Neutral Citation No.: [2009] NIFam 2 | *Ref:* **MORF7399**

Judgment: approved by the Court for handing down | *Delivered:* **04-02-09**

(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

_____

FAMILY DIVISION

OFFICE OF CARE AND PROTECTION

_____

Re JJ (welfare; non-accidental injury; heroin abuse)

_____

MORGAN J

[1] This is an application by the Trust for a Care Order in respect of a child, JJ, born on 31 October 2005. The child's mother is JB and his father is MK. Nothing should be reported which might identify either the child or the child's parents.

The Background

[2] JB has a long history of heroin abuse. She has sought treatment in relation to her condition on a number of occasions commencing in 2000 and continuing until the present. MK denies that he was an abuser of heroin but admits that he was a regular user of cannabis. In 1998 it was alleged against him that he slapped his 20 month old daughter in the face as a result of which his two children with a previous partner were placed on the Child Protection Register. He denies that he assaulted the child. In May 2000 he received a five-year prison sentence for armed robbery and in June 2007 he pleaded guilty to an offence of inflicting grievous bodily harm with intent and is presently serving a sentence as a result of which he is not due for release until January 2010.

[3] JB and MK had a relatively lengthy relationship as a result of which JB gave birth to a son on 21 June 2004. That child died suddenly on 7 January 2005. On 31 May 2005 the hospital social worker received a referral in respect of JB booking in for her second pregnancy in light of the death of the child. It appears that there were difficulties in the relationship with MK. On 14 June 2005 JB requested PSNI assistance as she alleged that MK was banging on her door. On 7 July 2005 she contacted PSNI because she discovered that someone had been in her house and she thought that this was MK. On 8 July

2005 she contacted PSNI alleging that MK had threatened her with a hammer. JB declined to make a statement of complaint and MK has denied his involvement in any of these matters.

The Birth of JJ and thereafter

[4] JJ was born on 31 October 2005. JB accepts that she smoked heroin and used cannabis while pregnant. On 18 November 2005 the social worker advised JB that there was an allegation that MK had assaulted his 20 month old child and advised her that any contact between MK and JJ should be supervised. A bruise to the upper lip of the child was noted on 17 November 2005 but the treating doctor thought that it could have been caused by the child's fingernail. In evidence JB asserted that she noted a bruise to the side of the child in the late autumn of 2005 but there appears to be no other evidence in relation to this.

[5] On 17 January 2006 a social worker visited JB and JJ about 11:30 a.m. and noticed a black bruise on JJ's forehead. JB said that her friend's child had clashed heads with JJ. The social worker advised JB to make an appointment with her GP. JB told the social worker that she had not seen MK for a few weeks and that he had not had recent contact with JJ. In fact MK had certainly seen JJ between 9 a.m. and 11 a.m. that morning and had given him his bottle while JB got dressed. JB subsequently alleged that the bruise was caused by MK.

[6] At approximately 3 20 p.m. on the same day a health visitor visited JB and again noticed the bruise. JB repeated the explanation that she had given to the social worker.

[7] Sometime after 7 p.m. on 17 January 2006 JB took JJ to the accident and emergency unit at the hospital and stated that JJ was unable to move his right arm. JJ was observed to have a bruise to his forehead and JB advised that she had clashed cheeks with JJ earlier on that day. She later told a social worker that it was MK who had clashed cheeks with the child. JJ also had a linear bruise to his upper lip and an ulcerated area to his palate. He was admitted to hospital. On 20 January 2006 he was diagnosed with a right supracondylar fracture of the humerus. At a later stage Dr Sweeney, consultant paediatric radiologist, concluded that he also sustained a fracture of the fourth rib laterally.

Threshold

[8] Article 50 (2) of the Children (Northern Ireland) Order 1995 sets out the conditions that have to be satisfied before a care order can be considered by the court.

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

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

(b) putting him under the supervision of a designated authority.

