, it also reflected some of the Scottish Social Services and medical records pertaining to F.

[35] During the compilation of this report, F and M suggested that they had moved from their initial place of residence in Scotland due to the "*heavy drinking culture*" prevalent there. [Having reviewed all the evidence, I consider this to be a joint self-serving claim of dubious substance]. They claimed that their relationship was stable, albeit with some tensions. M described her relationship with her parents as "*not good*" and "*strained*". F admitted to previous excessive drinking, denying that this was problematic and further denying having consumed any alcohol during recent months. [Contrast the domestic violence incident history given by both parents on 11th November 2008]. F stated that he had been unemployed since the couple had moved from their first place of residence in Scotland. [Contrast the "one weekend in four" history recorded by the Scottish health visitor – paragraph [8], *supra* - and M's evidence to the court that F had obtained three short lived jobs during this particular period, coupled with the fairly clear objective evidence that neither F nor M had been in gainful employment during a period of some one-and-a-half years or more]. He proffered as the reason for their move to Northern Ireland his "*offer of employment and accommodation in the area*". [However, he had been unemployed since arrival and evidently made no serious attempt to secure employment]. They claimed that they had no financial worries. [M subsequently suggested – at the stage of the second LAC Review – that arguments about money was one of the factors precipitating the termination of their relationship a few weeks later: see also the evidence of Mrs. MC, *infra*].

[36] M asserted that she had observed F's blackouts "*on many occasions*" at their first place of residence in Scotland, but not subsequently. [Contrast her evidence to the court, which was that F had suffered these episodes on "*about four or five*" occasions following their first house move, which occurred in Scotland]. This report also documents some of the information which had been assembled regarding F's history. It was noted that at this stage, medical investigations were incomplete. With regard to the "Scottish" injuries, the only explanation canvassed by him was his "blackout", when he "*fell on top of* [C]". [Of course, objectively, this cannot explain any of the Scottish injuries, given their estimated vintage: and, at the trial, this possible explanation was expressly abandoned by F's counsel]. F admitted to previous alcohol and drug abuse. He further acknowledged a criminal record, but declined to answer when asked whether a previous sentence of imprisonment was attributable to offences of violence. F suggested that there had been only one occasion in Northern Ireland when he had "*consumed alcohol to an extent*". M proffered the (now admitted) incident of domestic violence as the only possible explanation for C's "Northern Irish" injuries. [But neither F nor M, in evidence to the court or in any other information gathering context, has asserted *any physical trauma to C* in this incident]. An assessment of non-accidental injury was considered "*highly likely*".

[37] The outcome of this first LAC Review is documented in the following passage:

> "*PSNI investigation will continue and the Trust will take cognizance of any possible recommendations to the PPS in terms of care planning. However, it is acknowledged that given* [C's] *young age coupled with parents' plausible explanation and the medical view at this stage that it is highly probable that a number of the fractures are of a non-accidental nature that it is likely that rehabilitation will be ruled out in the foreseeable future if there is no indication that parents' explanations have altered or that either parent would be in a position to effectively safeguard and care for this baby and meet her needs*".

While no definitive care plan emerged from this review, this was, of course, an embryonic stage of the phase in question. C remained in foster care and both parents were permitted contact, of which they availed subsequently. However, during the period which intervened between this review and the next one, F did not attend on two occasions and certain explanations for this were proffered. The permitted contact was four times weekly, each session usually being of one and a half hours duration. This pattern has continued to date, with occasional slight increases.

The January 2009 LAC Review

[38] Again, it suffices to highlight only the salient features of this review. It was noted that during contact sessions, M presented with "*little emotion*". However, M asserted that this contact was "*the focus of her life at present*" and that she was "*very upset*" when not in contact with C. On 12th January 2009, M reported to the social worker that the couple had "*split up*". At the LAC meeting, attended by both parents, M "*… advised that it was mainly her decision to end the relationship given arguments over a lot of things i.e. money and work*". It appears that F neither concurred with nor dissented from this explanation. M's interaction with C during contact sessions was described as "*very appropriate*". F asserted that he had experienced various medical problems during the recent past. He further asserted that during one of the contact sessions he had suffered a blackout and that his last blackout had occurred "*prior to Christmas 2008*". He suggested that he had been "*… blacking out for approximately three years and was under investigation in Scotland for same …He has had a lot of difficulties in his overall health which have led to him blacking out.*" He further asserted that he coughed up blood every night. When asked whether he had brought any samples of this blood to his doctor in Northern Ireland, he was unsure. It was recorded that F had previously abused drugs *and* had been a supplier and distributor. He asserted that "*… he no longer uses drugs/alcohol*".

[39] The outcome of this second LAC Review is documented thus:

> "[The Area Principal Social Worker] *related that if the position remains the same in three months time the Trust will have no other choice but to rule out rehabilitation to*

> *either parent's care and if that is agreed at that stage the next option will be to pursue adoption in the absence of suitable placement with relatives which seems very unlikely given the parental histories …*
>
> *A Trust has to balance giving parents every opportunity to demonstrate that they have changed and can safely and effectively meet their child's needs balanced against unnecessary delay in terms of a child's developmental age and agreeing permanency …*".

The "*concurrent care planning*" outcome was to explore the following:

(a) Whether C could be returned to her parents' care, jointly or separately.

(b) Any "*permanency*" alternatives.

In evidence, the Senior Social Worker explained to the court that "*concurrent care planning*" denotes exploring all feasible care alternatives. The possibility of "*rehabilitation*" had not been excluded, at this stage.

<u>LAC Review, April 2009</u>

[40] At this stage, it was noted that M had secured a Non-molestation Order against F on 26th January 2009 and that, following twenty-seven breaches thereof, F had been imprisoned on 25th February 2009 (with his detention continuing until 14th July 2009). M's contact with C was clearly progressing in a very positive and progressive fashion. It was recorded that M had reported that *her mother* was a candidate carer for C. [In due course, in September 2009, M's mother made an application for a Residence Order in respect of C, which she withdrew subsequently]. This was noted with concern, given that some four months previously M had stated that her mother and stepfather "*drink too much now*" and that she had no regular contact with her mother, who "*only telephones when she is drunk*". M had also reported a drunken episode involving her parents at the family home in Scotland during the week following C's birth. This episode was confirmed, in essence, by M's mother. At this stage, M was asserting, for the first time, her conviction that F had perpetrated C's injuries and her disbelief of F's account of the blackout incident on 24th September 2008 in Scotland.

[41] It is abundantly clear from the records of this review that the Trust firmly espoused the view that M had not been candid regarding her knowledge of C's non-accidental injuries and their causation. The incomplete police investigation was also highlighted. Given these factors, the Trust was of the opinion that "… *any assessment of mother as a non abusing parent*" was not appropriate. [I observe that this remained the Trust's view thereafter]. This is particularly clear from the following passage:

> *" … There is very clear medical evidence outlining that* [C's] *injuries were non-accidental. The Trust would also have grave concerns in relation to* [M's] *lack of openness and honesty throughout the process and the Trust feel that at best she has been less than truthful and whilst acknowledging any reason why she may be afraid to be open as there is an ongoing criminal investigation she also delayed telling her mother and arguably misled her that* [C] *was still in her care when she was in foster care … she chose not to tell her mother until a couple of months ago …*
>
> *It is very difficult to progress any assessment of capacity to protect until the criminal proceedings have been concluded …*
>
> *Given* [C's] *young age this poses a real dilemma in terms of acknowledging parents' rights to a fair trial balanced against avoiding unnecessary drift and delay progressing permanency plans for such a young child"*.

The possibility of M undergoing a psychological assessment was expressly canvassed, in the context of a suggestion of "*lack of emotion*" and "*potential for manipulation*". It was also noted that steps designed to identify suitable adoptive parents for C had not been initiated. The outcome of this review entailed a decision incorporating, *inter alia*, the following element:

> "*In the event that the* [PPS] *decide not to proceed to trial, opinion to be sought as to how best to assess the suitability of mother taking on a parenting role of* [C] *…"*

While the possibility of a psychological assessment of M was also noted, it is clear that this was linked to the outcome of any assessment of M's mother as a potential primary carer of C. In the event, one year later, the PPS notified the Trust of its decision that there would be no prosecution and then affirmed this decision, when requested to conduct a review. The court enquired of the Trust witness whether, following this decision, the Trust, in accordance with the passage quoted above, proceeded to obtain the "*opinion*" mooted. Ultimately, the response to this question was negative, coupled with an acknowledgement that this was not the product of a conscious decision, rather a matter of default. It appears to the court that, from September 2009 (*infra*), when the Trust's care plan for C evolved from concurrent care planning to permanency/adoption, a notional door was firmly closed and, thereafter, the Trust personnel concerned did not have an open mind.

<u>LAC Review, September 2009</u>

[42] This is the last of the LAC Reviews which I consider it necessary to examine in some detail. I would add that none of the subsequent LAC Reviews featured in

the examination or cross-examination of any witness or the submissions of the parties. By this stage, the Trust had conducted a "Relative Foster Carer" assessment of M's mother and stepfather, with a negative outcome. Furthermore, associated enquiries of the local police elicited that there had been –

> " *…callouts to the family home due to domestic disputes and alcohol from May 2004 up to as recently as June 2009 …* [The police] *attended the … residence on over forty occasions … and* [on] *the vast majority of occasions have found them to be intoxicated*".

These enquiries also uncovered information that M's stepfather had assaulted her twice, in August 2004 and May 2005, with at least one ensuing prosecution and conviction. These revelations were contrasted with M's assertion that her mother and stepfather "*… drink once in a blue moon … not every weekend*" and her claim that she could not recall the last occasion when they had consumed alcohol, coupled with her description of her relationship with the stepfather as "*fine*". M had further suggested previously, in terms, that the relationship between her mother and stepfather was relatively normal. When asked about this information, M claimed to have "*forgotten*" the assaults and asserted that she was unaware of her stepfather's arrest and prosecution. [Ultimately, M's evidence to the court was to the effect that *none* of these forty police call outs had occurred prior to her initial departure from the family home, when aged almost seventeen years and only two of them occurred – in August 2004 and May 2005 – during the period of approximately one year when she returned to live in the family home: in August 2004, she was aged eighteen and in May 2005, she was aged nineteen]. The LAC report noted:

> "*… this would raise concern regarding* [M's] *insight and assessment of levels of potential risk which would inevitably impact on her ability to safeguard* [C] *if she returned to her care*".

Substantial concerns about M's honesty and candour were recorded. The absence of any further information forthcoming from either parent about C's injuries and the circumstances thereof was also highlighted. These considerations prompted the Trust to recommend that rehabilitation of C to M's care –

> "*… be ruled out at this stage and that her care plan change to permanence planning at this juncture*".

