MISS RECORDER HENLEY

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Before:

MISS RECORDER HENLEY

IN THE FAMILY COURT

Case No. NE16C00697

SITTING AT NEWCASTLE UPON TYNE

In the matter of the Children Act 1989

Date: 15 May 2017

In the matter of
K (born 2005)
C (born 2011)
D (born 2015)

BETWEEN:

A local authority

Applicant

-and-

(1) M

(2) TT

(3) MS

(4) JW

(5) K, C AND D

(Minors, acting through their Children's Guardian, Barbara Hewitt)

(6) JA

JUDGMENT

Representation

Applicant – Mr O'Sullivan (Counsel)

Respondent Mother – Miss Sweeting (Counsel)

Respondent Father of K – Mr Place (Solicitor)

Respondent Father of C – Mr Killeen (Solicitor)

Respondent Father of D – Mr Ainsley (Counsel)

JA – in person

Respondent Children – Miss Spenceley (Solicitor)

Introduction

1. This is an application for care orders brought by the local authority (LA).

2. The Court is concerned with three children: K (2005) now aged 11 years 9 months; C (born 2011) now aged 6 years 3 months and D (born 2015) now aged 22 months old.

3. The Mother of all three children is M aged 27 years, she is White British.

4. K's father is TT, he originates from Eritrea in North East Africa. He has lived in Newcastle during K's lifetime. K has had limited and irregular contact with her Father during her life. He was joined as second respondent to these proceedings at a hearing on 30th March 2017, following paternity being established via DNA testing. TT does not hold Parental Responsibility for K but seeks it, together with relevant declarations to confirm that he is her father. TT has another child, a son

called B, who lives in Scotland with his mother. During his involvement in these proceedings he has had two sessions of direct contact with K, supervised by the local authority.

5. C's father is MS aged 31 years, he does not hold Parental Responsibility for him but seeks it. C's paternity was confirmed via DNA testing commissioned during these proceedings. C's father originates from the Sudan, he has had the benefit of an Arabic speaking interpreter during these proceedings. C's father is currently residing in Birmingham with his partner and their new born baby. C does not have any direct contact with his father at the current time but does have indirect contact in the form of letters, cards and photographs.

6. D's father is JW aged 40 years, he does hold Parental Responsibility for him. He is White British. He has supervised contact with D once per week. A Court ordered capacity assessment was conducted in respect of JW by Professor Turkington, a Consultant Psychiatrist. His report is dated 21st November 2016. It is Professor Turkington's expert opinion that whilst JW suffers from a mild learning disability, he has litigation capacity.

7. JW's niece, JA was joined as the fifth respondent to these proceedings on 2nd March 2017. She appears in person. She joins JW's contact with D each week.

8. Two interveners were previously joined to these proceedings; LH, the children's maternal grandmother, RG, the children's great maternal grandmother. I discharged both interveners at the outset of the final hearing and joined RG as a party. I gave a full judgment at that stage; parts of that judgment are necessarily incorporated into this judgment.

9. This matter comes before the Court for a composite Final Hearing in public law proceedings. The hearing commenced on 15th May 2017. These proceedings were issued on 7th September 2016. The timetable for the conclusion of this case was

extended on 18th January 2017 by HHJ Moir due to the need for medical assessment of the needs of D and the need to carry out multiple kinship assessments with some of the proposed carers residing in the West Midlands.

Evidence

10. During this hearing, I have heard from counsel for each party. I have read the bundle of documents filed for these proceedings.

11. I heard evidence over the course of twelve days from the following witnesses: Dr Peter Morrell Consultant Paediatrician instructed as single joint expert; Dr Johnson Consultant Paediatric Radiologist instructed as single joint expert; Dr Wolny Consultant Paediatrician, D's lead treating paediatrician; Kate Matheson Health Visitor; the children's previous social worker Sarah Davies; the children's current social worker Helen McArthur; the Mother; MS; TT via his interpreter; JW and the Children's Guardian.

12. I have had the benefit of written submissions from each of the advocates, for which I am grateful.

Background

13. The Mother's own childhood was a traumatic one. She suffered neglect, physical and emotional harm and sexual abuse perpetrated by adult members of her family whilst in the care of her mother, LH. LH failed to protect her from suffering this abuse. She was then placed in the care of RG, her maternal grandmother. The Mother suffered further sexual abuse at the hands of a family member whilst in her care, which RG failed to protect her from.

14. When the Mother was 15 years old she became pregnant by TT. As a result of this unplanned pregnancy, K was born. The Mother was living with RG at the time.

RG reported TT to the Police for having sexual intercourse with a minor. TT (then aged 17 years old) accepted a Police Caution. There is dispute between K's parents as to whether their relationship amounted to a 'one night stand' as TT asserts, or whether it continued for as long as 18 months, on the Mother's account.

15. TT's case is that he was unaware of the pregnancy and K's birth. The Mother disputes this saying that he was aware of the pregnancy, did not want it to continue and offered to pay for a termination. Both parties agree that TT had no involvement in K's life until she was around 8 years old and that his contact with her thereafter was infrequent, occurring on a few occasions, facilitated by GA and RG. Prior to contact being arranged by the local authority he last saw K in 2016 around Christmas time. The Mother did not register TT as K's father on her birth certificate. Instead another man, MA-H, was registered. TT complains that the Mother failed to promote any contact or to assist in any way to allow him to establish a relationship with K.

16. The Mother and K remained living with RG until K was around four years of age, when the Mother secured her own property.

17. In May 2010 the Mother formed a relationship with MS who moved in with the Mother and K within a matter of months. They met through MS's cousin who is married to the Mother's sister, GA. The Mother fell pregnant with C very quickly into their relationship. When the Mother was around six months' pregnant MS moved permanently to Birmingham. He returned on the day of C's birth to see him but returned to Birmingham by train that same day. C's parents' relationship came to an end within months of his birth as a consequence of them disagreeing about his name. MS's contact with C was irregular over the years that followed. He complains that this is a result of the Mother failing to promote contact and asserts that the only way that contact could take place was as a consequence of covert arrangements made by GA and RG. The last such occasion being when the Mother was in hospital giving birth to D.

18. When C was born, the Mother moved back in with RG for a period of time before once again acquiring a property of her own.

19. In May 2014 the Mother began a relationship with JW. They had known each other for many years as a consequence of their families living near each other. There is a background of significant discord between the A family and JW's family. In 2008 one of JW's nephews, (JA's brother) was accused of the sexual assault of a number of other younger children in the Gateshead area. He was found not guilty following a Crown Court trial. In retaliation his family's home was petrol bombed. The Mother's sister, GA was one of four people convicted on 11th February 2010 in connection with this arson attack.

20. JW moved in with the Mother and attempted to assist her in parenting K and C. The couple continued their relationship throughout the Mother's pregnancy with D.

21. D was born a healthy child who was said to be meeting his developmental milestones in the first four months of his life. Between 14th December 2015 and 11th January 2016, D's weight dropped considerably. Professionals observed a notable and dramatic demise in the Mother's care of the children, with a significant deterioration in both her presentation and D's presentation in January 2016.

22. On 20th January 2016 D was brought to the Accident and Emergency Department of the Queen Elizabeth Hospital in Gateshead by the Mother, following the onset of seizures. He was admitted and then transferred to the Royal Victoria Infirmary on 21st January 2016 for further examination. He remained there until 29th January 2016 whereupon he was discharged back into the Mother's care. Medical investigations at that time showed no abnormalities and D had various medical tests including an MRI scan on his brain which was normal, two EEGs which were normal and various blood tests to exclude metabolic and genetic abnormalities. On 9th February 2016, D's health visitor caused an ambulance to be called, when during

a routine home visit, she identified that D appeared to be severely unwell. He was subsequently transferred to the RVI and admitted as an inpatient over the course of the nine days that followed. During subsequent investigations it became clear that he had sadly developed non-traumatic severe encephalopathy with associated conditions of global developmental delay and regression, epilepsy, seizures, reflux, hypotonia (floppiness) and severe visual impairment.

23. In February 2016 D's parents' relationship came to an end when JW moved out, back to the home of his mother. He complains that the Mother failed to promote contact thereafter and that this resulted in him going to see a solicitor in July 2016 with a view to seeking a private law order in order to secure contact.

24. The local authority had received referrals about the safety of the children since K was 2 years of age. Previous local authority assessments identified many positive features of the Mother's parenting capacity. The local authority had been treating the children as "Children in Need", with an increasingly high level of support from the Family Intervention Team.

25. In July 2016 the case was transferred to the Safeguarding and Care Planning Team. On 17th August 2016 all three children were made the subject of Child Protection Plans under the category of Neglect.

26. Professional concern about the welfare of the children in the lead up to this application centred on (1) the number of adults in the Mother's wider family who posed a risk of physical and sexual harm to the children, this included LH, the maternal grandmother (MGM) who is alleged to have sexually abused her son, the mother's brother, MA; and the mother's uncle AM who has been accused of the sexual abuse of another child in the family and who sexually abused the Mother and her sister GA when they were children (2) the Mother's capacity to protect the children from these individuals, (3) the Mother's capacity to meet D's increasingly complex needs, (4) the Mother's capacity to engage in an honest and meaningful

way with professionals, (5) the Mother breaching agreements with Children's Services (6) the impact of the acrimonious breakdown of the Mother's relationship with JW on the children, (7) the Mother exhibiting a lack of emotional warmth towards the children, (8) D's poor weight gain and missed medical appointments in the care of the Mother, (9) K's role in the family as a young carer for her siblings and as the Mother's confidant.

27. Until 30th August 2016, all three children had always been in the primary care of the Mother.

Precipitating event

28. On 30th August 2016 it was discovered that D, then aged 11 months, had sustained an unexplained fracture to his right femur.

29. D was and is an immobile child as a consequence of his condition. He has no formal diagnosis but the working hypothesis amongst his treating clinicians is that his condition may well be genetic in origin. He has complex health needs. He remains an unwell child with an unclear future prognosis. His condition is thought to be life limiting and so he has an end of life plan. His seizures are managed by medication. He is continuously fed via a gastronomy feeding tube. He has no head control and limited movement. He needs continuous care and supervision.

30. The Mother failed to provide an explanation for D's injury. It was suspected to be non-accidental in nature. Upon discovery of D's injury, his siblings K and C were voluntarily accommodated in local authority foster care pursuant to s.20 Children Act 1989. D remained in hospital at that time but was subsequently discharged from hospital into foster care on 11th October 2016.

31. K did not cope well with the transition to foster care, and following her demonstrating extreme distress and uncontrollable behaviour over the course of a

week, she was returned to the care of the Mother on 5th September 2016, subject to a written agreement designed to regulate contact between K and the maternal grandmother, LH and to protect her from a perceived risk of harm posed by other members of the wider maternal family. C and D have remained in foster care to date, in separate placements.

32. On 28th September 2016 HHJ Moir made interim care orders in respect of C and D and made an interim supervision order in respect of K, who remains in the care of the Mother.

Positions of the parties

33. The local authority seeks Care Orders in respect of all three children and advances care plans for each to continue to be placed separately in long-term foster care.

34. K's amended care plan, provides for her to be removed from the care of the Mother and be placed alone in long-term foster care. It provides for her to be afforded life story work to learn more about her father. Direct contact between K and her father will be promoted, it is hoped that this contact can take place in the community. The local authority has indicated a commitment to encouraging the development of K's relationship with her father.

35. C's amended care plan, provides for him to remain with his current foster carer on a long-term basis. It is proposed that C will have indirect contact with his father by way of letters and cards four times per year. He will also be given life story work to enable him to learn about his father. Photographs from the life story work will be sent to his father. MS will be invited to his LAC reviews and direct contact will take place if C wishes to see his father.

36. It is proposed that D remains placed in his current long-term foster placement and that he has supervised contact with each of his parents once per month. Additional contact will be promoted at times when he is in hospital.

37. Contact between the Mother and all three children is proposed on a monthly basis, following a gradual reduction from its current level of three times per week. Inter-sibling contact is proposed on a fortnightly basis to be arranged by the children's carers.

38. The local authority seeks threshold findings against the Mother, these include a finding that D's femoral fracture was a non-accidental injury, caused when he was in her care.

39. The Mother opposes the local authority's care plans in respect of all three children and seeks to care for all of them, or any of them, if the Court determines that she cannot manage to care for all three. In the event that it is determined that she cannot care for all or any of the children, she opposes them being cared for by any member of their paternal families. The Mother seeks a higher level of contact than is provided for the in local authority's care plans. The Mother disputes that the threshold criteria for the making of public law orders is crossed. She accepts that D suffered a femoral fracture but denies that she caused it. She asserts that this injury must have an organic unknown cause. She maintains that she does not know how MA-H came to be registered as K's father on her birth certificate. The Mother opposes C's father having Parental Responsibility. By the time of filing written submissions, she indicated that she was "now neutral in respect of K's father having Parental Responsibility" but that she continues to oppose declarations of parentage and non parentage being made in respect of K.

40. K's father, TT, opposes his daughter remaining in the care of the Mother and supports her removal to foster care and the making of a care order. He agrees that K should remain in foster care for the foreseeable future. He seeks to care for her

in the long term but adopts a realistic approach accepting that at the current time he is not in a position to care for her. He seeks reassurances that the local authority will actively encourage the progression of his contact and encourage a relationship to be built between him and his daughter whilst giving consideration to the possibility of K moving to live with him in the future via on going assessment. He seeks a Declaration of Non Parentage in respect of MA-H, a Declaration of Parentage and an order for Parental Responsibility in respect of K.