(2) A court may only make a care or a supervision order if it is satisfied-

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

(b) that the harm, or likelihood of harm, is attributable to-

(i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or

(ii) the child's being beyond parental control."

JB signed a statement on 13 June 2007 accepting the following facts.

1. JB accepts the child suffered some injuries while she was the primary carer and as a result she failed to protect the child from harm.

2. JB accepts she failed to demonstrate adequate supervision of the child.

3. JB accepts that she has a history of drug use including the use of heroin.

4. JB accepts she smoked heroin and used cannabis while pregnant with J. J. She accepts that she also smoked cigarettes throughout the pregnancy. After delivery, J. J. vomited and was jittery and JB's urine tested positive for cannabis, opiates and benzodiazepine. JB continued to accuse heroin while she had J. J. in her care.

5. JB accepts at a Child Protection Case Conference on 29 November 2005 she agreed not to allow M. K. unsupervised contact with J. J. as part of the Child Protection Plan. However, she repeatedly allowed M. K. to have unsupervised contact with J. J. and deliberately concealed this from the professionals involved at this time.

6. The relationship between JB and M. K. featured domestic violence. JB called the police on 14 June 2005, 7 July 2005 and 8 July 2005 to report M. K.'s behaviour. On 8 July 2005 JB said M. K. had threatened her with a hammer.

7. JB's lifestyle has involved associating with persons having drink and drug addictions and on occasions JB has allowed them into her home.

I then conducted a hearing to establish whether JJ had suffered any non-accidental injury and if so precisely what that injury was and if possible how and by whom it had been caused. I concluded that JJ sustained a fracture of the right humerus caused by a yanking movement which was not accidental. I was satisfied that the injury occurred between 3:20 p.m. on 17 January 2006 when he was seen by the health visitor and 5 p.m. on that afternoon. I was further satisfied that the child was in the sole custody of JB during that period. Although unable to identify the precise circumstances surrounding the injury I concluded that it was caused by JB. I was also satisfied that JJ had sustained an injury to the inside of his mouth which was not accidental and resulted in an ulceration which was noted that the time of his admission to hospital on 17 January 2006. Finally I was satisfied that he had sustained a fracture of the right fourth rib which was not accidental and probably caused during the early part of January 2006. JB and MK both had caring roles in respect of JJ during the period when these latter injuries were caused and consequently I concluded that each was in the pool of possible perpetrators.

Events since January 2006

[9] On 25 February 2006 JJ was placed in voluntary care. On 8 March 2006 an Interim Care Order was made and since then he has resided with foster carers. His mother has remained committed to him and has diligently attended the three contact sessions per week made available to her. All those who have observed the contact record that this is a good relationship between mother and child although she is clearly not the child's primary carer.

[10] Drugs continued to play an active part in JB's life in 2006 and 2007. She was recorded as abusing drugs between January and March 2006. She asserts that she had injected approximately 110 mg of heroin on the day that JJ's arm was fractured. She was placed on subutex in April 2006 and admitted to a residential facility in June 2006 for nine weeks. She attended aftercare services but in December 2006 a relapse was recorded. 2007 started very badly. On 9 February 2007 one of her closest friends was found dead in her flat having consumed alcohol and cannabis. On 28 February 2007 police recorded that a young man had overdosed on heroin in her flat. She denied that this was the case. On 1 May 2007 she failed a drug test and significant drug use was recorded in October 2007, November 2007 and December 2007. In February 2008 she admitted that she had been using heroin.

[11] JB was referred to a Family Centre in February 2007. She attended on a weekly basis and the purpose of the referral was to assess the likelihood of significant harm to the child if returned to her care. It has been a feature of

JB's life that she has tended to conceal the extent of her drug-taking from others and to have been untruthful in her account about it to family and professionals. This has inevitably made it difficult for her to sustain relationships of trust with either. The social worker undertaking the Family Centre work sought to establish an increasing relationship of trust. During 2007 that did not result in JB admitting those occasions when she had returned to drugs. In February 2008 the social worker realised that JB was under the influence of drugs at a meeting and she eventually admitted that she had relapsed.