[43] The Trust's care recommendation in respect of C was duly reasoned in the report prepared for the LAC Review. Of the various facts and factors duly rehearsed, the Trust witness confirmed to the court that the only novelty was the information which had been obtained from the Scottish police relating to what appears to have been a tempestuous and alcohol fuelled mother/stepfather relationship during a lengthy period. The Trust witness further agreed that this new

care recommendation represented a very significant change of direction. At this stage, the Trust was also in receipt of the report of Dr. Blumenthal, who had been jointly instructed by F and M. Those in attendance at the meeting debated the virtues of the competing options of rehabilitation and permanency. C's age and the continuing delays in the criminal justice process were highlighted. Also considered were Dr. Blumenthal's views that the falling incident could not explain any of C's injuries, that the metaphyseal fractures were " *… caused by wholly inappropriate handling of the child*" by a knowing perpetrator and that C had been "*… manhandled in a most cruel and inappropriate manner …*". The Chairperson made the contribution that, in her professional career, this was the worst case of its kind experienced by her. At one stage, Dr. Blumenthal's opinion that a non-perpetrating and non-witnessing parent "*… would have no reason to suspect that the child has fractures*" [a view which he ultimately modified – see the summary at the conclusion of paragraph [31] above] was also considered. Notably, the police had reported to the Trust at this stage that their recommendation to the PPS was that both F and M be prosecuted for the offences of neglect of C and causing her grievous bodily harm with intent. Also discussed was the possibility of having M undergo a psychological assessment. This seems to have been rejected on the ground that the trust was disbelieving of M's inability to explain any of C's injuries, coupled with the factor of the forthcoming psychological assessment of M by Dr. Rogers in the litigation process. The Chairperson further opined that even if M were prosecuted and acquitted –

> "*… the Trust would continue to have concerns regarding her parenting capacity and lack of openness …*
>
> *The Trust would still be mindful that neither parent have* [sic] *accepted responsibility for the injuries sustained by* [C], *thereby making it difficult to consider rehabilitation given lack of acknowledgement by either parent*".

While M protested that she had only received the Trust's report on the day of the meeting and wished to have further time to consider it, this was over-ruled.

[44] In the event, the outcome of the September 2009 LAC Review was an acceptance of the Trust recommendation, documented in the following terms:

> "*The Trust fully acknowledge that this is an interference with family life. However, given the serious injuries which* [C] *has sustained coupled with the parental position remaining as was at initial LAC Review and added concerns about the couple's openness and honesty as well as other issues as outlined in social work report for reasons for ruling out rehabilitation, it has been agreed that the Trust will pursue Full Care Order in due course with a view to advising the court that it would propose to pursue permanency via adoption in the first instance*".

In evidence, the Trust's witness confirmed to the court that this outcome was virtually preordained. When asked to elaborate on why, the answer given was that only M opposed it. The various passages in the September LAC review report quoted above, coupled with the evidence of the Trust's witness, convey the clear impression that with effect from September 2009 the Trust closed its mind to any care plan for C other than permanency via adoption. This emerges with particular clarity in the passage in which the hypothesis of a prosecution of M and ensuing acquittal was mooted (see paragraph [44] above.

[45] Following this meeting, LAC Reviews continued at intervals of approximately four months. As noted above, these later reviews did not feature either in the questioning of witnesses at the hearing or the submissions of any of the parties. I would simply highlight that at the stage of the May 2010 review, the first substantive hearing in this litigation saga had been completed (in March 2010) and the PPS decision not to initiate any prosecution had been received. This prompted a request for a review, which the PPS rejected around one month later. The most up to date Trust social care report was prepared for the substantive hearing in this court in March 2010. It contains a care plan which was updated in January 2011. It was confirmed on behalf of the Trust that these two care plans are materially indistinguishable. This report records that those consulted during its compilation included F and M. It reviews fairly extensively the history and the information assembled from various sources. It notes that M, at this stage, had supervised contact with C four days weekly for one-and-a-half hours per session. Once again, this is described in positive terms. The report further documents that F had not attended any contact sessions for a period of almost four months and there had been adverse reports about his conduct, including admitted heavy alcohol consumption. The report also adverts to the outcome of the most recent LAC Review, which had confirmed "*permanency via adoption*" as the best care plan for C. The report acknowledges that, from the outset, M had made the case that –

> "*… she was the primary carer and undertook the bulk of the day to day tasks …*
>
> *She has advised that there were two occasions when* [F] *undertook the care of the baby alone, when she returned to hospital when* [C] *was three days old and also when she visited the hairdresser on 24th September 2008*".

Of course, the medical evidence establishes that none of C's injuries was sustained on either of these dates. The Trust's enduring disbelief of M's protestations of innocence and lack of knowledge is recorded once again. The report continues:

> "*Social worker is concerned regarding* [M's] *lack of openness and honesty regarding her parents' alcohol and relationship difficulties, however is further concerned*

> *regarding her view that her parents would have been appropriate carers for* [C] *in the future pending the outcome of care proceedings …*
>
> *This would raise concern regarding* [M's] *insight and assessment of levels of potential risk which would inevitably impact on her ability to safeguard* [C] *if she returned to her care. Additionally it would highlight concern in relation to her ability to work in an open and honest manner with professionals to ensure the safety of* [C] *in the future*".

[46] The Social Care Report of March 2010 further records a series of new claims made by F about his relationship with M. At this stage M was asserting that this relationship –

> "*…was primarily based on illegal drug use. He alleges that* [M] *smoked cannabis before and throughout her pregnancy. He further alleges that she regularly took Class A substances such as Ecstasy and Cocaine until she discovered she was pregnant.*
>
> *Following* [C's] *reception into care, both he and* [M] *would regularly frequent a local 'health shop' … following contact with their daughter to purchase legal substances such as herbal ecstasy, herbal cocaine and salvia (a legal psychoactive drug used to facilitate visionary states of consciousness)*".

Notably, these claims were made by F for the first time during a meeting with the social worker on 7th February 2010, with the forthcoming first trial looming. This, of course, post-dated successive interviews of F by the police (November 2008 and February 2009) and occurred some fifteen months following his initial contact with Social Services in Northern Ireland. In the report, M's asserted lack of emotion was also highlighted as an issue of concern once again. The report also notes, with concern, M's willingness to suggest her mother as a primary support carer, in the event of M resecuring the care of C. M's assessed personality weaknesses and her refusal to acknowledge any personal shortcomings are also noted with concern. In this context, there is an observation that M may not be receptive to advice and information from others regarding the care of C, given her "*high opinion of her own parenting*".

[47] The concluding passages in the social work report of March 2010 include the following:

> "*It is a grave concern within this case that both parents sought medical help together for* [C] *on 17th and 24th September 2008. Both parents appeared to work in*

> *partnership with health visiting staff during home visits following* [C's] *birth. Both parents advised of a happy, stable relationship. However despite these factors* [C] *suffered [five] fractures and two eye injuries whilst in her parents' care …*
>
> *Both parents continue to deny responsibility for the injuries and both continue to allude that the other is the perpetrator*".

This is followed by a litany of the various other concerns and reservations entertained by the Trust regarding M. These may be summarised as lack of candour and honesty; failing to prioritise C's needs and interests; failing to seek medical care and attention for C; non-disclosure of material information to the health visitor and other professionals; a lack of insight; a failure to recognise personal shortcomings; and a probable reluctance to respond positively to advice and assistance. Given this combination of factors, the Trust continued to espouse a care plan excluding the possibility of the rehabilitation of C with M and favouring permanency via adoption. This was the most up to date report and care plan considered by the court at the stage of the first substantive hearing, in March 2010. There has been no development of any significance subsequently and the care plan remains essentially unchanged.

[48] In evidence, the Trust's witness questioned M's asserted lack of knowledge about both the infliction and the fact of the injuries sustained by C in Northern Ireland. She suggested that as M was the child's primary carer, this is not credible. She reiterated the various concerns and reservations documented extensively in the reports which I have read in full and have summarised above. Since C has been assigned to foster care, M has had contact four times weekly. It was acknowledged by the Trust's witness that the quality of this contact has been consistently very positive. C responds to M. During these sessions, M is very attentive to C. She arrives punctually, her attendance is excellent and she is clearly anxious that she be reinstated as C's carer. She has always been polite and co-operative. Her denials regarding C's injuries and her knowledge thereof have been consistent. It is accepted on behalf of the Trust that after leaving school M had a good working record; had acquired her own flat by the age of twenty-one years; has never previously been involved with the social services; has no criminal record; appears to have had no previous unsuitable relationships; has no alcohol or drug abuse history; and appears to have excellent maternal commitment. It is also accepted that there has been no restoration of the F and M relationship since January 2009.

[49] The Senior Social Worker further gave evidence of the Trust's opinion that C should be adopted. It was suggested that this would be clearly preferable to long term foster care, entailing greater stability for C and no social services involvement. C's foster carers since the events of November 2008 are not candidates as adoptive parents. The Trust's proposal is that the court make a care order in its favour, which

will be followed by a freeing application. In the short term, there would be gradual diminution in contact between M and C, identification of suitable adoptive parents and progressively increasing contact between C and them. Finally, it was suggested that suitable adoptive parents could be identified within a matter of weeks.

IX PSYCHOLOGICAL ASSESSMENT OF M

[50] The issues relating to M's veracity and credibility were ventilated particularly in the evidence of Dr. McCartan, a clinical psychologist, who prepared a report on M's behalf for the purpose of this litigation. Dr. McCartan's report is based on, *inter alia*, her interview of M, which had the following salient features:

(a) M described her childhood as "*normal*".

(b) She reported no abnormality or difficulty in her relationship with her parents.

(c) She suggested that alcohol consumption became a difficulty in the relationship between her parents after she had left home.

(d) Specifically, she recounted *one* incident involving the police, in this context.

(e) She stated that her parents had separated some two or three months previously and that this "*… resulted from stress associated with ongoing care proceedings*" (i.e. this litigation).

(f) She suggested that any deterioration in her relationship with her stepfather post dated her leaving home.

(g) She stopped smoking shortly before the commencement of her pregnancy.

(h) She disclosed no details regarding her abortion in May 2007.

(i) She described F as "*not the sort of person I would usually go for*".

(j) She disclosed nothing of note regarding her medical, psychological or psychiatric history.

(k) She gave an account of the episode of domestic violence in Northern Ireland which made no mention of her being on stairs or holding C at the time or falling with C in her arms. In giving this account, she was at pains to emphasize that she did not normally feed C downstairs.

(l) Subsequently (per M) she did not tell her doctor the truth about this incident on account of *embarrassment*.

(m) She did not clearly state the cause/s of the termination of her relationship with F in January 2009.

(n) She now regrets getting involved with F, contrary to the advice of friends and family.

(o) She considered parenting to be "*the best thing in the world*".

(p) She felt that she had provided "*the best possible care*" for C.

(q) She had not "*done anything wrong*" in her parenting of C.

(r) "*… I look back and … I think I done everything I could have done*".

(s) She was coping extremely well with her current situation.