41. C's father, MS, supports the making of a care order in respect of C. He opposes the Mother caring for C and supports him remaining in long-term foster care. He seeks to develop contact with his son together with an order for Parental Responsibility.

42. D's father, JW, accepts that he is unable to meet the care and welfare needs of his son. Prior to her acceptance that she is not in a position to care for D, he supported D being cared for by his niece, JA. He also put forward his sister, AW (JA's mother) and his mother, SW as potential alternative carers for D. AW and SW were each negatively assessed by the local authority. Neither has sought to challenge those assessments. Both indicated during their assessments that they are not in a position to care for D and that they put themselves forward in a supportive role only for whoever would care for him in their family. JW opposes the local authority's care plan to reduce his contact to once per month, preferring it to remain on a weekly basis for one hour per session or if not for it to reduce to a fortnightly basis for an extended period of 2 hours per session. He invites the Court to the view that his contact could move into a community child friendly setting as opposed to being at the local authority's contact venue. He would like contact to include his sister and mother as well as JA. He raises concern that health information is not regularly shared with him. He opposes D being cared for by the Mother.

43. JA was joined as a party to these proceedings on 10th February 2017 to enable her to advance a case to care for D. She is unrepresented. On 28th June 2017, the

Mother produced some Facebook entries purporting to contain information which suggested that JA may continue to be in a relationship with her former partner, SF, a man who had previously perpetrated significant domestic violence towards her and who is said to have suffered from heroin addiction. Whilst not accepting that this information was correct, JA indicated that she accepted that she was not in a position to care for D, prior to giving evidence.

44. RG sought to care for all or any of the three children in the event that the Mother was unable to. She was unrepresented. Sadly on 2nd June 2017, before the case concluded and before she was able to give oral evidence, she unexpectedly passed away.

45. The Children's Guardian supports the making of Care Orders in respect of all three children, and supports the local authority's amended care plans in respect of each child being placed in long term foster care in separate placements. The Children's Guardian has provided a letter written by K addressed to me, within that document K indicates her opposition to the local authority's care plans and in respect of her brothers says she "wants them home".

The Law

46. The law to be applied when considering the issues before the court is well settled. When considering the findings sought by the local authority the court applies the following well established principles.

47. The burden of proving the facts pleaded rests with the local authority. In cases of alleged inflicted injury, it is for the local authority to establish on the balance of probabilities that the injuries in question were inflicted. There is no requirement on the parents to show that the injuries have an innocent explanation.

48. The standard to which the local authority must satisfy the court is the simple balance of probabilities. The inherent probability or improbability of an event remains a

matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred (*Re B* [2008] UKHL 35 at [15]). Within this context, there is no room for a finding by the court that something *might* have happened. The court may decide that it did or that it did not (*Re B* [2008] UKHL 35 at [2]).

49. Findings of fact must be based on evidence not on speculation. The decision on whether the facts in issue have been proved to the requisite standard must be based on *all* of the available evidence and should have regard to the wide context of social, emotional, ethical and moral factors (*A County Council v A Mother, A Father and X, Y and Z* [2005] EWHC 31 (Fam)).

50. In determining whether the local authority has discharged the burden upon it the court looks at what has been described as 'the broad canvass' of the evidence before it. The role of the court is to consider the evidence in its totality and to make findings on the balance of probabilities accordingly. Within this context, the court must consider each piece of evidence in the context of all of the other evidence (*Re T* [2004] 2 FLR 838 at [33]).

51. In this context, and self-evidently, I am not limited to the expert evidence before me but may take account of a wide range of matters, including my assessment of the credibility of the witnesses and inferences that can be properly drawn from the evidence. The opinions of the medical experts need to be considered in the context of all of the other evidence. When considering the medical evidence, the court must bear in mind, to the extent appropriate in the given case, the possibility of the unknown cause (*R v Henderson and Butler and Others* [2010] EWCA Crim 126 and *Re R (Care Proceedings: Causation)* [2011] EWHC 1715 Fam).

52. The evidence of the parents and carers is of utmost importance and it is essential that the court forms a clear assessment of their credibility and reliability. The court is likely to place considerable reliability and weight on the evidence and impression it forms of them. In this regard, it is important to bear in mind the observation of

Peter Jackson J in *Lancashire County Council v M and F* [2014] EWHC 3 (Fam) that:

> "To these matters I would only add that in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record keeping or recollection of the person hearing or relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith."

53. The court must always bear in mind that a witnesses may tell lies in the course of an investigation and the hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress. The fact that a witness has lied about some matters does not mean that he or she has lied above everything (*R v Lucas* [1982] QB 720).

54. It is also important when considering its decision as to the findings sought that the Court take into account of the presence or absence of any risk factors and any protective factors which are apparent on the evidence. In *Re BR* [2015] EWFC 41 Peter Jackson J sets out a useful summary of those factors drawn from information from the NSPCC, the Common Assessment Framework and the Patient UK Guidance for Health Professionals.

55. It is in the public interest that those who cause injury to children be identified (*Re K (Non-accidental Injuries: Perpetrator: New Evidence)* [2005] 1 FLR 285). The

court should accordingly endeavour to identify on the simple balance of probabilities the person or persons responsible for inflicting the injuries in question.

56. The Court should not, however, ‘strain’ the evidence before it in order to identify on the simple balance of probabilities the individual or individuals who inflicted the injuries. If it is clear that it is not possible on the evidence before the court for the court to conclude on the balance of probabilities who the perpetrator of the injuries is and the court remains genuinely uncertain, then the court should reach that conclusion (*Re D (Care Proceedings: Preliminary Hearing)* [2009] 2 FLR 668).

57. Where the court cannot identify a perpetrator or perpetrators on the simple balance of probabilities, it is still important to identify the pool of possible perpetrators by asking whether the evidence establishes that there is a ‘likelihood or real possibility’ that a given person perpetrated the injuries in question (*North Yorkshire CC v SA* [2003] 2 FLR 849). In such circumstances, the court must scrutinise the evidence carefully and consider whether anyone, and if so who, should be included in the pool of possible perpetrators of the injuries sustained by the child (*Re S (A Child)* [2014] 1 FLR 739). These principles were considered by the Supreme Court in the case of *Re J (Care Proceedings: Possible Perpetrators)* [2013] 1 FLR 1373 that case confirmed that the appropriate test to be applied when determining whether a person was within the pool of possible perpetrators with regards established injuries is the “real possibility” test.

58. Within this context, it is important to note that, in line with the principles outlined in the *R v Lucas*, in seeking to determine whether a person should be included within the pool of possible perpetrators it is essential that the court weighs any lies told by that person against any evidence that points away from them having been responsible (*H v City and Council of Swansea and Others* [2011] EWCA Civ 195).

The Law in respect of applications for Expert Evidence

59. The law to be applied when considering applications for expert evidence is found in Part 25 Family Procedure Rules 2010 and s.13 Children and Families Act 2014. Rule 25.4 FPR 2010 confirms the common law position in respect of all expert evidence namely Rule 25.4(2) a person may not without the permission of the Court put expert evidence (in any form) before the Court and Rule 25.4(3) the Court may give permission as mentioned in paragraph (2) only if the Court is of the opinion that the expert evidence is necessary to assist the Court to resolve proceedings.

60. In *Re H-L (Expert Evidence: Test for Permission) [2013] 2 FLR 1434* the President of the Family Division, Mr Justice Munby as he then was, confirmed that the word "necessary" was to be given its ordinary meaning.

61. Section 13 Children and Families Act 2014 provides:

> (1) A person may not without the permission of the court instruct a person to provide expert evidence for use in children proceedings.
>
> (5) In children proceedings, a person may not without the permission of the court put expert evidence (in any form) before the court.
>
> (6) The court may give permission only if the court is of the opinion that the expert evidence is necessary to assist the court to resolve the proceedings justly.
>
> (7) When deciding whether to give permission the court is to have regard in particular to—
>
> a. any impact which giving permission would be likely to have on the welfare of the children concerned,
>
> b. the issues to which the expert evidence would relate,
>
> c. the questions which the court would require the expert to answer,
>
> d. what other expert evidence is available (whether obtained before or after the start of proceedings),
>
> e. whether evidence could be given by another person on the matters on which the expert would give evidence,

f. the impact which giving permission would be likely to have on the timetable for, and duration and conduct of, the proceedings,

g. the cost of the expert evidence,

h. and any matters prescribed by Family Procedure Rules.

Legal Framework in respect of welfare decisions

62. I remind myself that each child's welfare is my paramount consideration. That is section 1(1) of the Children Act 1989. In considering what orders to make I have regard to the Welfare Check List found in section 1(3) of the 1989 Act.

63. In relation to the threshold criteria of section 31(2) Children Act 1989 I have regard to whether I am satisfied that each child has suffered or is at risk of suffering significant harm.

64. When considering which orders if any are in the best interests of the children I start very clearly from the position that, wherever possible, children should be brought up by their natural parents and if not by other members of their family. The state should not interfere in family life so as to separate children from their families unless it has been demonstrated to be both necessary and proportionate and that no other less radical form of order would achieve the essential aim of promoting their welfare. In Re B [2013] UKSC 33 the Supreme Court emphasised this, reminding us such orders are "very extreme", and should only be made when "necessary" for the protection of the child's interests, "when nothing else will do". The court "must never lose sight of the fact that (the child's) interests include being brought up by her natural family, ideally her parents, or at least one of them".

65. It is not for the court to look for a better placement for a child; social engineering is not permitted. In YC v United Kingdom [2012] 55 EHRR 967 it was said:

"Family ties may only be severed in very exceptional circumstances and…. everything must be done to preserve personal relations and, where appropriate, to 'rebuild' the family. It is not enough to show that a child could be placed in a more beneficial environment for his upbringing."

66. I have looked again at the words of the President in Re B-S (Children) [2013] EWCA Civ 1146 as well as the judgments in Re B (supra) and reminded myself of the importance of addressing my mind to all the realistic options for each child, taking into account the assistance and support which the authorities or others would offer.

67. In considering making Care Orders I have had close regard to the Article 6 ECHR and Article 8 ECHR rights of each family member and of each child, but I remind myself that where there is tension between the Article 8 rights of the parent or adult family member, on the one hand, and of the child, on the other, the rights of the child prevail; *Yousef v The Netherlands [2003] 1 FLR 210*.

Law in respect of Acquisition of Parental Responsibility by a Father

68. Pursuant to s.4 (1) c) Children Act 1989 the court, on an unmarried father's application, may order that he shall have Parental Responsibility for a child.

69. A father is entitled to ask the court to recognise his position as the father irrespective of any question of residence or contact. The order confers on the committed father the status of parenthood for which nature has already ordained he must bear responsibility; Re S (Parental Responsibility) [1995] 2 FLR 648, CA.

70. In Re D (Withdrawal of Parental Responsibility) [2015] 1 FLR 166, CA the Court encouraged the exercise of Parental Responsibility by fathers and confirmed that children have a right to that benefit.

71. In determining whether a father should acquire parental responsibility the Court considers the degree of commitment the father has shown towards the child, the degree of attachment between him and the child and the reasons why he is applying for the order but these three requirements, though a starting point, are not intended to be exhaustive and the Court must take into account all the relevant circumstances, bearing in mind that section 1 Children Act 1989 applies and the welfare of the child is therefore paramount: Re H (Parental Responsibility) [1998] 1 FLR 855, CA.

72. The leading case on the proper approach to determine parental responsibility is Re C and V (Minors) (Contact: Parental Responsibility Order) [1998] 1 FLR 392, CA which held that such applications are to be considered separately. Ward L.J. in the Court of Appeal stated that s.8 orders and parental responsibility orders were not linked. They were entirely separate. Parental responsibility was about status for an unmarried father who wished to assume the mantle of responsibility in law which nature had already thrust upon him, but also something which could bolster the self-esteem of the child.

Threshold Criteria

73. The local authority filed and served a revised schedule of findings sought to satisfy the threshold criteria, the relevant date of those findings being 30th August 2016, when the children were first accommodated by the local authority pursuant to section 20 Children Act 1989. This document is disputed. The Mother does not accept that the threshold criteria is crossed and it is therefore necessary for the Court to make factual determinations.

Factual determination as to threshold findings

D's femoral fracture

74. The local authority seeks the following findings in respect of D's femoral fracture:

"In the 4-5 days prior to 30th August 2016 D suffered a fractured right femur. He was non-mobile at the time and in the overall care of the Mother. In the absence of any plausible explanation as to how this injury occurred, it is likely that this injury was caused by a blow, impact or snapping action involving the infliction of significant force and is therefore a non accidental injury.

D's fracture would have caused him evident pain and distress and yet the Mother failed to obtain prompt medical attention for him, whether by herself or through another."

Pool of Perpetrators

75. On 16th May 2016 I gave a ruling with a fully reasoned judgment as to why two previously joined Interveners, RG and LH should be discharged as potential interveners in this matter. Only the Mother remains in the pool of potential perpetrators following that ruling. Relevant parts of that ruling are necessarily repeated here.