[12] Since that time there has been a transformation in her life. She did a 15 week course called "My Life Matters" into February 2008 attending two days per week. She completed the course and "divorced" heroin at the end of it. She followed this with a 10 week OCN II course which she completed in the same exemplary fashion. She has applied to do a further OCN III course and I have every reason to believe that she will achieve that. Throughout this period she has undergone random urine drug tests approximately 3 times per week and has attended on a weekly basis with a Community Psychiatric Nurse where she has undergone saliva testing approximately once every three weeks. All are satisfied that she has made remarkable progress and I accept that she has not used heroin for a period of approximately 1 year.

[13] Against this background 2 views have emerged as to how JJ's future might best be secured. In a draft report exchanged with the Trust in late June 2008 the Family Centre suggested that if rehabilitation was to be achieved it would necessitate the support and involvement of JB's family. They recommended the establishment of a latchkey system. Although this involves members of the family having a key for access to JB's flat and regular visits by them its underlying purpose is to promote the development of relationships within the family which will enable family members to both support JB and JJ and be alert to the needs of JJ in the event of JB having difficulty in dealing with any propensity to relapse. The system would also enable the family to monitor evenings and weekends when there was no testing. This is a technique which the Family Centre has successfully used in a number of addiction cases including three cases where the parent was recovering from a heroin addiction. None of these cases involved a non-accidental injury.

[14] It is clear that this was not a view shared by the Trust when first suggested at a joint meeting in late May 2008. When the Family Centre report was produced in late June 2008 a Family Group Conference was arranged for 28 July 2008. The Family Centre were not involved in that meeting and it seems clear to me that the Trust failed to appreciate the importance of establishing whether the family was prepared to engage in the process of relationship building and the need to start that process at that time if they were. In fact although the family did offer some support to JB the most important outcome of that meeting was an offer by the parents of MK to look

after JJ as long-term carers. In light of the difference of view between the Trust and the Family Centre the Trust decided to supplement its team of social workers with a Principal Practitioner who drew up a risk assessment for a joint meeting on 11 September 2008 where the differing views of the professionals were explored. At this stage the Trust was minded to follow a care plan leading to adoption. All the professionals recognised that there were high risks in this case. The difference between them lay in whether there was a mechanism that might be achieved for safely reducing those risks. A further Family Group Conference was arranged for 30 September 2008 and again the Family Centre were not involved and again it seems to me that the family did not have explained to them what was expected of them in terms of building relationships so as to improve their understanding of JB's situation and contribute to JJ's welfare if he was reunited with his mother. By November 2008 the Trust had decided to assess Mr and Mrs K, the parents of MK, as long-term carers and in December 2008 they were approved as long-term foster parents. The Trust care plan is to place JJ with them as long-term foster parents with reduced direct contact for JB to be reviewed at LAC meetings every six months or thereabouts.

Conclusion

[15] The starting point is dictated by article 3 (1) of the 1995 Order which requires the court to treat the child's welfare as the paramount consideration. In this case that means looking in particular at his physical, emotional and education needs, the harm which he has suffered or is at risk of suffering and how capable of meeting his needs each of his parents and others might be. He is a three-year-old child whose age and understanding would prevent any real issue arising in relation to his wishes, he is in any event going to have to be moved from his present placement and no particular additional issue arises in relation to his age or background. Although the child's welfare is the paramount consideration it is by no means the only consideration. The court of appeal in AR v Homefirst Community Trust [2005] NICA 5 has emphasised the need for the court to take into account and weigh proportionately any interference with the right to family life of the birth parents arising from article 8 of the ECHR. JB is anxious to have JJ returned to her and is supported by Dr Dale who is of the view that the Family Centre proposal represents a real opportunity for rehabilitation. The long-term fostering option is supported by his father who recognises that in light of his incarceration he cannot offer himself as an alternative for the child. The Trust and Guardian support a long-term foster placement with Mr and Mrs K and are supported by Dr McMillan. JB also supports this option if reunification cannot be achieved.