[51] On the basis of Dr. McCartan's report and her sworn evidence, there are certain other aspects of her interview of M worthy of highlighting. Firstly, in response to the court, Dr. McCartan confirmed that M was largely reactive throughout the interview: she made spontaneous disclosure of very little indeed. The main exception to this is reflected in the following passage, concerned with the incident of domestic violence in Northern Ireland:

> "[M] *said she went upstairs and brought* [C] *downstairs to feed her.* [M] *went into a great deal of detail on this point which was unprompted. Mostly relating to the fact that she did not usually feed* [C] *downstairs.*"

Secondly, throughout the interview, M was superficially composed and confident, responding quickly. However, when the interview focussed on the specific topic of the arrangements which she would make for C's care in the future:

> "*She became anxious during this discussion and changed her mind frequently. It was likely she had not prepared for this question and had not thought through her response*".

Dr. McCartan testified that M struggled during this part of the interview and she clearly found this striking. In particular, M clearly had no developed plans in relation to her own further education. Thirdly, in broad terms, M said very little indeed which could reflect adversely on her personal skills, competences and characteristics. This is linked to the conclusions in Dr. McCartan's report:

> "*… she makes an effort to present a socially acceptable front and resists admitting personal shortcomings. Responses indicated she considers psychological problems as a sign of emotional or moral weakness and she is likely to deny symptoms. This likely relates to concerns about being appraised unfavourably by others. She wants to appear composed, sociable and conventional in her behaviour … denial, contention and conformity are features that best characterise her. She tries her best to meet the expectation of others and fears criticism or derogation. …*
>
> *She is likely to possess feelings of insecurity and inadequacy …*
>
> [She] *denies her own shortcomings*".

[52] Elaborating in her sworn evidence, Dr. McCartan explained that M exhibited a strong personality trait which entailed the denial of personal weaknesses and the consistent provision of socially desirable responses to questioning. In both her report and initially in her evidence, Dr. McCartan espoused the thesis that M's choice of F was not consistent with her conservative personality profile and background generally. However, in cross-examination, she accepted that she had been misled by M's assertions of a conservative, normal, stable and happy upbringing. These assertions were exposed as untruthful particularly by the evidence relating to the frequent involvement of the police in her parents' relationship, the assaults perpetrated against M by her father and the two ensuing prosecutions. Dr. McCartan accepted that M had been untruthful to her in these respects. I interpose the observation that the court will have to consider Dr. McCartan's concessions in the light of all the other evidence, particularly M's evidence that all of these "police problems" *postdated* her initial departure from the family home when aged sixteen years *and* that there were two "police" incidents only during her return to the family home, between the ages of eighteen and nineteen.

[53] Dr. McCartan was asked also about the medical history disclosed to her by M, in response to questioning. She was questioned specifically about M's to disclose that she had been treated previously for depression. Dr. McCartan agreed that M had lied to her about these matters. She accepted that from the perspective of parenting this lack of truthfulness, coupled with her aforementioned personality trait and her failure to proactively volunteer the fact and circumstances of C's fractured femur in Scotland following the family's move to Northern Ireland, all constitute negative factors. Notwithstanding, Dr. McCartan espoused the view that M is a suitable candidate for a form of therapeutic intervention designed to address the personality frailties which, at present, would inhibit her successful interaction with professionals attempting to counsel and assist her in the future, in the context of reunification with C. The programme proposed by Dr. McCartan is described by her report in the following terms:

> "[M] *would benefit from parenting classes aimed at addressing the responsibility of parenting. She needs to develop the ability to follow through a process aimed at identifying sources of distress in her child. Integrated within this educational process should be strategies to enable* [M] *to develop a network of help and support …*
>
> [M] *would require ongoing support. She needs to develop a relationship with professionals involved in her and her child's care and try to overcome the tendencies in her personality to withhold socially undesirable information. The development of trust within these relationships is important. She needs to work towards increasing disclosure to professionals. She is likely to find this difficult, however it would be important for her to prioritise the needs of her child and develop more open and transparent relationships*".

Elaborating, Dr. McCartan opined that the course of parenting skills classes recommended should be preceded by a twelve week course of "*motivational interviews*", designed to ensure that M would be fully motivated for the parenting classes and to assist her positive and construction interaction with professionals. While Dr. McCartan agreed with the court that M's personality trait (as described above) is ingrained in nature, the thrust of her evidence was that it could be addressed by the therapy recommended by her. She further agreed that the main problem flowing from M's personality is a failure to make full and spontaneous disclosure of the truth. Notably, Dr. Rogers expresses a similar opinion in her reports (*infra*).

[54] Linked to the above, the evidence available to the court includes information supplied by the relevant Scottish Constabulary. This discloses that during the period April 2004 to June 2009, there were repeated incidents involving intoxication of both of M's parents at various hours of the day and allegations of assault: some forty in total. The beginning of this period – April 2004 – is of no little significance, given M's unchallenged evidence that she left the family home when aged almost seventeen viz. circa February 2003, for a period of some one and a half years, whereupon she resumed her residence there, remaining for about one year. The evidence establishes an assault perpetrated against M by her father in August 2004, resulting in prosecution and conviction. M acknowledged this when interviewed in the exercise of compiling the Trust's litigation reports. The second assault was perpetrated in May 2005 and this too was acknowledged by M. One of these assaults resulted in her father being prosecuted, about which M claimed to know nothing. The dates of the two stepfather's assaults – August 2004 and May 2005 – are consistent with M's evidence about leaving home when aged almost seventeen and returning later, after around one and a half years, for a period of about one year. I calculate that the second of these assaults was the ninth incident documented in the police records spanning a period of approximately one year. Thus the available

evidence points to a clear finding that approximately ten of the police incidents occurred after M had returned to live at home. I find further that she must have known of most of these incidents, either through observation or as a result of subsequent discovery. It follows that in her dealings with professionals and in her evidence to report, M has not been truthful about this discrete issue.

[55] In this context, it is also appropriate to record those documented aspects of M's medical history which are at variance with her assertion to Dr. McCartan that "*… she had no previous contact with psychology or psychiatry*". This is belied by three entries in M's Scottish medical records. Firstly, it is documented that on 15th October 2003, she attended her general practitioner, complaining of "*feeling emotional at times* [and] *not socialising as much …*". Examination was normal and it appears that no medication was prescribed. The second significant record is dated 25th March 2007 and records:

> "*Poor sleep for several months … nightmares … difficulty falling asleep and feels she is sleeping lightly. Will manage to get a few hours. Recent bereavements … has taken quite a few days off work and has had warnings.*"

M's general practitioner prescribed Trazodone for this condition, to be taken once nightly. Furthermore, the doctor certified a one week absence from employment on account of "*depression*". M was reviewed one month later, on 20th April 2007, when it was recorded "*Mood is normal now*". This discrepancy featured prominently in the cross-examination of Dr. McCartan. While Dr. McCartan became a little flustered at one stage of her cross-examination, I am satisfied that the essential thrust of her professional opinion evidence was not undermined.

[56] The psychological evidence relating to M includes reports prepared by Dr. Rodgers, who is described as a chartered psychologist. She was engaged by M's solicitors to assess M and report. While she did not give evidence to the court, her reports featured in the questioning of certain witnesses and, further, constitute admissible evidence under the Civil Evidence (NI) Order 1987. Notably, in common with Dr. McCartan, Dr. Rodgers assessed (*inter alia*) –

> "*…A lack of insight into her own potential weaknesses and how resilient one has to be for motherhood. Here, in this domain she needs intensive help.*"

Dr. Rodgers considered M to be sensible and emotionally stable. She noted the misrepresentation involved in M's claim that she had experienced a stable upbringing. She also recorded M's assertion that she had "*… never been treated by her GP for anxiety or a depressive illness …*". Dr. Rodgers noted some lack of emotion and insensitivity on the part of M. She recorded that M was unreceptive to the suggestion that she attend "Child Development" classes, prompting the comment that M –

> "*… needs to open up to professionals with regard to her emotions, in order to prove that she can become a responsible parent …*
>
> [M] *needs intensive counselling …* [and] *needs to prove … that she has the emotional skills to relate properly to* [C] *at the different stages in her life.*"

Once again, the symmetry between the two psychologists is noteworthy. Dr. Rodgers further opined that M had been "*very controlling*" during her relationship with F. Her report also comments:

> "*In many areas I found* [M] *to be highly manipulative and what is described in psychology as Faking Good. Basically she was not particularly truthful to me concerning some events. …*".

Dr. Rodgers was clearly of the opinion that M could benefit from certain psychological and other therapeutic interventions. Specifically, she opined:

> "*I have no doubt that* [M] *can look after* [C's] *physical needs and when I suggested that she attend Child Development classes she was unreceptive.* [M] *needs to open up to professionals, with regard to her emotions, in order to prove that she can become a responsible parent …*"

In this respect, there is an identifiable symmetry with the opinion expressed by Dr. McCartan, albeit not without qualification. Fundamentally, both psychologists envisage that C could, realistically, be rehabilitated with M. In this they were supported by Dr. Dale (*infra*). I would highlight one further aspect of Dr. Rodgers' opinion:

> "*It is important that* [M] *has a therapist to help her come to terms with the complexities of the case and to try to enhance her emotional ability to look after* [C]. *Within this case* [M] *has never had the opportunity to relive these experiences through therapy. Rather she goes from day to day in an automatic manner …*".

The court will bear in mind these observations when evaluating M's sworn evidence.

<u>Dr. Dale</u>

[57] While Dr. Dale is not a psychologist by profession, it is convenient to consider his evidence at this juncture. His qualifications and credentials belong mainly to the

spheres of child protection, family assessments and family counselling. He is a qualified psychiatric social worker and the subject of child abuse featured in his doctorate. I am satisfied that he professes expertise in the field of child protection. In these proceedings he prepared a report on behalf of M. He was not involved during the earlier phases of this litigation and the court was informed that he did not give evidence at the original trial. In summary terms, he advocates strongly an outcome involving the reunification of M and C. Dr. Dale espoused two alternative future care models for C. The first involves reunification of C with M in the setting of Mrs. MC's home. Within this framework, Mrs. MC will be available to provide any necessary support and advice to M, supplemented by appropriate input from social services. He described Mrs. MC in positive terms. He clearly espoused this as the paradigm model of future care for C. He opined that this model would be in C's best interests and is in no way dependent upon the availability of any support from M's mother. He stated in his evidence that it would be "*… difficult to conceive of something better*". When asked what his opinion would be if Mrs. MC were not available to perform this role, his immediate answer was that the reunification of M and C should be pursued. Dr. Dale agreed that he had not addressed this alternative model in his report and the court has had to reflect on whether he espoused it all too willingly. Having done so, I do not consider that he has investigated and evaluated this alternative care model fully. I would also observe that, in parts of his evidence, Dr. Dale did not engage or communicate well with the court. In particular, at times, he failed to provide concise, comprehensible answers to short, focussed questions and many of his replies were of unnecessary, occasionally bewildering, prolixity.