76. On 30th March 2017 HHJ Moir joined two interveners to these proceedings: LH, the maternal grandmother, and RG the maternal great grandmother. Their participation in these proceedings was anticipated to be limited to the circumstances surrounding D's fracture. I'm grateful to the advocates for clarifying that each Intervener was joined at that early stage, not because an active case was being put by any of the parties against them at that time, but purely to seek to avoid delay should evidence emerge to suggest that either of them were responsible in some way for his injury. At that stage none of the parties suggested that either of the Interveners inflicted D's injury but all of the parties and the Court recognised that they had had a lot of contact with D during the relevant time frame.

77. A case management order dated 30th March 2017 provides for the disclosure of redacted case papers to each Intervener, should they request them. I note that the same order provides for the local authority to file a revised schedule of findings sought and for the parties and interveners to respond. The local authority's case was therefore not fully pleaded at the time of their joinder and it was unclear whether a case would be put against them, either by the local authority or in due course by the Mother.

78. On 15th May 2017, the first day of the final hearing, RG attended Court unrepresented. LH did not attend. The local authority accepts that due to an erroneous address being cited in the bundle for LH previous attempts to serve her with notice of this hearing had not been successful. Mr O'Sullivan informed me that subsequent efforts to serve her may also have proven ineffective, as despite the fact that notice was sent by post the week before the start of the hearing, the entrance to her property is a communal one.

79. I made enquiries of RG directly in Court. She informed me that she had not received any papers in this case, save for the negative viability assessment of her. She attended Court due to receiving a notice requiring her to attend. She denied in any way causing D's injury or knowing how it was caused but agreed to give factual evidence about its causation if required.

80. I could not be satisfied, nor was it being suggested, that either of the Interveners had received any of the case papers in this matter, save that RG had received the negative viability assessment conducted in respect of her.

81. The local authority clarified in Court that the findings it seeks remain as drafted, with no findings sought against either of the Interveners. Accordingly, the local authority has not included them within the pool of possible perpetrators for the injury in its pleaded case and does not seek to put an active case against either of

them. The Mother does not suggest that either of the Interveners had caused D's injury.

82. In light of the evidence that I had read and the positions of the parties as I understood them to be, I invited the parties to take instructions and make submissions to me about whether, in circumstances in which no findings were sought against them, it was appropriate for the Interveners to remain in the case.

83. During the course of submissions, the local authority informed me that the Court had joined the Interveners out of an abundance of caution, in case further evidence emerged which indicated that there was a real possibility that they caused the injury. The local authority accepts that no such further evidence has emerged. It does not seek findings against either of the Interveners and accepted that they could be discharged. Ironically the intention of joining the Interveners at that early stage was to ensure that they had sufficient time to access the papers, seek legal advice and prepare their cases. Unfortunately those good intentions had not materialised in that way.

84. I am grateful to counsel for the Mother, Miss Sweeting, for clarifying in no uncertain terms what her instructions are in respect of whether she seeks to put a positive case against either of the Interveners. She told me that she had "clear and unequivocal instructions not to pursue an active case against either of the Interveners". That said, whilst she did not oppose the discharge of the interveners, she did not consent to the Interveners being discharged and invited the Court to determine whether there was sufficient evidence to justify their continued involvement in the case. It has therefore been necessary for me to give a ruling in respect of this matter.

85. K's father, TT, is neutral in respect of this issue._C's father, MS, is neutral in respect of this issue.

86. All parties accept that D’s father, JW is not in the pool of perpetrators for this injury. I canvassed his views about the Interveners remaining in the case and was informed that he has no case to put against them. I take the view that his views are particularly important in this regard as he is one of D’s parents.

87. JA made no representations about this issue, which largely did not concern her case.

88. The Children’s solicitor Miss Spenceley summarised her analysis of the evidence in the following way, “it does not appear that the Mother is putting a factual case against either of the Interveners and it does not appear from the written evidence that there was any incident or event giving rise to a real possibility that either of them could have caused the injury.”

89. There must be a proper evidential basis for including a person within the pool of perpetrators. The consequences of which can be profound for the individuals concerned. In reaching a decision as to whether to include a person within a pool of possible perpetrators the factual matrix must be carefully scrutinised and the lay evidence becomes of vital importance. In this particular case, it is the evidence of the Mother, which must inform the Court whether there was a real possibility that anyone other than her should be included in a pool of possible perpetrators.

90. At all material times the Mother accepts that she was the primary carer for D.

91. On 28th September 2016 the Mother was directed to file a statement setting out, with as much particularity as possible, the circumstances which may have led to, and the reporting of, the fracture to D’s femur. In her statement dated 28th October 2016 she sets out the care arrangements for D between 27th August 2016 and his admission to hospital. At no stage during that account does she describe a time when D was left alone in the sole care of either of the Interveners. At all material times he was in her care, in the same household as her. She was living in the home of RG at the time and although she describes RG providing assistance with D’s

care, she can point to no episode or incident during which he may have been injured by RG. There is no description of a discovered incident or accident, no obvious change in symptoms or evident distress following RG handling him or performing any other care tasks for him and no episode of obvious and sudden distress when she was in another room, for example. LH does not feature in her account at all.

92. In her response to the initial threshold criteria document dated 27th September 2016, she states "The Mother accepts that an injury occurred on either 28th or 29th August and that the child has sustained a fracture to his right femur above his knee. Mother is unable to provide an explanation for the injury."

93. The Mother was interviewed by the Police in connection with D's injury on 7th September 2016; a transcript of that interview is contained in the bundle. At no point during that interview does she say that she left D in the sole care of any other person. She does not point to any episode or incident in which he could have been injured without her knowledge or any time when she noticed any of the signs or symptoms indicative of such an injury having occurred in someone else's care. Other family members and indeed professionals were present at times in the relevant time frame, but the Mother points to no time in which anyone else had the sole care of D, by which I mean a time when she left the house or when he was taken out of the house without her. She does not identify any time when she witnessed, by sight or sound, any other person causing injury to him by any means.

94. At no stage in any of the evidence before the Court does the Mother suggest that either of the Interveners may have caused the injury or had the opportunity to do so without her being aware of it. It is difficult to identify an opportunity in which they could have injured D, less still an opportunity in which they could have done so without the Mother being aware of it.

95. I could therefore see no proper basis for including either of the Interveners in a pool of possible perpetrators. There is no real possibility that they caused D's injury on the evidence before me and accordingly they were both discharged as Interveners.

96. The Mother was re interviewed by the Police on 9th May 2017. A transcript of that interview was provided the day after my ruling. Within that interview the Mother again accepts that she was D's primary carer. Nothing within that interview has caused me to revisit my ruling in respect of the Interveners.

97. I am grateful to Mr Ainsley and Miss Sweeting for alerting me to two other possible matters – the first an allegation arising from the papers that LH may have dropped D on his head and the second an observation that within the local authority's evidence RG is included in the alternative to the Mother as potentially being responsible for K's arm injuries. I am grateful to the local authority for clarifying that no findings are sought against LH in respect of dropping D. The medical evidence is clear that his encephalopathy is non traumatic in origin and that such an incident could not explain his femoral fracture. I invited the local authority to reflect upon whether it was necessary or proportionate to pursue its finding number 5, namely that K suffered four separate arm injuries over the space of a month while she was in the general care of the mother, given the timeframe involved and the potential argument that RG may once again be implicated purely by reason of opportunity. I made clear that I did not consider on the evidence before me that this was sufficient reason for RG to continue to hold Intervener status. The local authority again clarified that no findings of this nature are sought against her and I find that it would be disproportionate to include her as an Intervener for the purposes of finding 5. The local authority does not put a case against her. The Mother's case is that these were accidental injuries and therefore once again, no party puts a positive case against her. Unlike D, K was a mobile healthy and much older child at the time of her injuries. I invited the local authority to reflect upon whether it is necessary to pursue this finding at all.

Applications for further expert evidence

98. The Mother accepts that D suffered a fracture but its causation is in dispute. The Mother submits that this may be a fracture with an unknown cause. The Mother made an application for a Part 25 expert/experts to explore this issue further during the final hearing. I refused her application, after hearing the expert evidence of Dr Morrell and Dr Johnson and the evidence of Dr Wolny, treating clinician. I gave a fully reasoned judgment in respect of those applications on 17th May 2017; parts of that ruling are necessarily repeated here.

99. The Mother's application was for an expert paediatric endocrinologist and a geneticist, she also sought for testing to be carried out to identify whether D suffers from one of more than five possible strains of Osteogenesis Imperfecta. This application was opposed in principle by the local authority and on behalf of the children.

100. The genesis for the Mother's application is found in Dr Peter Morrell's addendum report dated 26th April 2017, he writes, "I note that the report from Dr Wolny which has reference to a bone scan. The nature of this scan is not clear and as far as I am aware the results of this have not been presented. However, this could be of significance with regard to the femur fracture."

101. The background to the commission of the bone scan is explained in the report of Dr Helen Estyn-Jones dated 23.11.16 "D's x-rays from Tuesday 30th August 2016 were discussed in the Paediatric Radiology meeting on 6th September 2016. It was suggested that the bones looked osteopenic (reduced bone density) and that this might mean that a fracture could have happened more easily. This was subsequently discussed with Named and Designated Doctors for safeguarding at the Queen Elizabeth Hospital and the Great North Children's Hospital and a further Paediatric Radiology opinion was sought. D's plain films and skeletal survey have been reviewed by Dr Starzyk, Consultant Paediatric Radiologist at the Great North

Children's Hospital. In her opinion, plain films are not accurately able to assess bone density and a further assessment of D's bone density with a DEXA scan has therefore been requested."

102. Following receipt of Dr Morrell's addendum, the result of this DEXA bone scan, undertaken on 5th January 2017, was pursued by the parties. Obtaining this information proved very difficult to achieve and necessitated a third party disclosure order. The two single joint experts, Dr Morrell, Consultant Paediatrician and Dr Karl Johnson, Consultant Paediatric Radiologist were asked to comment upon these scans on an urgent basis. On the first day of the case, 15th May 2017 Dr Johnson had responded in an email dated 12th May 2017, but Dr Morrell's response was awaited.

103. When asked to comment upon the bone scan, Dr Johnson replied by email in the following way, "I can confirm I have seen the Bone densitometry scan performed on D on 05.01.17. I am not an expert in Bone densitometry and so I am unable to determine the significance of these findings with respect to D's bone strength and his femoral fracture. I would defer to the opinion of a paediatric endocrinologist in this regard. The comment I would make to the [sic] is that at Birmingham Children Hospital we do not perform these scans on children under the age of 5 years as the result in the younger age group are not deemed to be reliable. I would therefore defer to a bone endocrinologist as to the significance and relevance of this investigation in D's case."

104. Accordingly enquiries were made on behalf of the Mother of Professor Bishop, a Professor of Paediatric Bone Disease in anticipation of a Part 25 application being made. Professor Bishop responded, "I'm sorry I can't help due to existing clinical and academic commitments; however I can say that we would not use bone densitometry in this age group for diagnostic purposes; we would only undertake it in order to monitor the effects of interventions with bone active drugs such as bisphosphonates in infants/children with an existing diagnosis of bone

fragility – basically, we want to make sure that the intervention with a bisphosphonate, which is designed to increase bone mass, is actually being effective."

105. In circumstances in which the results of the DEXA bone scan were received into the case very recently and experts' responses had not been fully received at the outset of the hearing, I invited the Mother to delay making any potential Part 25 application until the conclusion of the evidence of the experts who were both scheduled to give evidence on the second day of the case. In that way this issue could be fully explored in evidence and there would be more time for a properly considered Part 25 application to be made. The Mother's application was accordingly made following live evidence being given by the two experts, Dr Morrell and Dr Johnson, and after Dr Wolny, treating Paediatrician, gave evidence.

Medical and Expert Evidence

106. Dr Karl Johnson, Consultant Paediatric Radiologist was jointly instructed by the parties as an expert to consider D's fractured femur. His substantive report is dated 13th January 2017. Based upon the radiological findings, his opinion is that D suffered an incomplete transverse fracture of the distal right femur. Although the dating of such a bony injury is imprecise, in his opinion it was probably no older than 4-5 days at the date of presentation to hospital on 30th August 2016. In his opinion this injury was caused as a result of a blow, impact or bending snapping action applied to the bone. The amount of force being applied to cause such an injury was significant, excessive and greater than that used in the normal care and handling of a child. This was not a self-inflicted injury. At the time that the fracture occurred D would have been in pain and demonstrating signs of distress. At the time of writing his report, no suitable explanation had been forthcoming for this injury. From a radiological perspective, D's bones appear normal and there is no evidence of underlying metabolic bone disease or other disorder, which would

predispose him to fracturing. Dr Johnson responded to written questions posed on behalf of the Mother, his opinion remained unchanged.