[16] For any young child separated from a parent the prospect of rehabilitation to that parent can offer enormous benefits because of the emotional long-term security it can offer the child as part of his natural

family. That is particularly the case where, as here, the child and parent have retained a good relationship thereby enhancing the prospect of the development of a secure attachment. The real issue in this case, however, is that this child in his first 11 weeks sustained a fractured humerus, a fractured rib and an injury to his mouth inflicted in some non-accidental fashion and that these injuries occurred not just on the mothers watch when she was looking after this vulnerable child, not just against a background of her leaving the child with MK when she had been advised not to do so because of concerns about the child's safety but as a direct result of infliction of harm by her in respect of at least the arm injury. The obligation of the court to scrutinise the arrangements for the protection of this child is, therefore, critical.

[17] I accept that it is highly likely that JB was chaotically abusing heroin at the time at which JJ suffered his injuries. There is no evidence that heroin should make one aggressive and I cannot come to a conclusion as to how it may have contributed to the injuries because JB has not given an account to me or others which I can accept. Like the Family Centre I am of the view that she has not made full disclosure of all that she knows about the manner in which these injuries were sustained. I am also satisfied, however, that she is not aggressive or violent by disposition and has not displayed traits of irritation or lack of control in contact with JJ or in her relationships with professionals. I am satisfied, therefore, that her drug-taking was the predominant factor leading to the infliction of the injuries on JJ. That accords with the view of Dr Dale. If I go down the rehabilitation route JB will in any event have a period of assessment and behavioural work and that would provide ample opportunity to review this finding. I conclude, therefore, that JJ would be at real risk of physical injury in the event that JB relapsed into drug use and I am also satisfied that in those circumstances his emotional needs would be neglected.

[18] I am satisfied that since February 2008 JB has done all that she can to deal with her drugs problem. This is a substantial achievement given the grip which drugs had upon her life for the last 18 years or more. She is clear that she has moved on and left drugs behind her. I hope that she is correct but I cannot assume so. The evidence of Dr Weir makes it clear that in these cases there is always a risk of relapse which might occur at any stage. In the event of relapse the real issue is how this might be managed in a way that would both protect JJ and also secure his emotional and physical development. It was to that end that the Family Centre put forward the development of family relationships as a means both of providing support for JB in terms of any difficulties that she might encounter and possibly contributing to JJ's development.

[19] I consider that the Family Group Conferences at the end of July 2008 and September 2008 were missed opportunities to explain to JB and her

family what was being suggested of them. The proposal from the Family Centre was directed in particular towards ongoing relationship development, understanding and support. This was against a background where JB had lived a life characterised by misrepresentation, concealment and dishonesty in her relationships with her family during her drug use. On any view the development of improved relationships would require a build-up of trust and confidence on the part of the family and a willingness to be open and truthful on the part of JB. In light of the previous history this was always going to be a slow process. There was no reason why this process could not have been attempted between July 2008 and the date of the hearing in January 2009. It would have provided the court and other professionals with information on which to base their opinions about the welfare of this child. It would not have undermined any case that the Trust intended to make at the trial. The reports of 27 June 2008 and 26 September 2008 from the Family Centre both made clear what was required and the failure of the Trust to convey accurately those requirements to the family is simply inexplicable.

[20] JB's parents have been separated for many years but both live relatively close to her. She has two younger brothers and two sisters. Neither of the sisters made statements and each has made clear that they do not feel able to offer any support to JB. This is a reflection of difficulties caused within the family as a result of JB's drug taking. It contrasts with the expressed view of JB that her relationship with the sisters was good. The two brothers have busy working lives and social commitments of their own. Each made statements but because of their work commitments neither was able to attend the hearing. I accept that each of them is anxious to help but recognise that their opportunities to do so over a sustained period are likely to be limited by their other commitments.