[58] Dr. Dale suggested that C's best interests would not be served if "*double severance*" were to eventuate: this would occur if C were separated from her current foster parents (with whom there is clearly a strong bond) *and* M. He opined that even if "*permanency via adoption*" were to be pursued, frequent continuing contact between M and C would bring "*huge benefits*" for C. His assessment did not identify any significant risk indicators which would contra indicate reunification of M with C. He suggested that, at this stage, there are no adverse psychosocial stress factors affecting M. He expressed the view that during the immediate post-birth phase there were three such factors: the increasingly difficult M/F relationship; M's adjustment to parenthood; and the developing isolation of M from her previous support system, her mother especially. I would observe that the first of these factors does not emerge clearly from the voluminous documentation available to the court; Dr. Dale confirmed that the second factor is a generalised one, not specific to M; and the third factor must be evaluated in the light of all the available evidence about M's relationship with her mother in the period preceding and during her pregnancy.

[59] I would record that a substantial part of the cross-examination of Dr. Dale entailed inviting him to comment on matters of consistency, reliability and veracity by reference to a series of reports and records. I am alert to these issues, have highlighted many of them above and will take them into account fully in the conclusions expressed in this judgment. However, little of substance or value

emerged from this series of questions. Dr. Dale adhered firmly to his opinion about the best future care plan for C. In doing so, he suggested that the Trust had formed the "*simplistic*" view that C would be at serious risk of further injury if reunited with M because the perpetrator of C's non-accidental injuries has not been identified. He described this as the "*major plank*" of the Trust's analysis. He appeared to attribute very little weight indeed to the other risk factors identified in the Trust's reports – in particular, M's veracity; the inconsistencies in some of the assertions and accounts provided by M; the diagnosis of M's "socially accepted responses" personality trait; M's unrealistically elevated view of her parenting skills; her denial of personal shortcomings; and her resistance to external interventions and assistance. I would observe that Dr. Dale's opinion involves an approach which effectively dismisses all of these concerns brusquely, rather than individually and critically. Properly analysed, he did not acknowledge in his evidence *any* factor adverse to the future care plan proposed by him. In particular, he did not acknowledge any significant frailty or shortcoming in M's personality, psychological architecture or life history. Having regard to all the evidence available, I do not consider this aspect of Dr. Dale's evidence convincing. However, it is incumbent on the court to consider Dr. Dale's evidence in its totality, balancing this assessment with other aspects of his evidence which point positively towards adoption of the reunification model. In particular, I accept that the various steps and assessments conducted by him in compiling his report were both objective and thorough and there is no identifiable criticism from this perspective. Further, his very favourable view of the current mother/child relationship is obviously an important factor and I note that this is not contested. Moreover, in my view, one of the most significant features of Dr. Dale's evidence is that it was strongly buttressed in certain key respects by the evidence of Mrs. MC. It is appropriate to consider her evidence at this juncture.

<u>Mrs. MC</u>

[60] I consider that Mrs. MC's evidence is to be analysed from two main perspectives. The first concerns the role which she could constructively play in a future care scenario involving M and C living with her. The second relates to the contribution which her evidence makes to the court's evaluation of the issues pertaining to parental perpetration of C's injuries and parental awareness of such injuries, within the contours of the framework sketched in paragraphs [3] – [6] above. Mrs MC gave evidence by video link. She had previously been the subject of a Trust assessment which, in content and tone, was reasonably positive. This assessment highlighted two areas of concern, namely Mrs. MC's commitment to three grandchildren who, with her son, are presently residing with her (and her husband) on account of her son's marital estrangement and, secondly, her state of health.

[61] Mrs. MC was previously F's foster mother. As such, she is particularly well equipped to provide accurate and reliable evidence of his personality and character. She testified that throughout the period of the fostering arrangement F's behaviour was volatile and unpredictable. In her words, he was "*… beyond reasoning, would not*

listen, would not take advice and was determined to go his own way". She recounted that she was quite frightened of him when he was under the influence of drink or drugs, a phenomenon which dates from his early teens. According to Mrs. MC, her home "*… was no longer a home, just a place of fear…*". She described F as angry, very aggressive and violent. He would "*trash the place*". She was afraid of what he was capable of doing. He perpetrated incidents of violence, assault and aggression in her home. These included assaults committed against her husband and son. Referring to his criminal record, she testified that on one occasion F stole the family car and smashed it. On another, he threatened girls with a knife. She described F as "*a control freak*".

[62] Mrs. MC had direct involvement in an earlier Scottish Social Services investigation involving F. (See the reference in paragraph [14] above). This arose when F was in a relationship with another female person, the mother of a young child. During this phase of his life, he called at Mrs. MC's home with some frequency. Mrs. MC considered the child to be very frightened of F, very timid, intimidated by him. On one occasion she noticed an injury to the child's face. F and the child's mother provided conflicting accounts of this, one describing a fall in the bath, the other recounting falling out of bed. Mrs. MC was sufficiently concerned about this to make a report to the Social Services. The duration of the relationship was confined to some months only. This aspect of Mrs. MC's evidence is corroborated by the Scottish Social Services records and was not challenged in cross-examination on behalf of F.

[63] F was aged nine years when the fostering placement with Mrs. MC began and it ended at the age of sixteen. Some time later, after F and M had initiated their relationship, they lived with Mrs. MC for a period. She was struck that F at no time left M on her own with Mrs. MC. According to her, F was "*controlling*" M, who was permitted to do only what F wanted. If F went out, M remained in her room. She described M as "*very nice, very sensible and reliable*". She suggested, in terms, that F would be quite prepared to fabricate allegations against both M and her. She added that if she were to have a role in M's reunification with C, F would "*do anything possible to upset this arrangement … he is a liar*". I would also highlight the following passage in Mrs. MC's written statement to the police, dated 19th May 2009:

> "*Some time around March or April … I received a call from* [F] *on the telephone …*
>
> *I took* [what he said] *to mean he was wanting to come and live here. I told* [F] *that wasn't an option … I had three grandchildren here and I did not want to jeopardise them.* [F] *replied '**Do you think I'm going up there to do the same to your children**' …*
>
> *I have never spoke* [sic] *with* [F] *about that comment he made. I was stunned when he said it.*"

[My emphasis].

I find that this conversation occurred, in the terms described. While its primary significance is self-evident, its secondary significance is its strong suggestion of the absence of any father/daughter bond of affection.

[64] The final aspect of Mrs. MC's evidence to be noted concerns the role which she might play in the reunification of M and C. She clearly has a warm and communicative relationship with M. It would appear that M is willing to trust and rely on Mrs. MC. She and M confide in each other, in the context of a close relationship and she is confident that M would accept her advice. Mrs. MC would be quite willing to co-operate with the Social Services. This would extend to making a report of anything untoward. There is a bedroom in Mrs. MC's home, which would be suitable for M and C. Mrs. MC testified that she would be vigilant vis-à-vis C. Her main role would be to provide such support and advice as might be required. She is now aged sixty-two and suffers from spinal arthritis. She mobilises without an aid indoors. She takes painkillers. Her husband is aged sixty-five and in reasonable health. He drives her grandchildren (ages five, four and three) when required. When her son returns home from work at 5.00pm daily he devotes most of his time and attention to the children.

X F'S HISTORY

[65] F is now aged twenty four years, having been born in January 1987. There are significant elements of duplication, repetition and overlap in the extensive reports which have been compiled from time to time. As a result, I have already touched on this discrete subject in various passages of this judgment. I shall, therefore, highlight only the most salient features of the other materials. I would add that in making the findings and reaching the conclusions set out at a later stage of this judgment, I have also taken into account the relevant passages in the transcript of the original first instance hearing. In particular, it was submitted by Mrs. Dinsmore QC (appearing with Ms Robinson, on behalf of M) that I should have regard to the transcript of F's evidence and, without objection by Ms McGrenera QC (appearing with Ms McGregor, on behalf of F), I have duly done so. I observe further that there was no dispute about the accuracy or completeness of the transcript. Given that it contains sworn evidence provided in a courtroom setting, its significance is clear. To this I would add only that most transcripts suffer from certain intrinsic limitations, in particular their inability to reproduce in full the live courtroom setting within which the demeanour of witnesses and the speed, tone and flow of their replies to questions feature prominently.

Criminal Record

[66] F was convicted of a series of offences between 2004 and 2007. These were an assortment of road traffic offences; public order offences; breach of probation and

offending whilst on bail. He was also convicted of three offences contrary to the Misuse of Drugs Act 1971. The indications are that these latter offences were of a relatively minor nature. In summary, F's criminal record was accumulated between the years 2001 and 2007 and consists of fifteen public order offences, two offences against the person, two offences against property, four breaches of probation and offending whilst on bail and three drugs offences. In a Social Inquiry Report prepared for the Sheriff Court in June 2007, it was recorded:

> "[F's] *lifestyle has been somewhat chaotic …*
>
> [F] *stated that he does enjoy going out drinking and socialising with his friends but unfortunately once he starts drinking he finds it difficult to stop. All his offending has been related to his substance misuse …*
>
> *Attempts to address this through probation etc. have been unsuccessful …he is not willing to totally abstain from alcohol. Until such time as he does or adopts a more controlled approach to his drinking he remains at risk of reoffending*".

In the context of discussing the series of non-custodial disposals previously administered to F:

> "*None of these community based disposals have been successful in dissuading* [F] *from reoffending and his compliance has been poor …*
>
> *The writer has carried out a risk assessment … which scores him at high risk of reoffending and low risk of harm. This is based on factors such as age at first conviction, number of criminal convictions, compliance with court orders and alcohol/drug misuse*".

<u>Substance Misuse</u>

[67] As a perusal of this judgment will confirm, this issue recurs throughout many of the various reports and records already considered above. The essence of this discrete subject is encapsulated in a psychiatric report of December 2005 addressed (apparently) to F's general medical practitioner. This states, *inter alia*:

> "*He claims to be having problems with his sleep pattern and was abusing drugs and had suicidal intent. He has been off drugs and alcohol for the last two days and was previously abusing ecstasy, cocaine, cannabis and alcohol …*

> *On examination he did have old injuries to his right forearm which were self inflicted by knife …*
>
> *He does have insight into his drug and alcohol problem …*
>
> *He has had life developmental problems associated with childhood trauma …*
>
> *Dr.* [C] *has advised Lifestyle counselling and support for issues dealing with life, drug and alcohol problems*".