107. Dr Johnson gave live evidence via video link on the second day of the hearing. He confirmed his reports and his opinion that radiologically D's bones appear normal. He did however accept that X-rays are a relatively poor discriminator of bone density and that they are not 100% accurate in assessing bone strength. He accepted that it is possible for bones to appear normal and yet have weakness. For that reason he defers to Paediatric opinion for clinical signs of weak bones. He told me that DEXA scans are not relevant for children of this age. He defers to Professor Bishop but confirmed that the information contained in the email from Professor Bishop mirrored information he had received from his colleagues. From a radiological perspective, it is his opinion that no further tests are warranted but he would defer to paediatric opinion as to whether the clinical or genetic history warrant them. In all aspects of the clinical findings he would defer to paediatric opinion. He told me that as a matter of general practice he looks for signs of Osteogenesis Imperfecta in all cases and that here there are no signs. In particular he looks for signs of very thin bones, bones that are osteopenic with no calcium in them, he looks for wormian bones in the skull, abnormal teeth, bent or less well aligned bones. Those are the classical features. He saw none of those signs in D's case. He accepted that Osteogenesis Imperfecta is a disease with a spectrum of findings and that some in the range can appear normal radiologically, others not. It is his practice to look for signs of abnormality in the bones first before looking for non-organic or traumatic causes of an injury. When cross examined on behalf of the Mother he said that at the time of writing his report he was aware that issues were being raised with regards to bone density, although he could not recall specifically reading the passage in Dr Estyn-Jones' report about this. He was aware that bone density was being raised and was aware of D's underlying medical problems and so he said that he specifically looked for evidence of osteopenia as he was fully aware of its relevance to the case. He repeated on a number of occasions during his evidence that the interpretation of DEXA scans is not his area

of expertise and the fact that such a scan had been requested would make no difference to his evidence as he does not interpret them and he understands that they are not a reliable or relevant test for children under the age of 5 years. The DEXA scans in this case were sent to him but he cannot interpret them and it is his understanding that the reason for their unreliability in children of D's age is that there is insufficient data to determine what a normal scan appearance would be. In his opinion, based upon review of the X-rays, the bone density appeared normal, that opinion, he said, is based upon him looking at children's bones every day of the week and this being his specialism. He did accept that there are rare cases in which bones can appear normal radiologically and yet children can have a weakness in bone density. At no stage during his evidence did he suggest that further tests or investigations were merited, or that this case was beyond his expertise. With regards to the question of whether radiology alone could fail to detect osteopenia, the relevant area of expertise he sought to defer to was Paediatric with regards to whether there were any clinical signs of weakness in the bones.

108. The bundle contains a number of Paediatric reports in respect of D. These include reports from his treating doctors, Dr Helen Estyn-Jones and Dr Susanne Wolny, Consultant Paediatricians at Queen Elizabeth Hospital Gateshead and from the Court appointed jointly instructed expert, Consultant Paediatrician Dr Peter Morrell.

109. Dr Morrell's substantive report is dated 12th January 2017, within it he describes the clinical investigations carried out at the RVI in respect of D, "D had blood tests taken on 31st August 2016. This showed a normal bone profile with normal levels of blood calcium, blood phosphate, alkaline phosphatase, parathyroid hormone and also a vitamin D level of 82.3 Nanomoles per litre which is in the normal range", he states "The blood tests that were taken when D was admitted to hospital on 30th August 2016 showed no evidence of any underlying metabolic bone disease. I have not seen a report from an expert Radiologist with regard to the appearance of the bones on x-ray and whether there was any evidence of osteopenia

or thin bones. Clearly D would be at some risk of developing osteopenia in view of the hypotonia and lack of movement in the legs. If this was the case then I would expect this to be evidenced on the x-rays." In his first addendum report dated 15th March 2017 he confirmed his agreement with the opinion of Dr Johnson with regards to D's femoral fracture. His second addendum report is dated 26th April 2017 within it he confirmed that D continues to present with severe global developmental delay and epilepsy, the cause of his condition remains unclear. A muscle biopsy displayed no evidence of any metabolic disorder and therefore his opinion remains unaltered. Dr Morrell provided a further update by email dated 15th May 2017, "I confirm I have now spoken to Dr Wolny and she confirms that the DEXA bone scan was normal for D's age. I agree with Dr Johnson that these scans are difficult to interpret in children of this age. However, in the absence of any abnormality my opinion is unchanged."

110. I heard oral evidence from Dr Morrell on the second day of the hearing. Dr Morrell kindly accepted my invitation to continue to provide assistance to the Court by responding as quickly as he could to any further questions posed of him, particularly should the DEXA bone scan results be made available. Dr Morrell explained that a DEXA scan is used to measure bone density. His understanding is that such scans are said to be unreliable for use in young children as there is insufficient data at the present time to ascertain a normal range. They are currently used in elderly patients with regards to Osteoporosis, in that age group they are considered reliable due to the sufficiency of data. I asked him how bone density could be reliably assessed in D's age group, his response was "The only way we have to assess bone density at the moment reliably is an X-ray which then needs to be interpreted by a radiologist, which is a matter of judgment." He confirmed that he had not seen the DEXA scan films and has no expertise in interpreting them but would ordinarily have liked to have obtained the written scan results rather than being told that they were normal by telephone. He noted that Dr Wolny had been at home when the telephone call with her took place, that the contents of the discussion related solely to the scan results and that she said they were "normal".

He deferred to Professor Bishop and Dr Johnson on the question of bone density. He confirmed that D had had a full set of blood tests done to ascertain whether metabolic bone disease was present and all results were normal. In answer to questions put on behalf of the Mother he said that he always preferred to see results in writing himself although could not interpret the scans. He deferred to Dr Johnson's expertise on bone density and observed that Dr Johnson was of the opinion that D's bones were not osteopenic. He said that it was not common for a bone density scans to be requested in this age group as such a scan is not very accurate. Miss Sweeting, on behalf of the Mother, explored a range of different possible causes, which may lead to osteopenia in D. In respect of the method of feeding he said that this was not relevant to D as he is not fed via Total Parental Nutrition; in respect of epilepsy medication he said that although some anticonvulsant medication can lead to osteopenia, D's medication does not have that side effect; he did accept that immobility can lead to osteopenia in children with severe disabilities but said that the examples he has seen include children with spina bifida where the child has no movement in the legs. In his experience this presents when a child is 4-5 years old as it takes time to appear. He notes that D was 11 months old at the time of the fracture and comments that no children are very mobile at that age. In his opinion it is unlikely that significant osteopenia would develop at the age of 11 months simply as a consequence of immobility. He confirmed his agreement with Dr Johnson's interpretation of the X-rays, which provides no evidence of genetic bone disorder although conceded that it was difficult to exclude that. He did say that he was unaware of any signs. Very specific blood tests can be done to exclude it and he was not aware of those being done but he deferred to Dr Johnson as to the appearance of the X-ray as far as genetic bone disorder is concerned.

111. Dr Morrell received the report accompanying the DEXA scan performed on 5th January 2017 on the third day of the trial, its author is T Watson, it reads "No aged matched data available for patients below the age of 4. However, when adjusting for bone size, Total Body BMC (Bone Mineral Content) is below what

we would expect for height and bone area. Lumbar spine BMC for bone size is also below the theoretic normal limit." Dr Morrell has kindly reduced his opinion once again to writing and provided it within hours of receipt of the scan report. He states that his interpretation of this report is that D's bone density is below expected levels for his size. He states that the relevance of this is uncertain because as the report states there is no age-matched data available in children of this age. He goes on to say that he does not have expertise in the interpretation of bone density studies and he assumes that an expert in paediatric metabolic bone disease would need to be consulted.

112. Dr Johnson was sent a copy of the extra sheet containing the narrative by T Watson on the third day of the trial. He confirmed that his opinion remained unchanged but he would defer to a paediatric endocrinologist regarding the interpretation.

113. I have also had the advantage of hearing live evidence from Dr Wolny, she produced the report of T Watson and therefore had seen it prior to giving her evidence, she is the lead treating paediatric clinician for D. She was able to tell me that from a clinical point of view no further tests or investigations are required to assess bone mineral density. She did tell me of discussions she had had that morning prior to giving evidence with a colleague - Dr Kate Owen, Paediatric Endocrinologist based at the RVI - she told me that the purpose of the discussion was because she knew she was coming to Court to give evidence. She was told that there is no "normal data" for D's age group but there are some specialist Paediatric Endocrinologists who could be consulted. Dr Owen had recommended two names within the Freeman Hospital; Dr Terry Watson and Dr Dave Rowling. Dr Owen recommended that the scans be sent to one of them. From a clinical perspective however, there is no further action required in respect of the DEXA scan. D is in receipt of treatment to prevent reduced bone density. That is in the form of a daily multivitamin. This treatment is preventative in nature and is recommended for all children under the age of 5 years in any event in accordance with the Government's

Guidance. There are two enhanced risk factors for D – immobility and anticonvulsant medication. However, he does not take the type of anticonvulsant medication that can lead to osteopenia, namely Sodium Valporate. She confirmed that there have been no clinical signs, which would indicate the need to test for Osteogenesis Imperfecta in D's case, and that he has suffered no further fractures since his femoral fracture was discovered.

114. At the conclusion of the live evidence of the two experts, I heard submissions on behalf of the Mother, the local authority and the Children's Guardian. At that point it was accepted by counsel on behalf of the Mother that a written application for a Part 25 expert had not been completed, nor had an expert been identified who was willing and able to report. I indicated that I would permit the Mother a further evening to attempt to locate an expert and complete the application but would hear submissions as to whether further expert evidence was necessary in principle. A written application was provided to me over the luncheon adjournment on the third day of the trial, still no expert had been identified. I permitted further submissions following receipt of that paper application and upon the arrival of Dr Morrell's addendum report dated 17.5.17, this followed the evidence of Dr Wolny. During the course of further submissions on the third day of the hearing, I received information that two expert paediatric endocrinologists had been identified, one of whom could report within three weeks of instruction. No CVs were provided. No geneticist had been identified to report in the case.

115. Miss Sweeting, counsel for the Mother, submitted that the totality of the medical and expert evidence indicates that it is necessary and proportionate to commission further expert evidence in this case. Her submissions principally focussed on the need to find an expert who could interpret the DEXA bone scan. When later pressed she enlarged her application orally to include, in prospect, a geneticist and possible further testing and investigations above and beyond a paper review to ascertain whether D suffers from one of more than five potential strains of Osteogenesis Imperfecta. She submitted that "plain radiological imaging may

not be sufficient" and that this may be one of those rare cases referred to in Dr Johnson's evidence in which the radiology appears normal and yet there is an underlying weakness resulting in an organic fracture and therefore that a full and proper investigation must be undertaken. She submitted that fairness to the children dictates that her applications are granted. She submitted that the case should be adjourned to give her time to source an expert and that only an expert in the relevant fields of paediatric endocrinology and genetics can assist. She submitted that it would be wholly unfair to proceed without that evidence and that to do so would, in effect, be a breach of the Mother's and the children's Article 6 and 8 ECHR rights.

116. The Mother's application was strenuously opposed by the local authority and on behalf of the children. Mr O'Sullivan, counsel for the local authority, submitted that there is no gap in the evidence, no necessity and even if there were that a DEXA scan is not the solution. He highlighted the obvious practical difficulties with the application and its deficiencies when considering the Part 25 criteria. He submitted that the opinion of Dr Starzyk, Consultant Paediatric Radiologist as relayed within the report of Dr Estyn-Jones should be interpreted as a general opinion about the merits of DEXA scanning and that it should not be taken to mean that a DEXA scan is required for forensic use in this case. He submitted that the evidence is clear and unequivocal, that the experts have been fully questioned about these issues and have applied their minds to it. All the evidence currently available to the Court is that DEXA scans are unreliable in this age group, and that is confirmed once again in Dr Morrell's most recent addendum. He reminded me of the legal position in respect of remote possibilities and the standard of proof to be applied when ultimately determining how an injury of this nature has been caused.

117. On behalf of the children, Mr O'Sullivan's submissions were adopted. Miss Spenceley added that the evidence of the experts was clear that DEXA scans cannot be interpreted for diagnostic purposes and that they are simply unreliable. She

informed me that extensive enquiries had been undertaken by her firm to identify an expert capable of interpreting DEXA scans without any positive outcome.

118. I refused the Mother's application for expert evidence, agreeing entirely with the submissions made by Mr O'Sullivan on behalf of the local authority. I made no criticism of Miss Sweeting for making these applications, nor indeed the timing of them given the late receipt of information about the DEXA scan and the development of the medical evidence that followed. Her role as counsel for the Mother is to leave no stone unturned. I afforded the Mother a full opportunity to pursue these applications, allowing extra time to attempt to locate relevant experts willing and able to report in this case, and to put together a complete Part 25 application. I permitted a full exploration of the need for further expert evidence by permitting the Mother to fully test the evidence of the Court appointed experts and D's treating clinician Dr Wolny and by suggesting that any application be made after doing so, so as to her give the best opportunity to put her case as fully as she was able to on this issue. In dealing with the application in that way I was ever conscious of the draconian nature of the orders sought by the local authority and the care plans put before the Court.

119. When applying the relevant statutory criteria to these applications they plainly fail to fulfill those criteria for a number of reasons.

120. Firstly, the applications lacked the necessary particularity required, CVs were not provided; no expert geneticist had been identified, no details had been supplied as to how and where further testing for Osteogenesis Imperfecta would be carried out, no estimate of costs had been provided nor timescales for the production of all of the further evidence given.