[21] JB's father has always maintained a relationship with his daughter and indeed with the other members of the family. He sees her every Sunday and on occasions through the week because of his employment as a taxi driver. He also regularly visits his other children. It is striking, however, that in his evidence he displayed no particular knowledge of JB's friends or habits and the relationship with his daughter seems to be at a fairly superficial level. He did not realise that JB was taking drugs when looking after each of her two children. Until the day of this evidence he did not know that JB had used a significant quantity of drugs on the day JJ was injured despite the fact that this was part of her case and set out in her statement to the court. In September 2008 he told the Guardian that he thought JJ's injuries had been caused accidentally by him falling off a changing table.

[22] JB's mother has always had a difficult relationship with her daughter. She left home when JB was in her teenage years. Dr Dale recognised that this was a fractured relationship and would be likely to be difficult for some time. JB's mother has taken an active interest in JJ and has attended contact several

times per month when able to do so. She works at a number of part-time jobs. She supports the fact that JB has changed over the last few months but issues of trust and truthfulness still remain. In September 2008 she reported that JB had asked her to tell the social worker nothing when she was being interviewed in respect of this application. There is no evidence of any recent conversation touching on JB's difficulties with drug use although JB's mother appears to have a better understanding of those occasions when her daughter is using drugs. Her ability to help will be affected by her part-time work and her other commitments.

[23] I consider that there are considerable risks to the physical and emotional welfare of this child if reunification with his mother is attempted. The injuries sustained by him during the short period he was in her care indicate the nature of the risk to which he might be exposed. His protection against that risk depends on sustained drug tests, which are possible, and the development of relationships of trust and confidence with other family members. In my view none of the family members are anywhere close to the sort of relationship which would be necessary. Their involvement in JB's life seems to be on the periphery. Her friends and activities appear to be largely unknown. Rehabilitation could not take place until sufficient trust and understanding was established and that would require openness and truthfulness from JB and persistence and commitment from her family. This would be a major change for JB and her family, none of whom seem at this stage to feel able to intrude into JB's private life. There is a substantial likelihood that these relationships will not be capable of being achieved. In those circumstances JJ would be exposed to a prolonged period of uncertainty and confusion at a time when he is already showing some of the problems that arise from insecure attachment.

[24] Mr and Mrs K offer a long-term prospect of stability for this child as well as the opportunity for his birth parents to have a real role in his life. JB recognised that this was a good second best from her viewpoint. She has developed a good relationship with Mr and Mrs K and there is every reason to believe that she could play an important supportive role in JJ's future. This is an outcome which shows considerable respect for the family life of a mother but provides JJ with an opportunity for secure attachment in a stable and harmonious environment throughout his childhood years. It is important to acknowledge that long-term fostering is not a halfway house to another outcome but a long-term framework for this child.

[25] Although, therefore, I am minded to accept the long term proposal put forward by the Trust I have very considerable reservations indeed about the proposal to reduce the mother's contact with the child. I accept that this will be a period of upheaval for the child but I am satisfied on the basis of the evidence that I have heard that the mother is committed to the child's welfare and that she is likely to do all that she can to make the transition as easy as

possible for the child. JJ has been accustomed to seeing his mother three times a week for an enjoyable contact and I consider that the maintenance of that contact in an environment where the mother was supporting the new placement would be of considerable benefit to him as well as properly respecting the mother's right to family life. I can appreciate that when the child goes to nursery or school further considerations may need to be taken into account but I am entirely unconvinced that there is any reason to reduce the contact at this point. The contact is supervised so it seems to me that the Trust would be in a very good position to advise the mother on the right messages that she should be giving the child and to ensure that they were actually being delivered. I am, therefore, going to provide the Trust with an opportunity to review that element of the care plan.