It is noteworthy that while this report was based on an assessment conducted on 22nd November 2005, within less than two weeks F attended the hospital in a significantly intoxicated state, asserting that he had a painful left elbow without any recollection of how this had occurred and then discharged himself. There is a noteworthy hospital report of August 2005 recording "*Drug overdose*" in respect of F:

> "*This young man with a previous history of alcohol intoxication and most probably Ecstasy abuse was brought by the police to the Casualty Department with abnormal movements and hallucinations. He was not aware of his surroundings and later on became very aggressive and agitated …*
>
> *He woke up in the morning swearing profusely, very aggressive and agitated, not aware of where he was. He dressed himself and discharged himself.*"

<u>F's Medical History: " Blackouts"</u>

[68] I consider this discrete issue to be of some importance and worthy of separate consideration. As appears from the foregoing, both F and M have made various statements at different times concerning this topic. On a number of occasions, F has described his alleged "blackouts" in tandem with other symptoms or conditions including coughing up blood. His assertions about this must be evaluated particularly by reference to his medical records. In this respect, it is recorded that in August and September 2007 F reported symptoms of "*coughing up blood stained sputum*". It is clear from the records that F was investigated in February 2008 in response to his report of "*episodes of intermittent haematemesis*". He was linking vomiting with coughing up small quantities of blood. He gave a history of having formerly consumed cannabis and described himself as a previous heavy drinker, "*but this has resolved over the last few months*". Following appropriate investigations, including a CT scan, no abnormality was detected. At this stage, M was pregnant and she gave birth to C six months later. The next significant record is dated 24th September 2008 and belongs to the VI Hospital. This notes:

> "*No neurological symptoms. No signs of seizure. Had IX previously – may require neuro clinic assessment. History of haematemesis …*
>
> *Discharge with GP follow up.*"

The diagnosis was "*collapse plus episode coffee ground vomit*".

The following day, F's general practitioner compiled this record:

> "*Claims had blackout whilst holding baby daughter. Baby now in RHSC with broken leg. Unwitnessed blackout – partner came home to find him on floor and baby crying. Patient seen as VIC. Nil of note … No substance misuse. Fine today. Says has happened before. Never investigated. Relocating to Northern Ireland in four days for three years. Advised to re-register with GP and pursue investigation.*"

Having trawled through F's Scottish medical records and having raised this with counsel as one of a series of discrete "information" issues upon which the court was seeking assistance, I have found nothing else bearing on this particular subject.

[69] I now turn to consider the Northern Ireland phase. Following registration at the "M" Family Surgery in Northern Ireland, F was first assessed by his new general practitioner, Dr. D, on 20th October 2008. Although he had been advised less than one month previously, in Scotland, to pursue his alleged "blackouts" following re-registration in Northern Ireland, he did not do so at this stage. Nor did he raise this issue when he returned to the surgery on 28th October 2008. In this context, the chronology is of some importance, given the agreed evidence that all of C's Northern Irish injuries were sustained between 24th October and 7th November 2008. Next, there is a general practitioner's record dated 5th November 2008, compiled by Dr. P, in the following terms:

> "*Gives a three-year history of passing out, coughing blood, vomiting blood, blood in urine and faeces, abdominal pain.* ***Even dropped child during an episode and child got a fractured femur. Claims has been seen in hospital but nothing done. Story doesn't add up – get notes urgently, bloods and self-refer A and E if worse***".

[My emphasis].

This record was a crucial factor in the chain of events which ensued on 5th and 6th November 2008. I note from his custody record that following F's arrest on 7th November 2008, he asserted that he was suffering from "*fits, blackouts and … severe abdominal pain*". Following the seminal events of 6th November 2008, F reattended the surgery on 10th November 2008, when it was noted:

> "*Still claims collapse and fell on daughter. Admits past history of jail and drug abuse and claims has been clean for past two and a half years.*"

It appears that Diazepam was prescribed. Many of the medical records in the immediately ensuing phase relates to prescriptions of this kind. Two days later, F returned to the surgery:

> "*Claims Diazepam not helping and keen for sleepers*".

A short course of Temazepam as prescribed. On 18th November 2008, he returned to the surgery asserting that the Diazepam prescription was exhausted. A further prescription, entailing four tablets combined per day, was given.

[70] On 27th November 2008, F gave a history in the following terms:

> "*Alleges collapsed at visit with* [C] *and admitted to surgical ward…*
>
> *Given Tramadol and requesting same. Advised not to take with sleepers …*".

The corresponding Social Services record documents that F was grimacing and seemed to have a lot of stomach pain, but makes no reference to him collapsing. The context was one of a session of joint parental contact with C. The record continues:

> "[M] *explained to* [social worker] *that this was how* [C] *had got her injuries.* [M] *seemed to be very calm as she explained to the paramedics* [F's] *medical history*".

Next on 28th November 2008, the hospital reported to Dr. D regarding a variety of asserted symptoms, none of which included "blackouts". On 1st December 2008, F continued to assert symptoms of blood in phlegm, vomit and urine. However, it was noted that the investigation of these symptoms in Scotland was normal. Dr. D advised him to reduce and stop his existing medication, provoking an angry reaction. On 15th December 2008, F returned to the surgery, asserting the persistence of symptoms. The next hospital report, which is dated 17th December 2008, makes no mention of "blackouts". On 19th December 2008, F requested Cocodamol. He returned to the surgery on three further occasions in the month of December. On 12th January 2009, he was requested, and was refused, sleeping tablets.

[71] At this juncture, it is appropriate to reflect on the report of Mr. Byrnes, consultant neurosurgeon, who examined F in a litigation context on 30th June 2009. Mr. Byrnes recorded:

> *"He claims to suffer two ongoing difficulties. One is what he terms 'blackouts' and the other is a combination of asthma and coughing up blood …*
>
> *He claims to have had several episodes of loss of consciousness now for more than three years. He states these episodes have recurred between ten and fifteen times and have been witnessed on occasion by others, including …* [M] … [and] *workmates while at sea fishing, both in Scotland and Northern Ireland…*
>
> *The episodes last some five to ten minutes. In response to leading questions he states that he has bitten his tongue during these events …*
>
> *In spite of falling unconscious he has suffered no serious injuries. The last attack was some three months ago prior to the date of this interview in June of this year …*
>
> *He feels that they are getting worse …*".

The tone of Mr. Byrnes' report is somewhat sceptical. He considered that the only realistic possibility was that of epilepsy and concluded that this could not be diagnosed in the absence of further evidence and medical investigations, including a scan. Mr. Byrnes commented:

> "*When these investigations are completed I am bound to say that I suspect no abnormalities will be found*".

F's solicitors then arranged to obtain a report from a consultant neuroradiologist (Dr. Flynn). As a result, an MRI scan of F's brain was performed, giving rise to a report confirming that there was no abnormality. Most recently, Dr. Byrnes, having considered this report, has commented:

> "*I have little to add to my report … beyond stating that this lessens the likelihood – but not the possibility – that there is anything amiss neurologically.*"

In short, there is no evidence before the court diagnosing any recognised medical condition which could account for F's alleged "blackouts". Indeed, quite the contrary: the orientation of all of the medical evidence bearing on this particular issue questions and undermines F's subjective claims. I shall consider the significance of this at a later stage of this judgment.

<u>Previous Child Care Concerns</u>

[72] It is clear from various sources that F had a difficult upbringing. One of the reports describes his early life as "*turbulent*". Effectively, with the exception of one very short period, he has been reared in residential and foster care since the age of three years. It is recorded that when aged twelve and thirteen years he was physically and verbally aggressive and abusive towards his carers and this gave rise to complications in his accommodation and management at this stage. When aged seventeen years he began a relationship with a young lady aged twenty-one years who had a two year old baby. It is recorded that he remained at home, caring for the child while his partner went out to work. An investigation resulted from the discovery that the child's face was bruised. Part of this investigation entailed an interview by the social worker with Mrs. MC (see the summary of her evidence to the court above). The history given by F was that the child "*… had hit her head off the table leg or something …*" while he and the child's mother were occupied upstairs. During this investigation, which Mrs. MC reported:

> "[F] *is a control freak and can be very cruel.* [The child] *was made to sit on a chair and sit nice and not get off the chair. She hardly speaks …*
>
> [The foster mother] … *felt unhappy that* [F] *was looking after the child*".

It was recorded that concerns about the care of the child had postdated the commencement of this relationship.

[73] Another report recorded that, on one occasion, F had gone to bed, leaving the child alone. It was further reported that the child was withdrawn and fearful in F's presence. A doctor apparently opined that the child's bruised face was consistent with having banged into furniture. It was reported that during one visit by a social worker F had threatened "*I'll break your legs*". As the investigation progressed, the mother decided to leave her job so as to provide enhanced care to her child. The outcome of the investigation was that the child's name was recorded on the Child Protection Register, being at risk of physical and emotional abuse. This was discontinued at a later stage after the mother's relationship with F had terminated. There is no suggestion that any prosecution ensued. This discrete topic overlaps with that of F's alleged "blackout", on account of his swift assertion, when asked about the previous child care incident at the initial hearing, that this was "*exactly the same incident*" which eventually matured into a suggestion that the child had fallen on a slippery bathroom floor out of his sight. Later, he sought to bolster an impression of innocence by adding a claim that the child was fearful of all males. Evidently the two adults separated quickly following the involvement of the social services. The manner in which F dealt with questioning about a suggestion that he had threatened to break the legs of a lady social worker is also striking: initially he denied the suggestion; then he admitted it; he justified his initial denial seemingly on the basis of limited recollection; and then he admitted to having threatened the lady on multiple occasions.

XI M'S EVIDENCE TO THE COURT

[74] M spent a lengthy period of time in the witness box. This entailed some unavoidable interruptions, to facilitate other witnesses. She made good eye contact with the court and answered most questions articulately and with minimal hesitation. She is clearly an intelligent young woman. While I have reviewed her evidence in its totality I do not propose to rehearse same, *in extenso*. Rather, I shall focus on certain salient aspects. At the outset, I observe that F and M are both Scottish nationals and, following the initiation of their relationship, they made one move in Scotland, preceding C's birth. This was followed by their move to Northern Ireland.

[75] M was born on 20th February 1986 and she is now aged twenty-five years. She is an only child. Her father died when she was around aged ten and her mother remarried. Her mother and stepfather apparently remain together, notwithstanding a significant degree of turbulence. M left school when aged fifteen years. At the age of almost seventeen, she left home and lived independently for a period of about one and a half years. Then she returned to live with her parents for around one year. She has had a number of different jobs and earned and saved sufficiently to become the owner of a flat. She first met F in June 2007. It would appear that their relationship commenced towards the latter end of F's documented criminal career. The pregnancy giving rise to C's birth was a planned one. Their house move in Scotland took place in April 2008, roughly mid pregnancy. Throughout the entirety of the pregnancy, F worked for one week only, as a fisherman (essentially, his trade).

[76] In her evidence to the court M either asserted or admitted the following (*inter alia*):

(a) F was quite intoxicated when he assaulted her in Northern Ireland on 24th October 2008. [At the first hearing, F readily admitted to having consumed a very large quantity of alcohol]. She had never seen him drunk previously.

(b) She subsequently lied about this assault because she did not want anyone to think that their relationship was always like this.