121. These pieces of information are not mere formalities; they are a vital part of any application for an expert. In a case of this nature, the likely timescale for the production of expert evidence is of crucial importance. These applications were made during the final hearing. If granted they would necessitate an adjournment and inevitable delay for the children. Miss Sweeting invited me to give more time

to complete her application by permitting her to source an expert. The delay she envisaged was not the end of the matter, it simply afforded time to attempt to try to find an expert to report, not to obtain the expert evidence itself. Because timescale was unknown, its impact upon the likely duration and timescale of these proceedings was not known. That is unacceptable in a case, which is already beyond its 26 week timetable. I was being invited to grant applications in principle. To do so would have resulted in an open-ended search for experts and an open-ended timescale for the filing of this evidence. An open-ended adjournment would be unfair to the children. I was satisfied that the inevitable delays caused would be prejudicial to their welfare. They deserve decisions to be taken about their future at the earliest possible juncture. I note that K is due to move schools in September 2017. A move of school will be a big change in her life. She needs a decision about where she is to live and what is to happen to her brothers as early as possible to give her the best opportunity to settle into her new school. Further delay would plainly not be in the best interests of any of the children. I was satisfied that the impact of these applications on the children, if granted, would be a detrimental one.

122. Secondly, I was satisfied that these applications fail on their merits in principle and therefore even though the case could not be concluded in May and had to be adjourned to the week of the 19th June 2017 with a possibility that the technical deficiencies in the applications could be remedied and further experts sourced over the course of the days and weeks that followed until its resumption, the applications were refused. I am satisfied that these applications fail the "necessary test" irrespective of timescale, cost and availability of expert.

123. By the time I came to give my ruling in respect of this issue a paediatric endocrinologist had been identified who could report within 3 weeks of the date of instruction and another who could report by he end of July. No CVs or details as to costs were provided, save that they would be outside the rates permitted on legal aid. Notwithstanding the possibility that a report from an endocrinologist could be furnished to the Court within a reasonable timescale, I refused this application on the basis that this evidence was not necessary.

124. I am not satisfied that any further expert evidence is necessary in this case. Dr Morrell and Dr Johnson have made clear that the reliable method to test bone density in D's age group at the present time is by radiological examination coupled with clinical presentation. Both experts confirmed that the appropriate expertise for radiological examination is possessed by a Consultant Paediatric Radiologist – Dr Johnson confirmed that he is the appropriate expert to undertake this task and that this is his field of specialism – as he said, this is what he does every day of the week. Miss Sweeting invited me to the view that this may be one of those rare cases in which a child's bones may appear normal from a radiological perspective and yet the child may in fact have weak bones. However, Dr Johnson made clear that in those rare cases it is Paediatric opinion that he would defer to, not any other discipline of expert. The Court already has the benefit of both treating and expert paediatric evidence in this matter.

125. Both of the current court appointed experts offered the same information about DEXA scans in children under the age of five years – namely that they are unreliable due to the insufficiency of data to permit a normal range to be established. To put it simply there is no reliable "normal" to compare D's results to. Both experts accepted that DEXA scan interpretation was outwith their field of expertise and that to interpret such scans they would defer to a paediatric endocrinologist. This is however within the expertise of Professor Bishop, who was described as the leading expert in these matters by Dr Morrell. Professor Bishop's email confirms that DEXA scans would not be used in this age group for diagnostic purposes. This view is repeated in the report of T Watson that accompanies the DEXA scan result itself. The body of expert and clinical opinion before the Court is therefore unanimous in that regard. I am satisfied that a DEXA scan is not a useful or reliable piece of evidence in this case. Its interpretation is unreliable and I am satisfied that it would not assist me to resolve the issues in the case. I accept that the experts currently instructed in this case are not the appropriate experts to interpret a DEXA scan, they have each volunteered as much,

but I am not satisfied that interpretation of a DEXA scan is required for me to reach a decision about the causation of D's injury.

126. I am satisfied that I already have all of the necessary expert evidence required to resolve this case justly and that the expertise of Dr Johnson and Dr Morrell, when taken together, is sufficient. That evidence has now been fully tested. Neither of the independent experts suggest that there is a need for any further expert evidence. I am satisfied that there is no gap in the evidence. Dr Wolny made further enquiries of a Paediatric Endocrinologist based upon the fact that she knew she was coming to Court to give evidence that day, not because there was a clinical need to. She again confirmed the lack of reliable data to establish what is normal in a DEXA scan in D's age group. She gave the names of two other treating Consultant Paediatric Endocrinologists who may be able to assist and said that Dr Kate Owens recommended they be contacted. However, that recommendation is not for clinical purposes. This information comes second hand and from a treating doctor who, I have no doubt was doing her best to assist, but who had no knowledge of this case. I take the view that this issue has been fully and fairly explored by and with the instructed joint experts in the case and that all of the information before me points to the DEXA scan being inherently unreliable for children under 4/5 years of age. It is not a question of expertise in interpretation. The difficulty with the DEXA scan is that there is an insufficient body of data to interpret it and determine what is normal for comparative purposes. Since there is no established normal limit for comparison, to say a result is low does not assist me without knowing what that normal limit should be. As Professor Bishop's email informs us, these scans are not used for diagnostic purposes and I am satisfied that to permit an attempt to use a DEXA scan for a diagnostic purpose in a forensic setting would be misleading and unsafe.

127. Although no formal written application was before me for any other form of expert evidence, Miss Sweeting addressed me orally in respect of the need to investigate the potential presence of Osteogenesis Imperfecta in D and the need for

a geneticist. I dealt with those matters during the same ruling. Testing for Osteogenesis Imperfecta would involve further commissioned investigations not simply a paper review. I am satisfied that those investigations are not indicated in this case on the evidence before me. A battery of tests has already been performed in respect of D by his treating team of clinicians. Those tests have been independently scrutinised by two independent Court appointed experts. Neither his clinical team nor the independent experts suggest that this is a condition that should be tested for. There is no evidential or clinical basis for it and I am not prepared to direct it. Nor am I prepared to sanction any genetic testing, to do so at this stage is not merited, could lead to lengthy delays and I am satisfied is unlikely to add any useful information to assist me to resolve the key issue, namely the causation of D's femoral fracture. There is no evidential basis to indicate that genetic abnormality of the bone is likely. I am satisfied that both D's treating team of clinicians, which is an extensive one given the nature and extent of his disabilities, and the two independent court appointed experts have thoroughly and rigorously investigated whether an organic cause for the fracture can be found and that I have sufficient medical and expert evidence to take a decision about its causation.

128. In reaching this decision I had firmly in mind the nature and extent of D's disabilities and that his diagnosis remains unknown. Both Court appointed experts were well aware of D's condition prior to expressing opinions in this matter. D's treating team were also obviously well aware of the nature and extent of his difficulties. Their evidence was clear and unequivocal to the Court notwithstanding his medical condition. There are no clinical or radiological signs of weakness in D's bones. Crucially, his femoral fracture is an isolated fracture; no other fractures have been occasioned to him before or after it was caused.

129. Miss Sweeting addressed me on the third day of the hearing in respect of whether I was prepared to take a case management decision to limit the scope of the findings sought by the local authority at that stage. I was not prepared to do that in respect of the findings pertaining to the femoral fracture. In reaching a

decision about that injury and its causation I remind myself that I must survey a "broad canvass of evidence", that means that I must consider all of the evidence, including the evidence of the Mother before reaching a determination. I indicated that my ruling did not preclude the Mother from running a case that the injury was an organic one and that it had an "unknown cause" and indicated that I had all of the medical and expert evidence I required to reach a decision about that, the key piece of evidence for me to hear and weigh in the balance against that was the evidence of the Mother, together with the other relevant lay evidence.

Causation of D's femoral fracture

130. I heard evidence from the Mother on the 21st and 22nd June 2017. I permitted her to have breaks where requested or when I deemed necessary. She gave her evidence without the need for many breaks. The Mother's case is that she simply does not know how the femoral fracture occurred. She remains clear that if it is non-accidental in nature only she could have caused it. She was open to the possibility that she might have done, although said that if she had it was accidental. However, she could point to no incident or accident that may account for it. I bear in mind when assessing her evidence that giving evidence in care proceedings is stressful for any parent and that that is particularly so in her case given that she is recently bereaved and suffering from mental health difficulties. She was however able to give her account in a forthright manner.

131. Dr Helen Estyn-Jones, the treating paediatrician who dealt with D upon his arrival at hospital on 30th August 2016, confirmed the presence of D's femoral fracture, together with the associated evident distress that it would have caused him in her report dated 30th August 2016. She is critical of the Mother's delay in seeking medical attention in respect of this injury, based upon the Mother's reported comment that he had presented with pain in his legs on the day prior to his hospital admission. She notes that this fracture is unexplained and occurred within a non-mobile child.

132. Dr Morrell indicated in his oral evidence that he agreed with Dr Johnson's opinion in respect of the likely causation of the fracture. He said that following such an injury; pain commonly lasts up to 30 minutes although signs can be variable. He said in oral evidence "Initial pain is severe. Once settled there will be continuing pain on movement. I would expect reduced movement and if the limb were to be moved, for example if the child were dressed, the child would continue to be in pain until it started to heal. Really for a few days. I understand D was often irritable and may have had reflux, which would be painful so he could have cried at other times. The pain would be sudden. I would expect a carer to know something significant occurred and that this was outside a normal reaction. There would be loss of use of the leg straight away or much reduced movement." I accept his evidence in respect of likely symptomology following the causation of a femoral fracture.

133. I am faced with two possibilities in respect of D's injury – either that this is an organic fracture with an unknown cause or that it is a non-accidental injury, caused by the Mother. The burden rests with the local authority to establish that this was a non-accidental injury. In reaching a decision about this matter I have firmly in mind the words of Baroness Hale in the case of Re B (Care Proceedings: Standard of Proof) [2008] 2 FLR 141 who emphasised that there is no logical or necessary connection between seriousness and probability. Inherent probability remains simply something to be taken into account, where relevant, in determining where the truth lies. In this context, the lack of any logical or necessary connection between seriousness applies with particular force. It may be unlikely that any parent would inflict serious injuries to their child however, once the evidence is clear that the child has sustained serious injuries, it ceases to be improbable.

134. When considering whether this was an organic injury with an unknown cause I bear in mind that D's condition is not fully diagnosed. He has complex medical needs. The origin of his condition may be genetic and has not yet been

fully identified. However, the nature of his condition is neurological with no skeletal difficulties having been identified to date. He has sustained no other fractures before or since this femoral fracture. Clinically and radiologically there are and were no signs of weakness to his bones. By reason of his condition and his age he was an immobile baby at the time that his fracture was occasioned. He required constant care and supervision.

135. Even if D did suffer from a degree of osteopenia, his fracture would still be painful. The unchallenged evidence of Dr Estyn-Jones is that "Whether or not D has reduced bone mineral density a broken bone is immediately and very painful and I would have expected him to show more distress and be much more difficult to settle than usual. I would expect those caring for him to notice this change in the level of his distress and to respond to it with the same urgency."

136. It is against this background that I find the Mother's account a troubling one. She was D's sole carer. He was entirely dependent upon her. She changed his nappy, bathed him, and changed his clothes. She had the care of him overnight when she slept on a sofa in the same room as him - the living room, where he slept in a travel cot. She told me that on the night of Sunday 28th August 2016 RG assisted her with the care of D by joining her and D in the sitting room in the early hours of that Monday morning. The Mother told me that RG had done this because she, (the Mother) was tired. On the night of Monday 29th August 2016 she was alone with D. No one else was present throughout that night. She tended to him alone. She cannot recall any time when she left him in the sole care of anyone else during the relevant timeframe. She can give no explanation whatsoever for his injury. She does not seek to blame anyone else for it. She does say that she may have caused it, albeit 'accidentally' but cannot pin point a time when this may have happened or a mechanism by which it occurred. She told the Police during her interview on 7th September 2016 that it could have been caused during her handling of him – when massaging him, playing with him or picking him up. During cross-examination by Mr O'Sullivan she said that these were all aspects of his normal

routine and that she had not handled him differently. She said in oral evidence “If I have done it accidentally I probably picked him up, changed him or handled him”.

137. The picture that emerges from the lay and social work evidence in this case is one of a mother struggling to cope with three demanding children. A rapid deterioration was noted by professionals in the Mother’s presentation and that of D from January 2016 onwards. She separated from JW in February 2016 due to her mother’s behaviour towards him and his family. When she gave her evidence to me it was clear that she blamed her mother for this separation and had otherwise in the most part viewed this relationship as a positive one. As a consequence of the separation she was deprived of his assistance and of his family’s assistance with the children. There was considerable acrimony between the two families and in June 2016 she reported that JA had made a serious threat towards her in the community, in the presence of the children. From January 2016 until the discovery of his fracture, it had become increasingly clear that D was suffering from a profound disability. His care needs had increased exponentially. He required regular, frequent and unexpected hospital admissions, some of which were lengthy. The mother had support from her grandmother RG, which increased following her separation from JW, but otherwise her familial support networks were extremely limited. In June 2016 the Mother complained that RG was prioritising AM (RG’ son) above her need for support and above the children. This was a source of frustration for the Mother. I am satisfied that the Mother’s frustration was an indication that she was not getting the support she needed from RG. She was a single parent to three children, one of whom was a severely disabled baby. I am satisfied that her own mother’s presence was a positively detrimental feature in her life. Whatever assistance her mother had been giving her was curtailed by the introduction of a written agreement in May 2016.