(c) Shortly after the commencement of the relationship, F had stopped abusing drink and drugs and was in no further trouble with the police.

(d) In the aftermath of the traumatic events in early November 2008, F "*got bombed out*" on the prescribed Tamazepam and Diazepam.

(e) Neither of them consumed illegal drugs following the inception of their relationship.

(f) Following her birth, C had symptoms of colic and M administered Infacol to her from the first week of her life.

(g) At the Scottish hospital on 24th September 2008, M ventilated her concern about the restricted movement of C's right leg. By the following day, C was not moving her leg at all. Prior to 24th September, C's leg was absolutely fine.

(h) The hospital discharge letter was in a sealed envelope. It was handed to M by the last doctor who dealt with her. She knew this was a letter of discharge and she understood the instruction that this was to be given to C's new medical practitioner in Northern Ireland.

(i) M was C's primary carer. She left C alone with F only when going to the bathroom or showering or performing household tasks.

(j) She was aged almost seventeen when she left home, returning about one year later. The two alcohol fuelled assaults perpetrated against her by her stepfather occurred subsequently. She remained at home for around one and a half years. As regards her mother and stepfather, she was unaware of any problems relating to alcohol consumption.

(k) Difficulties in her relationship with her mother dated from the initiation of her association with F. Her mother disapproved of this. Following their house move in Scotland, there was limited contact by telephone, with her mother phoning when she was drinking. The post-birth incident in Scotland, circa 28th August 2008, was "*a major bust up*".

(l) M did not inform her mother of the emergency protection order until some three months later. Since then, their relationship has become progressively better. She became aware of her mother's proposal to become C's primary carer and supported this. Her mother has now turned her life around and M expects to receive substantial support from her in the future, in the event of reunification with C.

(m) F's first "blackout" was witnessed by her shortly after their house move in Scotland. She described a particular incident in some detail. She also recounted other occasions when F would "*go blank*".

(n) She told a lie about the discharge letter as she was unable to find it and did not wish to admit that she had lost it.

[77] I would highlight the following features of M's cross-examination:

(a) She agreed that in the statement compiled by her for the non-molestation order proceedings, in January 2009, she omitted any mention of slapping F (regarding the incident of domestic violence) and she erroneously asserted that she had taken C to the hospital in its aftermath.

(b) She did not mention colic during her police interviews.

(c) Her fabrication about the domestic violence incident continued through the first phase of police interviews, until F and M jointly retracted it.

(d) She denied that there had ever been a blister on C's lip.

(e) The occasion of the domestic violence incident represented the only serious argument during their entire relationship.

(f) She could not explain why she had not mentioned either colic or Infacol to the Health Visitor in Northern Ireland.

(g) Her assertion to the Health Visitor that C had no medical history of note was untrue. She could offer no explanation for this. She agreed that she repeated the lie subsequently. She assented to the suggestion that this was irresponsible conduct on her part, a significant flaw in her parenting.

(h) Prior to their house move in Scotland, F's "blackouts" and other symptoms had been the subject of medical investigation and tests, including a CT scan, which disclosed no abnormality.

(i) She admitted that she had smoked cannabis a few times, when aged fifteen and, also, had collapsed on one occasion after drinking alcohol.

(j) She denied any knowledge of a photographed occasion showing F smoking cannabis after the initiation of their relationship (documented in the police interview transcripts).

(k) She agreed that her assertion, recorded in the Scottish hospital records, that F had suffered four recent blackout episodes was untrue.

(l) She conceded that she had disclosed the Scottish Social Services investigation, including the instruction that F was not to be left in sole charge of C, to no one in Northern Ireland.

(m) She denied that she was the instigator of the initial lie concerning the domestic violence incident.

(n) She claimed that F had told Mrs. MC that, in any court proceedings, he would allege that M had been rough in her handling of C and he would fabricate lies against her.

(o) She asserted that, initially, she did not want to believe that F had inflicted the injuries.

(p) She claimed that she had never felt frightened or threatened by F.

(q) Following Christmas 2008, F's conduct became increasingly "*strange*". On one particular occasion, having "overdosed" on the prescription tablets, he pushed a table into her stomach and threatened that he would frame her for what had happened.

[78] The transcripts of the police interviews of F and M formed part of the evidence available to the court. I have noted in particular those passages upon which the cross-examination of M was based. I do not propose to rehearse these materials *in extenso*. They are accurately summarised in the proposition that M made a number of replies to questions which are not reconcilable with accounts given by her to others and her evidence to the court. These relate to matters such as the consumption of alcohol; F's conduct and motivation following their move to Northern Ireland; her relationship with her mother; F's "blackouts"; her *current* possession of the Scottish hospital letter of discharge; their joint "desperation" that F should find employment; the circumstances in which she sustained a facial injury in Northern Ireland; the state of her relationship with F following C's birth and subsequently; the kind of baby C was; and F's consumption of drugs during the period of their relationship. The police interviews of M were carried out on two separate dates, 7th November 2008 and 24th February 2009. On the second of these dates, M's disposition vis-à-vis F had altered markedly. Her tone had become quite hostile and accusatory. By this stage, the parents had separated and M had secured a non-molestation order against F, whose imprisonment for multiple breaches thereof was to materialise just two days later. In this context, I record, finally, that while there was some limited deployment of certain police witness statements during the trial and I have duly considered same, the assistance to be derived therefrom is, in my judgment, minimal, principally because most of the authors did not evidence at the trial.

[79] Finally, in this context, it is appropriate to interpose the evidence relating to M's first suggestion to anyone that F had been the perpetrator of C's injuries. This is documented in a social worker's record of a conversation with M on 16th February 2009, in the following terms:

> "*… she believes* [F] *is a very jealous person and this is why he injured* [C]; *his foster mother* [Mrs MC] *said to her that he is more than capable of doing it and would do the same*

> *thing again. He kept saying when* [C] *was initially placed in care that his mother would take her, he didn't seem to be fighting for her and that it shouldn't stop us being together. He doesn't know I've turned against him as if he did he would make threats and has said I'll make sure you wont get* [C] *back*".

Notably, F made a comparable allegation against M. However, this did not occur until one year later, when he was speaking to a social worker (on 8th February 2010), the context being a discussion arising out of the court's direction on 3rd February 2010 highlighting the onus on the parents to disclose the maximum information in their possession relating to C's injuries. In this context:

> "[F] *stated he felt* [M] *was rough in her handling of* [C] *when changing her etc…*
>
> *He also stated if he had additional information he would not share it as per advice of legal representatives …*
>
> [F] *enquired if social services were aware of* [M's] *drug use. He advised that their relationship was primarily based on drugs. They regularly took ecstasy, cocaine, uppers, downers, smoked cannabis/grass before* [C] *was born …* [M] *smoked cannabis daily throughout her pregnancy.*"

XII LEGAL FRAMEWORK

[80] I remind myself at the outset that, in accordance with Article 50 of the 1995 Order, it is open to the court to make a care order (or a supervision order) only if satisfied of two matters. The first is that C is suffering, or is likely to suffer, significant harm. The second (in the circumstances of this case) 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 C. This constitutes the statutory threshold for intervention by the court. This must be considered in the context of the "threshold criteria" (see paragraph [90], *infra*). If satisfied that the statutory threshold is overcome, 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 in relation to the three protagonists. At the apex of the legal pyramid is the best interests of C, which must be the court's paramount consideration.

[81] In ***Re B (Children- Care Proceedings: Standard of Proof)*** [2009] AC 11, the House of Lords approved the following statement of the learned President in ***Re U (Child)*** [2005] Fam 134, at pp. 143-144:

> *"We understand that in many applications for care orders counsel are now submitting that the correct approach to the standard of proof is to treat the distinction between criminal and civil standards as 'largely illusory'. In our judgment this approach is mistaken. The standard of proof to be applied in Children Act 1989 cases is the balance of probabilities and the approach to these difficult cases was laid down by Lord Nicholls in **In re H (Minors) (Sexual Abuse: Standard of Proof)** [1996] AC 563. That test has not been varied nor adjusted by the dicta of Lord Bingham of Cornhill CJ or Lord Steyn who were considering applications made under a different statute. There would appear to be no good reason to leap across a division, on the one hand, between crime and preventative measures taken to restrain defendants for the benefit of the community and, on the other hand, wholly different considerations of child protection and child welfare nor to apply the reasoning in **McCann's** case [2003] 1 AC 787 to public, or indeed to private, law cases concerning children. The strict rules of evidence applicable in a criminal trial which is adversarial in nature is to be contrasted with the partly inquisitorial approach of the court dealing with children cases in which the rules of evidence are considerably relaxed. In our judgment therefore…the principles set out by Lord Nicholls should continue to be followed by the judiciary trying family cases and by magistrates sitting in the family proceedings courts."*

In this passage the learned President was referring to the opinion of Lord Nicholls in ***Re H*** (***Minors – Sexual Abuse: Standard of Proof***) [1996] AC 563, at p. 586, containing a formulation which has been frequently cited in assorted litigation contexts subsequently. In ***Re B,*** Lord Hoffmann added:

> *"[15] Lord Nicholls was not laying down any rule of law. There is only one rule of law, namely that the occurrence of the fact in issue must be proved to have been more probable than not. Common sense, not law, requires that in deciding this question, regard should be had, to whatever extent appropriate, to inherent probabilities. If a child alleges sexual abuse by a parent, it is common sense to start with the assumption that most parents do not abuse their children. But this assumption may be swiftly dispelled by other compelling evidence of the relationship between parent and child or parent and other children. It would be absurd to suggest that the tribunal must in all cases assume that serious conduct is unlikely to have occurred. In many cases,*

> *the other evidence will show that it was all too likely. If, for example, it is clear that a child was assaulted by one or other of two people, it would make no sense to start one's reasoning by saying that assaulting children is a serious matter and therefore neither of them is likely to have done so. The fact is that one of them did and the question for the tribunal is simply whether it is more probable that one rather than the other was the perpetrator."*

These observations are particularly apposite in a case such as the present. Baroness Hale, for her part, expressed the applicable legal rule in the following terms:

> *"[70] I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under section 31(2) or the welfare considerations in section 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies."*

XIII CONCLUSIONS

[82] In the written submission of Mr. Toner QC and Miss Sholdis on behalf of the Trust, it is stated:

> "*The critical assessment in this case is as to whether there is substantial risk of harm to* [C] *should she be returned to her mother's care*".

Counsel for the other parties confirmed to the court that they concur with this formulation. In making the findings and reaching the conclusions which follow, I have given careful consideration to the well constructed final written submissions of all parties, for which I am grateful. I also bear in mind the following recent observations of Lady Justice Black:

> *"[29] I am only too aware how anxious is the task of a judge who must attempt to identify who caused injuries to a young child, knowing that because of the way in which our legal system approaches such matters, a finding that A has caused injury is tantamount to a finding that B has not and knowing also that if one mistakenly excludes from the list of possible perpetrators the name of the person who has actually been responsible, the children will not be protected against that person. The task was all the more anxious for*

> *this judge because he had concluded, with justification, that whoever caused CJ's injuries 'represents a real danger to infant children and perhaps children in general'."*

[***H –v- City and County of Swansea*** [2010] 2 FCR 271 and [2011] EWCA. Civ 195].