138. The Mother has complex mental heath difficulties which result in “significant mood swings and a mixed presentation” according to a letter from her GP dated 15th June 2017. She described what I’m satisfied amounts to a propensity

to lose her temper in her oral evidence. This has manifested itself in a smashed kitchen and on another occasion a dissembled Christmas tree. She has injured herself during one of these episodes – cutting her hand on a Christmas decoration. When asked about the impact of these episodes on the children it was clear from her answers that she was unable to consider them in the heat of the moment. She did repeatedly tell me however, that she would never harm her children, that it was "not in her nature to do so" and that these manifestations of anger were very different to "taking out" her temper on the children.

139. The evidence of the professionals tells a different story. In her statement dated 7th September 2016 Sarah Davies describes visiting the Mother and the children on 1st August 2016 with Mandy Brown from the crisis intervention service at Children North East. The Mother was at RG' address with the children. She describes "M appeared stressed and agitated during the visit. She confirmed that her mother continues to have no direct contact with the children. She said that she is managing the best that she can but she again referred to D as being whingey and said that she has no patience and so she needs to let her grandmother take over when he becomes difficult to manage. Both myself and Ms Brown were distressed and upset at witnessing the way in which M handled D. She demonstrated no emotional warmth towards him and did not support his head or body when she picked him up. At one point she pulled his leg to move him nearer to her. I had to point out that his feeding tube was leaking and so he was not getting his feed. This appeared to irritate M as it meant she had to change the tube. M was informed of the Child Protection Procedures and, given the level of professional concern, she was asked permission to accommodate the children which she refused."

140. Sarah Davies was the children's social worker between July and November 2016. She was the author of the parenting assessment of RG and wrote up the assessment of MS, (although much of the assessment itself was carried out by Helen McArthur, the children's current social worker). Ms Davies did not alter her account under cross-examination. I accept the submissions on behalf of the Mother

with regards to the opinion evidence she gave – at times she lacked balance and was unable to make appropriate concessions. I was dismayed that she was unable to accept that the Mother loved her children for example. However, putting opinion evidence aside, I did find her to be a truthful witness. Her evidence with regards to matters of fact was cogent and I am satisfied that she was not embellishing or exaggerating first hand accounts of incidents she had witnessed. I accept her account of this incident.

141. On 22nd June 2016 Kate Matheson, Health Visitor, undertook a home visit. Upon arrival she noted that the Mother was "visibly agitated". The Mother said that she was "fucking fed up". When the Mother was leaving RG' home, Ms Matheson observed the Mother to bounce D roughly down the steps. In her statement dated 24th August 2016 Ms Matheson describes D as "visibly distressed" during the visit. He was "noted to cry and whimper in his pushchair". He was soiled when he was stripped to be weighed. When the mother rocked him on her knee his "head was observed to roll back." Ms Matheson "noted two small marks" to D's back, one on the right side of his lower trunk and the other to the left side of his chin. The Mother "acknowledged she must have scratched him when winding him".

142. The unchallenged written evidence provided by the Children's Community Nursing Team describes a home visit on 4th August 2016 during which the nursing team advised the Mother that an ambulance was required for D as he was difficult to rouse, "to which M replied that 'he is asleep'. M began huffing and puffing and said "another 4 fucking hours in A & E."

143. Within Dr Morrell's chronology prepared from D's medical records an unchallenged reference for 6th August 2016 describes the Mother as "struggling to cope because D was increasingly distressed with symptoms of reflux and possible seizures."

144. On 17th August 2016, Kate Matheson attended an Initial Child Protection Conference and described the Mother as "presenting as overwhelmed, stressed and struggling to cope." D was made the subject of a child protection plan under the category of neglect on the same day. He returned from hospital to the Mother's care on 23rd August 2016.

145. The Mother does not accept the accounts of Sarah Davies or Kate Matheson but on balance I prefer the accounts of these professionals to the Mother's evidence. Kate Matheson has been involved with the family in the role of Health Visitor since 2013, she remains involved to date. I found her to be a careful, fair and credible witness. She attended to give evidence equipped with original files and where necessary referred to them to refresh her memory and check details such as the length of a visit. Her written evidence is lengthy and detailed. I found her evidence to be balanced, she made appropriate concessions and was able to tell me about good and, at times, excellent interactions between the Mother and D prior to January 2016. During cross-examination, she did not alter the evidence that she gave and was able to expand upon her account with compelling detail.

146. When Sarah Davies and Kate Matheson gave evidence orally they did not change their accounts when questioned. Neither of these witnesses had any reason to embellish their evidence or lie. They gave first hand accounts of what they witnessed.

147. Conversely, I found the Mother to be evasive at times in her evidence, often saying a question was for another witness or that an issue was not a concern of hers. There was a worrying lack of clarity in so far as when and how she first became aware that D had sustained an injury. Her account shifted several times both in the witness box and throughout the papers as to whether she first noted symptoms on the Monday or Tuesday and at what time of day.

148. The Mother accepted that on Monday 29th August 2016 the community nursing team had telephoned her. They made a contemporaneous recording that during that telephone call the Mother reported that D was unsettled and that she thought he had pain in his legs. The detail of which is contained in the statement of Alison Ryder the Team Lead of the Children's Community Nursing Team. Her written evidence and the evidence provided by her team was not challenged and so neither she nor any other member of her team was required to give oral evidence during the hearing. Her statement is dated 28th September 2016, it contains a chronology of Community Nursing involvement with the family. Next to the entry dated 29th August 2016 she writes "Ms Stephanie Moore, Children's Community Nurse (Band 5) telephoned M for an update on D (subject)… D could be heard crying in the background. M reported that "its as if he's in pain with his legs". M stated that D was 'sweaty' with crying. M stated that D had not vomited, had opened his bowels and did not have a temperature. Ms Stephanie Moore advised M to take D to the Accident and Emergency Department if D did not settle." The Mother said in evidence that she could not recall saying that he was in pain with his legs, although was not suggesting that the note was inaccurate or untrue. In evidence she said "I know they wouldn't have written that if I didn't say it".

149. Her account during her oral evidence was different. M told me that she changed D, bathed him and dressed him on the Monday and that she never noticed any pain in his legs "nothing at all". At the conclusion of her oral evidence I asked her about the events of the Sunday and asked her to think again about how D was on the Monday. She accepted that he had been "crying in pain" on the Monday but added that she only knew it was his leg on the Tuesday when she saw the swelling. I am satisfied that the note made by the community nursing team is correct and that the Mother did report that he was in pain "with his legs" on Monday 29th August 2016. D didn't arrive for medical attention until 4.12pm on Tuesday 30th August 2016. The Mother did ultimately accept that she noticed swelling in his leg at around 10am on Tuesday morning when she changed him, albeit after initially asserting that she first noticed this on Tuesday afternoon. She went on to say that

she was mistaken about this and that the morning was correct. In her report dated 23rd November 2016, Dr Estyn-Jones records "M told the nurse at triage that she felt D's right thigh was more swollen than the left and he appeared distressed when she moved him. She felt he was tensing. M told the Paediatric Registrar that the day before D had been a bit irritable and not his usual self but there was nothing specifically wrong." I am satisfied that the M attempted to mitigate her delay in seeking medical attention by changing her account in this regard. I am satisfied that D was presenting with symptoms consistent with a leg injury, namely pain in his leg, on the Monday. The Mother was fully aware that the hospital was concerned that she had delayed in presenting him for medical treatment. She told me she "might have tried not to make it sound so bad". I fully accept that given D's difficulties which are described as reflux or colic he may have cried in pain at other times and this could have masked his symptoms to a non-perpetrator. However, a perpetrator would have known the cause. I find it no coincidence that the Mother reported pain in his leg to the community nursing team on the Monday and am satisfied that she knew that he had injured his leg in some way then. She may not have appreciated that he had sustained a fracture but I am satisfied that she knew he was in pain and that the pain was emanating from his leg. I am satisfied that she had been advised by the Community Nursing Team to take him to Accident and Emergency on the Monday should he continue to be unsettled and that she failed to do so despite the fact that he remained unsettled and was in evident pain.

150. In her oral evidence to me the Mother's explanation for failing to obtain medical treatment between 10am and 4pm on Tuesday 30th August 2016 included that she didn't know where K was, that she couldn't afford a taxi to transport D to hospital, couldn't get a lift and had no one to look after the other children. I did not find her explanations to be particularly convincing. I note that the Mother failed to mention any of these reasons to the Police in her interview on 11th May 2017. Even if these really are the reasons why she delayed I am troubled that she did not know where her then 10 year old daughter was, that she had no way of accessing transport to obtain medical attention for her disabled baby and that his need for medical

attention was not her first priority. The Mother accepted that RG was with her at the time and I am satisfied that RG could have cared for the older two children, whilst she took D to hospital as she had often done in the past. It beggars belief that K and C "wouldn't stay" with RG as the Mother asserted. On the Mother's own account RG would regularly look after the older two children when D was in hospital or at other times when the Mother needed her to. These were not the reasons that she initially gave to the hospital for delaying medical attention when asked. On Tuesday 30th August 2016 she described to the hospital what her commitments on Monday had been as a reason why she had not sought medical attention. D's hospital notes dated 30th August 2016, completed by Dr Estyn-Jones read as follows "She also explained delay in bringing to A & E saying she had school nurses out for the older children as well as Children's Social Care and had to wait for men to finish although she had noticed D's leg was swollen before. She also had to wait for a minibus to bring him up." On the Monday the Mother did have a number of planned appointments. I find that the reason she was describing Monday's commitments was because she had known since Monday that he needed medical attention. I am satisfied that none of those commitments should properly have precluded her from seeking medical attention for D.

151. In her report dated 23rd November 2016 Dr Estyn-Jones records the history that the Mother gave upon D's admission as follows, "She said that on the morning of admission she had noticed that his right thigh was swollen when he woke up and that he was crying when moved and on nappy changes. He was also not moving his right leg… M told me that she had brought D to Accident and Emergency because he remained unsettled from the day before and she noticed his leg was swollen this morning. She wasn't sure when he became unsettled yesterday perhaps after dinner and she tried to settle him with a warm bath and massage. His leg wasn't swollen when he went to bed." When I asked the Mother whether D was distressed during her massage of his legs on Monday evening she said "He was fine when I was massaging his legs. He was loving it." In her oral evidence she accepted noticing his leg was swollen during a nappy change at around 10am on

Tuesday morning. If this part of her account in oral evidence is to be accepted D went to bed without injury on the Monday night and had a swollen leg by 10am on the Tuesday morning. He was alone with the mother in the sitting room all Monday night. I do not accept this account. I find that the Mother is attempting to mitigate her delay in seeking medical attention and that, as recorded by the community nursing team, he was in pain from the Monday. I find that she did indeed attempt to settle him by massaging his legs but cannot accept that he was fine or "loving it" as the Mother described, it is likely that the pain she was reporting on the Monday was as a consequence of his leg being fractured. It follows that he would have been in pain whenever his leg was moved. Attempts to massage his leg will have caused him pain and that pain would have been obvious to the Mother.

152. The Mother is not being honest about the events and circumstances leading to D's fracture. I am satisfied that she knows how it was caused. He was with her at all relevant times. The Mother accepted in her evidence that she "is the only person who could be responsible for it" if it is not an organic fracture. I am satisfied on the totality of the evidence that D's injury is not an injury with an 'unknown cause'. I find that this is a non-accidental injury. I am satisfied that it occurred whilst D was in the care of the Mother and that she caused it at some time prior to her reporting that he had pain in his leg on the Monday. I am satisfied that there was an unacceptable delay in seeking medical attention for this injury and that such a delay constitutes gross neglect of his medical needs. I find that the Mother inflicted this injury and that she did so whilst under exceptionally difficult circumstances. She was caring for a profoundly disabled child. She had limited familial support. In the build up to this injury occurring she was observed to be under increasing amounts of stress. She had refused to permit the children to be accommodated in the lead up to it being occasioned. I am satisfied that she was becoming increasingly rough in her handling of D in the days and weeks leading up to this injury being caused, as witnessed by Sarah Davies and Kate Matheson. She was simply not coping.

153. I asked the Mother about the events of the Sunday. In the early hours of the Sunday morning she told me that D's feeding tube had come out. It was out for several hours. K had unsuccessfully attempted to contact the community nursing team later that morning whilst the Mother was in bed. RG had taken over D's care in the early hours of that morning as the Mother told me she was "tired". The tube was still out when the Mother awoke. K had attempted to telephone the nursing team earlier that morning but couldn't get through, her phone was on silent and so they missed the returned call. The Mother managed to get the community nursing team out later that morning to replace the tube. The statement provided by the Community Nursing Team, written by Alison Ryder dated 28th September 2016 confirms the Mother's account. In the entry dated 28th August 2016 dated 09.45 it reads "Mrs Tammy Hennon, Children's Community Nurse (Band 5) received a telephone call from M, Mother stating that D's nasogastric tube had come out. Initial phone call (07.03) had been from an unknown number with no message left – it was ascertained that K (subject) had made the phone call but not left a message. When Mrs Tammy Hennon, Children's Community Nurse (Band 5) had tried to return call there was no reply. Mrs Carol Liddle, Children's Community Nurse (Band 5) and Tammy Hennon, visited RG (maternal great grandmother) home to replace D's nasogastric tube. Due to D's nasogastric tube coming out there had been a delay in his feed commencing but M reassured the Children's Community Nursing Team that she would ensure that D received the full volume of feed over the day."