[83] It is convenient to begin with the evidence of Dr. McCartan about M's personality, which I accept: see paragraph [53] – [54] above. In short, M exhibits a strong personality trait which entails the denial of personal weaknesses and the consistent provision of socially desirable responses to questioning. A significant problem which this arouses is a failure to make full and spontaneous disclosure of the truth. In this respect, I note the symmetry in the evidence of Dr. McCartan and the reports of Dr. Rogers. When M gave her evidence to the court I had the opportunity to observe her during a lengthy period. In her demeanour, facial expressions, eye contact with the court, speed of response and choice of words she exhibited this personality trait repeatedly. Its presence and prominence were unmistakable throughout her evidence.

[84] Next, I turn to the issue of character. The burden of the evidence is that M is a person of good character, a responsible and industrious young lady. She has no criminal record and has worked hard and saved actively since leaving school. While there are sporadic indications of excesses during her teenage years, I consider this unremarkable. The planned nature of her pregnancy suggests that she considered herself to be in a serious and stable relationship. Moreover, it is indicative of a conscious decision to assume the burdens and responsibilities of motherhood. I also attribute some weight to Mrs. MC's positive assessment of M's character. Mrs. MC was an impressive, convincing and demonstrably truthful witness. I further take into account, M's demonstrated parenting skills and the strong mother/daughter bond which has developed in the adverse circumstances prevailing. I also take into account that since the seminal events of November 2008, M has continued to reside in Northern Ireland, in circumstances of social and familial isolation. She has no ties with the local community and appears to have no serious friends. Her existence here must have been miserable at times. Almost two and a half years have elapsed since the mother/daughter separation occurred. I find that she has willingly suffered certain privations and other disadvantages for the sole purpose of being united with her daughter. All of this, in my view, accrues to M's benefit. In summary, from the perspectives of antecedents, personality and character I consider that M has all the appearances of a most unlikely perpetrator of C's injuries.

[85] When I turn to consider F's character, a very different picture emerges. Firstly, there is the objectively verifiable evidence about his repeated offending, drug consumption and excessive alcohol consumption. Secondly, there is the evidence of Mrs. MC, which I accept in full. It is clear from her evidence F is an impetuous, aggressive and violent person. Mrs. MC also denounced him in uncompromising terms as "*a liar*". She asserted without hesitation that F would fabricate allegations against M. I consider that the motivation for this would clearly be a combination of

spite and self-exoneration. I note in particular that he delayed until the eve of trial (February 2010) in alleging that M had perpetrated C's injuries. F had a turbulent and abnormal upbringing, devoid of security and stability. He presents as a highly disturbed young man. The evidence further establishes significant past child care concerns relating to him. I have formed the clear view that F at no time had any real interest in C, did not form any paternal bond with her and has made no effort to do so since the child's removal into care. Furthermore, I find that F was keen to extend his relationship with M, for a combination of emotional and financial reasons and he viewed C as an obstacle, an unwelcome distraction.

[86] I consider both the timing and the content of F's revelation to Dr. P on 5th November 2008 to be telling. It occurred at a time when the family's interaction with the Health Visitor and general practitioner was intensifying. It is unlikely that either F or M had anticipated such intensive activity on this front. On the basis of all the evidence, F had no compelling health reason to attend Dr. P on the date in question. There is no evidence that he needed medical assistance or attention. There is no suggestion of any concerns about his health since the alleged blackout in mid-September. Furthermore, there is no evidence that he had reported any relevant symptoms to a general practitioner whilst in Scotland and nothing to suggest that, on 25th September 2008, he received medical advice to have further investigations conducted after moving to Northern Ireland: see, in this context, paragraph [8] above. I have no doubt that F's conduct on 5th November 2008 was motivated by his desire to lay a false trail, exonerating him of any blame for C's injuries. The relevant contemporaneous record makes clear that Dr. P **immediately** diagnosed two "stories". The first related to F's alleged "*long history of illness*". The second related to the circumstances in which, according to F, C had sustained a fractured femur. Both the speed and the extent of Dr. P's disbelief are, in my view, highly telling factors. Indeed, Dr. P was so concerned and suspicious that he contacted the Social Services at once. Moreover, Dr. P's swift rejection of F's claims about a "*long history of illness*" (clearly designed to encompass the alleged "blackouts") has been vindicated by a combination of the subsequent medical records and investigations and the opinion of Dr. Byrnes.

[87] To summarise, the indications that F is the perpetrator of C's injuries are twofold. Firstly, there is the extensive evidence regarding his antecedents, personality and character. Secondly, there is the court's assessment of other evidence, including in particular the evidence relating to the events on 5th November 2008; the evidence of Mrs. MC; the timing of F's allegations against M; the evidence given by F at the first hearing, including his admission that he burned the Scottish hospital letter of discharge and his incomplete and (in any event) manifestly unconvincing attempt to implicate M in this act; the manner whereby and speed with which C's injuries were almost certainly inflicted; and, finally, F's demonstrably obvious lack of interest in C. Having reached this point, I must reflect on those aspects of the evidence which are negative from M's perspective. These include in particular (but not exhaustively) her failure to provide complete and truthful answers and accounts to a range of professionals – including Dr.

McCartan, Dr. Dale, the Health Visitor, Social Services personnel and the police; the associated untruthfulness of parts of her evidence to the court; her fabrication of a story plainly designed to suppress from external consumption F's perpetration of domestic violence against her; her reprehensible failure to disclose C's medical history to the Health Visitor; the inconsistencies in her portrayals of her upbringing and her relationship with her mother; her claims that she was aware of only two of the forty police incidents involving her mother and stepfather, which I reject; her inaccurate description of her medical history to Dr. McCartan; and her wholly unsatisfactory evidence about the fate of the hospital letter of discharge. This prompts two main questions. Does any of this evidence point to the conclusion that M, singly or jointly, perpetrated all of C's injuries or any of them? Furthermore, does any of it undermine her claims that she at no time observed F perpetrate any injury against C?

[88] In reflecting on these questions I note, and gratefully adopt, the observations of Weir J in ***Belfast Health and Social Care Trust –v- SM and EW*** [2010] NI. Fam 10:

> "*[25] … I remind myself that there can be motives for telling lies other than guilt of the particular discreditable action alleged. For example, people sometimes lie out of shame, or a desire to conceal other wrongful behaviour or, in a case such as this, a powerful fear that, if the other wrongful behaviour is admitted to, the consequence will be a conclusion by social workers that the parent is unable to cope, resulting in the removal of the children*".

In my opinion, these observations, with suitable adaptation, apply fully to M. I find that she defied her mother and stepmother in initiating and then perpetuating her relationship with F. In maintaining this relationship, she was making a strong and strident statement to the effect that she knew better than others and would prove others wrong. She invested much in the relationship, both financially and emotionally, to the extent that a planned pregnancy occurred during its first year. In my view, with the passage of time, the magnitude of a profound error of judgment on her part gradually became apparent to her. There were significant failings in the relationship which became progressively worse. In my opinion, M actively and industriously concealed these from external awareness and scrutiny. To have done otherwise would, in her estimation, have exposed her own imprudence and weaknesses, reflecting badly on her in consequence. This analysis explains the most significant of the inconsistencies and untruths which emerged in her dealings with the professionals and others mentioned above. Furthermore, she plainly espoused the unrealistic belief that the dark cloud vis-à-vis C which had gathered during the Scotland phase could be suppressed following their move to Northern Ireland. Relatedly, I consider that neither she nor M had anticipated the degree of scrutiny and intrusion which materialised following their move. Finally, one grafts on to all of this M's personality, as diagnosed by Dr. McCartan.

[89] The final issue which I propose to address is that of *opportunity*. The one strong and consistent thread in all of M's accounts to others and her evidence to the court is that she was C's primary carer and, as such, was in C's presence during most of the time. The only – and very limited – exceptions occurred on account of visits to the bathroom or items of housework. Having regard to my assessment in the immediately preceding paragraph, juxtaposed with the evidence of M's personality, I consider that M was guilty of overstatement in this respect. In particular, she would plainly have been reluctant to admit to having left C in F's care at any time, even for the briefest of periods, on account of her admitted awareness of the instruction from the Scottish Social Services prohibiting this. I find that C was probably in F's sole charge more than M was prepared to admit. This afforded F the opportunity to perpetrate the injuries, unobserved. Moreover, I take into account the evidence that all of the injuries were capable of being inflicted in the twinkling of an eye, by an abrupt grabbing or shaking action. In my view, nothing could be more easily accomplished, even in circumstances of very limited opportunity. This supports a further finding that the infliction of each of the subject injuries was almost certainly the product of a sudden, impetuous act. All of the evidence points firmly to the conclusion that F is pre-eminently capable of acts of sudden and spontaneous aggression. Finally, I take into account F's decision not to give evidence to this court. This was a matter of election for him and no acceptable explanation has been proffered. An inference adverse to him can properly be made and I propose to do so.

[90] Based on the findings observations and assessments set out above, I am satisfied to a high degree of probability that F perpetrated all of C's injuries. I find that M perpetrated none of them. I further find that M was not present when any of the injuries were inflicted. The last issue which I propose to consider is whether M *became aware* of any of C's injuries. In considering this question, I take into account two matters in particular. The first is the evidence relating to those occasions, in both Scotland and Northern Ireland, when M on her own initiative sought medical advice and attention for C, from the Health Visitors concerned and also in two successive hospitals. This gives rise to the conclusion that M did not hesitate to take appropriate action on occasions when she considered that medical care or advice in respect of C was required. Secondly, I have regard to the evidence of Dr. Hughes, Mr. Cowie and Dr. Blumenthal. Having considered the Scottish evidence, I find that C did exhibit symptoms of irritability and colic. Dr. Hughes agreed that M could reasonably have believed that C was suffering from colic. Both Mr. Cowie and Dr. Blumenthal acknowledged the possibility that the symptoms of pain and discomfort which C would have been expected to exhibit in consequence of the injuries could have been interpreted as indicative of a young baby who was simply irritable and unsettled. I balance this with my finding that C's attendances at hospital in Scotland were brought about exclusively by M and were motivated by M's genuine concerns for C's welfare. Finally, I find that throughout both the Scottish and Northern Ireland phases, M did not suspect that F had perpetrated any injury against C. This is linked to my earlier findings about M's investment in this relationship, her expectations thereof and her plans and hopes for the future. I make two conclusions

accordingly. The first is that M did not become aware of any of C's injuries, with the exception of the fractured femur and the bilateral subconjunctival haemorrhages. The second is that M took timeous and appropriate action upon becoming aware of symptoms related to these injuries.