154. The Mother accepted that D would have been hungry from the early hours of the morning when the tube came out, until it was replaced. She accepted that D, like any baby, cries when he is hungry. I am satisfied that he had been crying for several hours that morning. I am further satisfied that the Mother gets irritated by his feeding tube coming out – that irritation had been disclosed during Sarah Davies' visit of 1st August 2016. I cannot be satisfied whether this triggered the Mother to cause D's injury but I am satisfied that it was another relevant factor in the lead up to it being occasioned. The Mother was tired, stressed and caring for a

baby who had been continuously crying. By the time she spoke to the community nursing team on the Monday, I am satisfied that she had caused his injury.

Other Threshold Findings Sought

155. The local authority alleges that the children had suffered and/ or were at risk of suffering significant harm on the basis of the following:

156. The Mother has failed to keep/ disengaged from essential medical appointments for D including physiotherapy treatment, home health monitoring and weekly group visits.

157. The Mother asserts that "any appointments missed were for good reason and the authorities were informed that they would not be kept."

158. In Sarah Davies' statement dated 7th September 2016 she describes the Mother's failure to ensure that D's essential medical appointments were kept, "On 4th July 2016 M missed a very important medical appointment with the gastro team at the RVI. They were supposed to be arranging for a peg to be fitted, which would ease the pressure of him having to be continuously tube fed. He has now been discharged and will need to be re referred to the service again… Also on 25th July 2016 Faye Hamilton, senior physiotherapist, expressed her concerns … M has only attended 3 out of a possible 16 appointments for D and by not engaging with this service the physiotherapist concludes "D needs a lot of input around handling and positioning, developmental exercises and assessment for specialist equipment. By not accessing our group and not being available for home visits, D's development is being severely compromised and this has potential to make his future much more difficult."" I accept that this information is correct.

159. The Mother was unable to give an adequate explanation for these missed appointments in her evidence. When cross-examined by Mr O'Sullivan she

accepted that she "could understand why the physio put the referral in." I am not satisfied that the Mother had good reason to miss so many appointments. Having listened to the Mother's evidence, I am satisfied that these multiple missed appointments were symptomatic of a Mother who was struggling to cope with the care of her children and unable to prioritise D's health needs. I am satisfied that D's health needs in this regard were neglected and I make the finding sought.

160. **The Mother has neglected D's basic care needs in that she has: failed to handle him with appropriate care; failed to implement basic safe care advice regarding the use of pillows; failed to change his soiled nappy in sufficient time; failed to ensure that he was regularly and sufficiently fed, resulting in weight loss; failed to administer him with regular medication**.

161. The Mother does not accept this.

162. I am satisfied on the basis of the accounts of Kate Matheson and Sarah Davies that the Mother failed to handle D with appropriate care. I have already set out their evidence in respect of this and I accept its accuracy. I am satisfied that another example of inappropriate handling was the episode the Mother admitted when she caused scratches to D when winding him.

163. Sarah Davies also gave evidence that the Mother had missed some of D's appointments with the Speech and Language Team and with the Community Nursing team and regularly runs out of feed and essential medications for him. I accept that this information is accurate and find that the Mother failed to administer D with regular medication.

164. Kate Matheson, Health Visitor explained in her evidence that D's weight was of concern. "It faltered". She told me that the Mother had maintained to her that she was giving D his full feeds and "couldn't understand his weight loss". D had been prescribed five feeds a day via his naso-gastric tube. On 2nd August 2016

the Mother had admitted to the Dietician, Tracey Dixon that she had not in fact been giving D all his feeds as she "couldn't fit them all in" and deal with the other children. The Mother had reported that she "had no time for herself" and that "there were not enough hours in the day". The Mother had not admitted this to the health visitor, who had been weighing D on a weekly basis, and who had been trying to find out the reason for his significant weight loss.

165. The feeding plan for D to be fed five times per day had been put in place on 31st March 2016. It involved him being tube fed from 7am until midnight every day with weekly weights being taken. His weight was faltering and dropping from June 2016 without explanation. It took until August 2016 for the Mother to admit the reason why. I accept the evidence of Kate Matheson. D dropped through two centiles without the Mother offering an honest account of why this was occurring. The Mother told me in evidence that "It was impossible to feed him five times a day". She said "it would work out from 7am until midnight" in a manner that suggested that this was a wholly unrealistic request of her. I am satisfied that the Mother failed to comply with the feeding plan for D and concealed that failure from professionals until 2nd August 2016 when she finally admitted the truth to the dietician, by which time she had failed to follow the plan for four months, resulting in significant weight loss. I acknowledge that D is reported to vomit his feeds and that the Mother said in evidence that he was not tolerating the full feeds. However, I am satisfied that it is likely that the Mother's failure to feed D in accordance with the feeding plan resulted in him dropping weight and amounted to neglect of his basic care needs. It imperilled his health and contributed towards his distress. If vomiting and a failure to tolerate feeds also contributed to his weight loss the Mother should have reported that to the health visitor. She did not do that and had no explanation for her failure to do so. I find that the Mother failed to ensure that D was regularly and sufficiently fed, resulting in weight loss.

166. On 21st April 2016 Kate Matheson, health visitor advised the Mother not to use a pillow in D's cot but she ignored this advice and was observed to continue to

use a pillow in his cot until his admission to hospital in August 2016, according to Sarah Davies. I accept their evidence and find that the Mother failed to implement basic safe care advice regarding the use of pillows.

167. On 22nd June 2016 and 25th June 2016 Kate Matheson undertook home visits and noted that D was in soiled nappies that appeared not to have been changed for some time. In her report she documents the comments that she made to the Initial Child Protection Conference on 17th August 2016, namely that "he had lost weight whist he was at home, had persistent nappy rash and had not attended several health appointments essential to meeting his health needs." I accept her evidence and find that the Mother failed to change D's soiled nappy in sufficient time.

168. I find that the Mother neglected D's basic care needs and that this was indicative of her overall inability to cope with the care of the children at the time. I accept that this was not always the position and that at times she had been able to met his basic care needs and those of the other children but am satisfied that from January 2016 onwards, as D's health needs became more complex, the Mother struggled to cope with his care and failed to meet his basic care needs as a consequence.

169. The Mother has neglected D's emotional needs by failing to demonstrate appropriate concern, responsiveness, emotional warmth and attachment towards D at times when he has exhibited signs of being unwell, unsettled, uncomfortable or distressed. Examples include that on 25th January 2016, 28th April 2016 and 10th May 2016 she showed a greater interest in her telephone than his care needs; on 9th February 2016 and thereafter whilst he was in hospital she failed to recognise that he was seriously unwell; on 9th February an ambulance had been required to take him to hospital; further similar examples occurred on 8th April 2016, 26th May 2016 and 17th August 2017; on 10th April 2016, 28th April 2016 and 10th May 2016 when D was plainly unwell she left him on the ward with the child K and further sought to leave

him with her mother so that she could go shopping – neither of these family members had been trained to administer his feeds; she generally left him in his cot or buggy for protracted periods of time.

170. The Mother does not accept this. She asserts that on the occasion that an ambulance was called for D, she was "in the process of seeking medical assistance" and she states that when D was in hospital, "that on each occasion she left the ward, the nursing staff were advised."

171. Evidence relating to the findings sought is contained in the written report of Kate Matheson, Health Visitor dated 24th August 2016. She provided a chronology of health entries which include the following, "A Cause for Concern was received on 10th May 2016 from the Queen Elizabeth Hospital Gateshead dated 28th April 2016 [D] was admitted to the Children's short stay unit later that day for overnight observation having presented in Accident and Emergency Department with an active seizure. On arrival [D] was noted to be screaming and very unsettled. It was noted that whilst nurses and doctors attended to [D] [the Mother] sat to the side. Staff observed no emotional attachment towards [D] and reported that [the Mother] was on her phone throughout the whole event and queried whether [the Mother] had been on Facebook. It was noted that [D] continued to be distressed but [the Mother] asked repeatedly to go down to the shop and wanted to sit and eat on a chair with [K]. [D] required an overnight stay in hospital. It was noted that [the Mother] did not want to stay and asked if [RG] could stay instead. [RG] had not had any training or input in [D's] care and did not know how to administer [his] feeds. [The Mother] was advised by staff (not named) that this was unacceptable as if [D] fitted overnight he would require transfer to The Great North Children's Hospital and [he] would need [the Mother] to be present. It was noted that [the Mother] was concerned that [K] and [C] needed to go to school the following day and that [RG] was unable to take them and needed to wait in for a delivery." I heard no direct evidence from any of the medical staff involved in this incident and do not have statements from them.

172. In her statement dated 7th September 2016 Sarah Davies describes visiting the Mother and the children on 1st August 2016 with Mandy Brown from the crisis intervention service at Children North East. She describes "M appeared stressed and agitated during the visit... She said that she is managing the best that she can but she again referred to D as being whingey and said that she has no patience and so she needs to let her grandmother take over when he becomes difficult to manage. Both myself and Ms Brown were distressed and upset at witnessing the way in which M handled D. She demonstrated no emotional warmth towards him and did not support his head or body when she picked him up." She confirmed this account in oral evidence and emphasised the lack of emotional warmth that the Mother demonstrated towards D.

173. Kate Matheson's entry for 9th February 2016 is a first hand account of a home visit she conducted at 10.25am that morning. She notes that D was unsettled upon her arrival and that the Mother and LH were both present at the address. D was crying continuously. The Mother told her that he had been "like that for two days solid" and had had loose stools for three days. Kate Matheson observed D to be extremely distressed, his eyes were observed to jerk to the right, he had poor head control with his head falling forward when sat upright. He became very floppy after an episode of screaming, his skin was pale. He had a high-pitched cry followed by a period of unresponsiveness. Kate Matheson called for a paramedic and requested that LH packed a bag for D and the Mother to attend hospital. LH refused, stating that she was going to have a bath and that D was "fine" and was unsettled because he had been given gripe water. Kate Matheson informed the Mother and LH that this was not the case and that he was very unwell. The Mother is then described as becoming distressed and admitting that she had not eaten for two days because she had been worrying about D. D was taken by ambulance to hospital.

174. I heard direct evidence from Kate Matheson about the incident on 9th February 2016. She was not challenged about the necessity to call an ambulance on that occasion. She said that the Mother "didn't seem concerned about D. She was an experienced Mam but wasn't recognising that he was unwell. She'd say that he was crying/unsettled but didn't recognise he was unwell…She wasn't seeking advice. I had to call an ambulance – she hadn't recognised that…[The Mother] didn't know how poorly D was. She said that he had been like that for two days. He had abnormal eyes, abnormal posture, a high-pitched cry. [The Mother] became really distressed when I called an ambulance and said that she hadn't eaten for two days. LH was really calm and said he'd had gripe water and was fine. LH didn't think he needed an ambulance. She undermined things."

175. When the Mother was questioned about the incident on 9th February 2016 she said that she didn't agree that D's presentation was due to gripe water. She admitted that he had been crying for two days and said that she was "already going to the GP that day" and that the health visitor was an expert and recognised something she had not. When questioned by Miss Spenceley on behalf of the children the Mother admitted that D had been crying and in pain for two days before the health visitor rang an ambulance.

176. The evidence from the Community Nursing team was not challenged. Within their report there is an entry for 28th April 2016. It states that the Mother telephoned Carol Liddle, Children's Community Nurse that day and reported that D had had a period of being unsettled and rolling his eyes and asked what to do. The Mother was advised to take D to Accident and Emergency and if she was concerned to ring an ambulance to get him there quickly. There is a further entry that on 26th May 2016 a home visit was completed by Tammy Hennon Children's Community Nurse who noted on arrival that D was very upset, coughing and very snuffly. The Mother had advised that he had had a cough for a couple of days and was teething. The Mother was advised to make a GP appointment, which she did prior to the Nurse leaving. It transpired that D had a chest infection and required

antibiotics. The evidence of Kate Matheson supported this entry, within her report there is an entry of the same date. It records that Tammy Hennon telephoned Kate Matheson that day to report that D had been unwell and inconsolable during that visit, that it took her 20 minutes to settle him so that he could be weighed and that she had had to inform the Mother that he was unwell and to make a GP appointment. A chest infection had subsequently been diagnosed by the GP.

177. Sarah Davies' statement contains information from D's physiotherapy team – "on 25th July 2016 Faye Hamilton, senior physiotherapist, expressed her concerns about M's ability to meet D's health needs. She is concerned that he is always contained in a cot or buggy and that M is not engaging with the service to learn how to stimulate him".

178. The statement of Kate Matheson sets out that "[D's] health needs have necessitated input from the Community Children's Nursing Team regarding care of D's nasogastric tube. On 08/04/16 Ms Alison Ryder, Team Lead Children's Community Nursing Team, called an ambulance because [D] was difficult to rouse and had low oxygen levels, [the Mother] had not recognised that he was unwell." In the Mother's statement dated 7th October 2016 she accepts that an ambulance was called for D on 8th April 2016. She states that she did not know he was unwell as he was asleep. In the same statement she accepts having left D in hospital with K, "for about two minutes while I went to get some milk. Looking back I accept that this was not the right thing to do."