The Threshold Criteria

[91] Finally, I turn to the threshold criteria. At the outset, I observe that the court is not bound by any concession on the part of any party. My findings, *seriatim* are as follows:

(a) The first of the criteria is that on 7th November 2008, C was admitted to hospital and the various injuries listed in paragraph [4] above were duly diagnosed. I find that this criterion is established.

(b) The second criterion is that the injuries were non-accidental in nature: this too is established.

(c) The third is that both parents assert that they at no time left C in the care of anyone else: this is also established.

(d) The fourth criterion is that the injuries were caused by M and/or F. As recited above, I find that all of C's injuries were perpetrated exclusively by F.

(e) The fifth of the criteria is that each parent failed to seek appropriate medical intervention for C. Based on the findings set out above, I conclude that this criterion is established vis-à-vis F, but not M. In particular, while both the Trust's final submission and the evidence of Mr. Cowie, FRCS highlight the vintage of C's fractured femur, in my view the decisive fact is that neither this injury nor *any leg injury* was diagnosed at hospital on 24th September 2008.

(f) The sixth of the criteria recites that each parent failed to provide the health professionals in Northern Ireland with the Scottish hospital discharge letter and did not alert the professionals, in a timely fashion, to the fact that the child had been admitted to hospital on account of a fractured femur. I find that this criterion is established vis-à-vis both parents.

(g) The seventh criterion is that M and/or F failed to protect C from harm. Logically and sensibly, in light of my findings about the identity of the perpetrator of C's injuries, it seems to me that the only residual question is whether M failed to protect C from the harm inflicted by F. Consistent with my findings about the manner in which the injuries were probably inflicted and M's lack of knowledge, I find that this

criterion is not established vis-à-vis M. Insofar as it makes any sense to decide whether F failed to protect C from harm perpetrated by him – which I seriously doubt – I further find that he failed to do so.

(h) The eighth criterion is that each parent failed to act with appropriate vigilance to ensure the protection of C. This is in essence a repetition of the seventh criterion and I note that this is tacitly acknowledged in the Trust's written submission. Thus I refer to, but need not repeat, my above findings.

(i) The ninth criterion entails the assertion that each parent prioritised his/her relationship with the other above the needs of C. I find that this criterion is established vis-à-vis F, but not M.

(j) The tenth criterion is that M and/or F failed to accept the seriousness of the injuries or to have any appropriate insight into the pain, suffering and distress of C following those injuries. I find that this criterion is established vis-à-vis F, but not M.

(k) The eleventh criterion is that M has not been open and honest with the professionals and her failure to disclose in formation has had adverse consequences for C. There is some want of particularity in this discrete criterion. Subject thereto, I find that M was not open and honest in her dealings with certain professionals, as this judgment makes clear. However, bearing in mind the lack of particularity, I do not find that this had any adverse consequences for C. This criterion further asserts that M has provided conflicting and contradictory information to the professionals and the police: I have already found accordingly. Finally, this criterion asserts that M's need to provide socially desirable answers will preclude her from being open and honest in the future and whereby her child's needs will continue to be adversely affected. I find that this criterion is not established, in light of (i) my earlier findings that M's lack of candour and co-operation are not attributable exclusively to this personality trait, but must be considered in the context of other facts and factors and (ii) my acceptance of Dr. McCartan's evidence that there are certain therapeutic and educational steps which can be taken to address the negative aspects of M's personality. I make no finding at this stage about whether any such steps would have the desired outcome. I confine myself to concluding that they represent an available, viable course of action and, subject to further argument from the parties, and having regard to the welfare principle and the imperative of expedition, I consider that these steps should be initiated as quickly as possible.

(l) The twelfth of the criteria asserts that M and/or F failed to provide a safe home environment for C. Having regard to the agreed nature and

extent of C's injuries, the finding that her home environment was not safe follows inexorably. Applying a necessary degree of interpretation to this criterion, I find further that this was a culpable failing as regards F, but not M. Accordingly, I find that this criterion is established vis-à-vis F, but not M.

(m) The last of the threshold criteria asserts F's history of alcohol and drug misuse; the post-separation non-molestation order; F's consequential imprisonment; and F's perpetration of the domestic violence incident and resulting injury to M in October 2008. This criterion is not in dispute and I find that it has been established.

XIV DISPOSAL

[92] Accordingly, the specified threshold criteria for the making of a care order vis-à-vis C in favour of the Trust have not been established. In the final written submission, it was contended on behalf of the Trust that the evidence does not permit the court to decide which of the parents perpetrated C's injuries or, indeed, whether both did so. As appears from the above findings, I reject this submission. The Trust's care plan for C entails securing a care order, as a prelude to a freeing for adoption application, entailing permanent removal of C from M. It follows that I reject this care plan.

[93] Following delivery of this judgment, there was no agreement among the parties about the appropriate order to be made. It was submitted on behalf of the Trust that, having regard to the court's findings and conclusions, the appropriate disposal should be a dismiss of the Trust's application, with no further order. On behalf of M, it was submitted that the court should make no public law order. It was further submitted that if the court were to make any private law order, this should take the form of a residence order, with or without conditions. The position adopted by the Guardian ad Litem was that the judgment would be challenged on appeal. In consequence, the Guardian's main concern was to secure a stay on the final order of the court, to facilitate an appeal. This gave rise to submissions about whether the Guardian would have standing to pursue an appeal, having regard to the provisions of Article 60 of the 1995 Order. In my opinion, it is not the function of this court to determine this issue. If the issue arises, it will be a matter for determination by the Court of Appeal.

[94] While alert to the no delay principle and conscious of the protracted course of the litigation to date, I was anxious to ensure that the final order should not be made with undue haste. In the event, dating from the delivery of judgment, a period of approximately one month (including the Easter recess) elapsed. This facilitated certain developments and enabled the court to be more fully informed at the final stage. During the intervening period, M and C were reunited and, with appropriate assistance from the Trust and the foster parents, the re-establishment of the mother/ daughter relationship appeared positive and promising. Furthermore, there was

some engagement (albeit limited) between M and Dr. McCartan. At this juncture, M is proposing to return with C to Scotland, where they will reside in the MC family household for a suitable period. In this respect, I refer to paragraphs [60] – [64] and [84] above. Having regard to all the evidence rehearsed exhaustively in the body of this judgment, I conclude that it would clearly be in C's best interests that her reunification with M proceed in the setting of the MC family household. Mrs. MC testified unequivocally to the court that this is a feasible proposal. I have no doubt that Mrs. MC can make a positive contribution to the reunification process and the upbringing of C generally. This contribution will be manifestly in C's best interests. In marked contrast, the continued residence of M and C in Northern Ireland is plainly not in C's interests, having regard to M's acute social isolation here. The evidence suggests a marked absence of friendships and support. The current mother and child residential and social settings are unnatural and unsupported, a forced product of the events rehearsed herein.

[95] By virtue of Article 3(5) of the 1995 Order, I am enjoined not to make any order unless of the opinion that to do so "*… would be better for the child than making no order at all*". At this juncture, there are two extant orders:

(a) A residence order of an interim nature, made pursuant to Article 8 of the 1995 Order, whereby C resides with M until further order. This order was made following delivery of the main judgment, consequent upon the Trust's application that the existing interim care order (the most recent of a series of such orders made periodically since the initiation of these proceedings) be discharged, having regard to the court's findings.

(b) A prohibited steps order, also under Article 8, whereby C is prohibited from leaving Northern Ireland without the court's permission.

An Article 33 Order is not an option, as C has not been in the Trust's care since the discharge of the interim care order, upon delivery of the substantive part of this judgment. In these circumstances I consider that, from the perspective of final disposal, the two realistic candidates are:

(i) No order.

(ii) A residence order.

[96] In my opinion, an unconditional residence order would be pointless, since, pursuant to the main judgment of the court, M is exercising and will continue to exercise parental rights in a context where M and C reside, and will continue to reside, in the same household. Thus, in the circumstances prevailing, the real question becomes whether a conditional residence order should be made. By virtue of Article 8(1), "*residence order*" is defined as "*an order settling the arrangements to be*

made as to the person with whom a child is to live". Article 10(1)(b) empowers the court to make such an order of its own motion. By Article 11(7), such an order may (a) contain directions about how it is to be carried into effect and (b) impose conditions which (in the present context) **must** be observed by C. Further, an Article 8 Order may be restricted to a specified period, in whole or in part, per Article 11(7)(c).

[97] In determining whether to make a conditional residence order, I take into account a number of factors: in particular, the limited opportunity which C has had to develop parenting skills; the protracted period of the M/C separation; the termination of the progressively close and dependent relationship between C and her foster parents; the unavailability of the support which M and C have received and continue to receive from the Northern Ireland Social Services, from the moment of their departure for Scotland; the very different circumstances which will prevail following such move; the unavoidable element of unpredictability; and the benefits which would undoubtedly accrue to C if agencies other than and additional to the MC household were available to provide any necessary advice, support and therapy. Furthermore, I refer to my findings adverse to M in paragraph 91(f) and (k) above. I also take into account the findings which I have made in respect of F. It follows logically from those findings that I consider F to present a significant risk to C. While he clearly has no paternal interest in the child, C would plainly be at risk in his presence by virtue of his temperament and personality.

[98] Giving effect to the principle that C's welfare shall be the court's paramount consideration, I conclude that a conditional residence order is appropriate and, from the perspective of C's welfare, is plainly a better option than that of making no order. To give effect to this discrete conclusion and the other findings and conclusions in this judgment:

(a) I dismiss the Trust's application for a care order under Article 50 of the 1995 Order.

(b) I make a conditional residence order under Article 8. Pursuant to this order, C will reside with M, in accordance with the following conditions:

   (i) M, following her return to Scotland, shall make contact with the local social services within seventy-two hours.

   (ii) Thereafter, M shall engage and co-operate fully with the Scottish Social Services.

   (iii) In particular, M shall comply with the requirements of the Social Services, shall engage fully with all social care and other professionals to whom she may be referred and shall participate fully in such courses or therapies or like arrangements as may be devised.

(iv) Following their return to Scotland, M and C shall reside with Mrs. MC until C attains her fourth birthday (in August 2012).

(v) There shall be no contact of any kind between F and C.

(c) I discharge the Prohibited Steps Order

Linked to the above, I make a further order under Rule 4.24 of the Family Proceedings Rules (NI) 1966, acceding to the application lodged on behalf of M, on 15th April 2011 (as amended on 12th May 2011). The effect of this order, in substance, is to arrange for the transfer to the Scottish Social Services of this judgment and the totality of the documentary evidence assembled during the course of these proceedings: in short, the records generated by all of the relevant agencies – Social Services, medical and police, emanating from the two jurisdictions concerned. The exhaustive list will appear in the final order of the court.

[99] All orders are stayed until 4pm on 18 May 2011. Finally, the costs order will be determined following representations from all parties.