179. The professional evidence portrays a theme of the Mother failing to appreciate and/ or act upon signs that D was unwell and needed medical care. I prefer the accounts of the professionals to the evidence of the Mother about this and am satisfied that it is likely that their evidence is correct. I am satisfied that the Mother was under increasingly high levels of stress and as a consequence of this, coupled with her lack of support and her mental health difficulties she neglected D's emotional needs by failing to demonstrate appropriate concern, responsiveness,

emotional warmth and attachment towards D at times when he has exhibited signs of being unwell, unsettled, uncomfortable or distressed.

180. In respect of the incident on 9th February 2016 I am satisfied that the presence of LH in the family home and her attitude towards D requiring medical care inhibited the Mother from obtaining the medical care that he desperately needed. I am satisfied that it was obvious that he needed urgent medical attention by the time that Kate Matheson telephoned an ambulance, not just obvious to her as an 'expert' but obvious to the Mother as well. I am satisfied that D had required medical care for two days by the time that an ambulance was called and that the Mother was aware of this and had failed to access medical care for him.

181. I am satisfied that when D was plainly unwell and in hospital the Mother left him on the ward with the child K, on the basis of the Mother's admissions. I am satisfied on the basis of the professional evidence that she also sought to leave him with RG whilst in hospital and that neither of these family members had been trained to administer his feeds. I am satisfied on the basis of the professional evidence that she generally left him in his cot or buggy for protracted periods of time. The Mother was unaware of how to stimulate D as she had failed to attend the vast majority of his physiotherapy sessions.

182. The Mother has, through her own vulnerability, dependence and family dynamics, despite clear and repeated professional advice allowed the children to come into contact and/ or live with and /or be cared for by the maternal grandmother LH and other individuals who pose a risk of harm to the children (for example AM who abused the Mother when she was a child and MA) despite those individuals having been implicated in violence, sexual misconduct including the abuse of children and LH having a Caution for an offence of child cruelty. The Mother has denied or lied about the risks posed by these individuals.

183. Within the Mother's written response she states, "This is not accepted by the Mother. For example she adhered to a written agreement to keep LH away and sought an injunction against AM."

184. LH has a caution for Child Cruelty. She has been accused of sexually abusing her son, MA. She was excluded from the RVI hospital as a consequence of alleged inappropriate touching of male staff. I am satisfied that that Mother was made aware of all of these matters by 5th May 2016 at the latest, when she signed a written agreement agreeing not to permit LH to have unsupervised contact with the children.

185. AM has been accused historically of sexually abusing children in the family, including the Mother and her sister GA, when they were children. On 1st May 2016 he was charged with attempting to penetrate the Mother's 9-year-old niece, (GA's daughter).

186. Although the Mother did take out an injunction against AM in September 2011, she admitted in oral evidence that she had told the Police she would "get it dropped" in 2012. She told me that she was prepared to do this because of his health problems – "he's not a well man". She cited that he had stomach ulcers as a consequence of his alcoholism. When listening to the Mother's evidence about this issue I gained the impression that she felt some sympathy for him and that this had softened her attitude towards him. The Mother appeared unable to appreciate that whether he had health problems or not, he remained a serious risk of sexual harm to children.

187. In November 2016 the Mother allowed K to walk home from school alone despite knowing that AM had been released from prison and was homeless. The Mother accepted in her evidence that she is aware that in recent times he has been living in RG' shed, proximate to the family home where K lives. In evidence she appeared unconcerned about this and appeared not to appreciate the risks posed to

K as a consequence of him being in such close proximity. During the Mother's evidence it was clear that K regularly plays outside in the vicinity of both her home and the home of RG'. In April 2017 K met a male foster child and accused him of sexual assault and giving her cigarettes, these allegations stemmed from K being permitted to play outside unsupervised. The Mother has therefore been unable or unwilling to heed warnings about AM being in the vicinity. This information has not caused her to put in place protective measures to ensure that K is supervised in the area in which he is present, giving rise to a risk that he may approach her.

188. The Mother admitted during her oral evidence that she had lied to children's services about her mother being present in her home and that the evidence of Sarah Davies was correct in that on 1st August 2016 LH had been at her home in breach of the written agreement entered into in May 2016. She admitted that her mother had in fact had a key to her property and although she denied that LH was living at her address, she did admit that LH would stay overnight, albeit that she asserted that this was at times when she was in hospital with D.

189. LH had informed the local authority on 1st August 2016 that she had been living with the Mother since February 2016 and was sharing a bedroom with K and C. A range of professionals who were conducting home visits during this timeframe corroborated this information. They were reporting that LH was present in the home during visits to the property; at times she was wearing her pyjamas. The Mother denied that LH had been living in the family home in her oral evidence. I found the Mother's evidence about this to be unconvincing. I gained the impression from the Mother's evidence that she was simply unable to stand up to her mother at all and that LH used her key to come and go as she pleased. I note that her written response denied any breaches of this written agreement at all. When I asked the Mother about what it was she admitted being 'dishonest' about during earlier answers she told me "I was dishonest about Linda being in my property – she had a spare key. She had stayed there a few times but never lived there." On 17th August 2016 during the Initial Child Protection Conference, the Mother had

"admitted that her mother had refused to leave her address and that she continued to reside with her and the children. She also commented that she did not consider her mother to pose a risk to her or the children as her mother "had done nothing to her or the children." I am satisfied that the Mother repeatedly breached the written agreement as far as LH was concerned, thereby failing to protect the children from her.

190. The Mother now says that she is estranged from LH since an incident at Easter time this year when LH attended RG' address and 'head butted' K. This alleged assault occurred in the Mother's presence and led to Police involvement. Both the Mother and K had told Helen McArthur that this alleged assault was prompted by K threatening to show the Police and social services photographs of bruising to her back. The Mother told me that LH also caused this bruising, during an earlier assault. Each alleged assault occurred whilst K was in the Mother's care, during the currency of these proceedings. I am satisfied that each of these incidents demonstrates that the Mother is incapable of protecting the children from the risk of harm posed by LH.

191. During the Mother's evidence, for the first time, she admitted that the first of these two episodes of alleged physical harm perpetrated by LH towards K was prompted by K threatening to tell the Police and local authority about recordings that she had made of LH verbally abusing her. The Mother said that K had about five of these recordings on her mobile telephone and that the time period over which they had been recorded was around a year and a half. The Mother said that K had made them in order to evidence that she was telling the truth. Some of these episodes of alleged emotional abuse occurred in the Mother's presence. Neither K nor the Mother had ever reported them to the local authority, no reference is made to them in any of the Mother's written evidence for the Court. These incidents predated the start of these proceedings. During the course of this hearing, for the first time, one of these recordings was played from the mother's mobile telephone initially for the Guardian and social worker and later for the Court. The recording

is not sufficiently clear to hear precise details of the incident but what is abundantly clear from listening to the recording is that K is extremely distressed and being shouted at, with expletives being used. I am satisfied that the Mother has failed to protect K from LH and that these incidents alone amply demonstrated to the Mother the risk that LH posed to her children. The Mother is incapable of protecting the children from that risk and has permitted a situation where K has alleged that she has suffered abuse whilst in the Mother's care.

192. During the Guardian's oral evidence she described a care team meeting in April 2017 when professionals attempted to explain to the Mother that the way she was then feeling (following an attempted suicide) was linked to her childhood and that her mother was a risk of harm to her children. Even then the Mother would not accept that LH posed a risk.

193. Despite the Mother being told about and witnessing for herself the risk of harm that adults in her family pose to her children, in June 2017 she chose to take K to the crematorium for RG' funeral. She also took K to the wake that took place in a public house afterwards.

194. I heard evidence from the children's current social worker, Helen McArthur about this. I found Helen McArthur to be a careful, fair and honest witness. She told me, and I accept, that the Mother asked to take C and D to the crematorium and wake as well but that she advised the Mother not to. I accept Helen McArthur's evidence that the Mother was advised not to take K. The Mother admitted in her oral evidence that Helen McArthur offered to collect K after the crematorium to avoid her being at the wake. The Mother declined. LH and AM were both present at the wake. The Mother told me that LH was told to leave after "letting her mouth go". I am satisfied that the Mother's choice to take K to the wake in a public house in the knowledge that these family members would be present amply demonstrates her continued inability to protect K. LH is alleged to have verbally and physically assaulted K in recent months whilst the Mother was present and it seems was

powerless to stop her. By taking K to the wake she presented LH with a further opportunity to perpetrate harm, placing K at risk of significant emotional and physical harm. AM was also at the Wake. By Taking K to it the Mother demonstrated her inability to appreciate the risk that these individuals pose to K and her inability to protect her from that risk. At one stage the Mother accepted that she had gone outside to have a cigarette, leaving K inside the pub "with her granddad". The Mother did not personally supervise K at all times, despite the presence of these two high-risk individuals. D and C were only prevented from attending these events because they are in the care of the local authority. I am satisfied that had they not been, they too would have been placed at risk of significant harm by being taken to the crematorium and wake as well.

195. I accept that the death and funeral of a close family member is an exceptional event, however, the Mother's decision making is deeply troubling. It represents a pattern in which the Mother first minimises or lies about the risk that individuals in her family pose and then seeks to excuse the contact that the children have with them.

196. I make this finding as drafted.

197. The Mother has caused or permitted the child, K, to assume a false parenting role for her younger siblings and inappropriately exposed her to adult issues such as the clinical views about D's injury and the mother's health.

198. The Mother denies this.

199. Sarah Davies gave the following oral evidence "Its clear to professionals that K parents the Mother more than the Mother parents K. K checks on the Mother's welfare, offers the Mother physical affection and comfort, K is the one who informs professionals about D's health." She said that during K's admission to foster care in August 2016, her foster carer revealed that K was refusing to allow

her to undertake basic care tasks for C. Sarah Davies said that she visited the children in placement on 2nd September 2016 and witnessed "K trying to prise C from the foster carer's arms. K would not let the foster carer care for C in any way. She said that K had described to the foster carer how she would bath C, get him ready for bed, get herself ready for bed, put him into bed and then get into bed with him. In Sarah Davies' opinion K was acting as a young carer. K had said that she was worried about her Mother and was aware that the Mother was not eating. She told C that the Mother had said he had a "split personality". Sarah Davies was of the opinion that the Mother shared inappropriate information with K.

200. I was struck by the Mother's oral evidence in respect of her admission that she had told K that K's father had not wanted her and had offered to pay for an abortion. The Mother could see nothing wrong with telling K this information. Quite apart from the damage it could inflict to any potential relationship that K may develop with her father, when asked about why she found it necessary to tell K this, the Mother said "K deserves to know the truth. I was told the truth about my childhood when I was 11, why shouldn't she be told the truth too?".

201. The Mother admitted in her oral evidence that K had overheard her talking to RG about B, K's half brother, and in that way had discovered his existence. The existence of B had been deliberately kept from K up until that point as professionals wanted to manage how she was to learn about him and involve K's father in the process. The Mother was aware of this. This information was shared with K during the final hearing, after its commencement and before RG died.

202. During the Mother's oral evidence she said "I agree K knows things she shouldn't. If I've got documents lying around or spoken about things she's overheard. Sometimes I do tell her things. I've told her quite a lot about her father, the time with the Christmas tree, the fact I've disappeared, she knows I was found on the flyover – she was in the house when I was brought home…I've got an eating disorder, she worries I don't eat properly. I rang her a few times when she was in

foster care. I said I missed her and was not eating well. K bathed C. When I've had my hands full with D she's offered to bath C and get him ready for bed. I didn't force her to do it. I had my nana around. C wouldn't go to bed without K." The Mother admitted that K went looking for her when she went missing in December 2016 and in March 2017 and that K worries about her. "The time with the Christmas tree" the Mother admits, is a reference to an occasion in which she damaged the family Christmas tree, causing injury to her hand in the process. This episode occurred when K was at school but the Mother accepts that when K returned home she told her about the incident and showed her the injury.

203. The Mother accepted that K had told the social worker that if the Mother had caused D's injury it was an accident. I agree with Mr O'Sullivan's submission that it is critically revealing in many respects that it was K who contacted the community nursing team on her mobile telephone to report the dislodging of D's feeding tube and that there is a real possibility that she may have had at least some exposure to the general circumstances of her baby's brother's fracture.

204. I agree with the Guardian that the Mother has not always been able to put K's needs before her own. The Guardian observes in her final report that the Mother "is noted by all professionals to treat K like a friend rather than a daughter and despite advice continues to tell K everything that is happening in her life." I am satisfied that the Mother treats K as an adult and inappropriately exposes her to adult issues. Having listened to the Mother's evidence I am satisfied that the Mother is unable to appreciate that treating K in this way is emotionally harmful to her. I am satisfied on the basis of the Mother's admissions and Sarah Davies' evidence that K acted as a young carer for her siblings.

205. I find that the Mother has caused or permitted the child, K, to assume a false parenting role for her younger siblings and inappropriately exposed her to adult issues such as the clinical views about D's injury and the mother's health.

206. The Mother compromised the emotional and developmental welfare of the children by failing to promote regular contact with their fathers. Each child's father in turn failed to take reasonable steps to ensure that such contact took place.

207. The Mother denies this; she asserts, "JW showed no commitment to contact. MS did not request contact and TT exercised contact on occasions."

208. Having heard the evidence of each of the parents a theme emerges in which each Father did not have regular and consistent contact with his child following separation from the Mother. The accounts of MS and TT bore some striking similarities in respect of the way that contact was covertly arranged for them as a consequence of the intervention of the Mother's sister, GA and her grandmother, RG. Whilst at times the Mother was able to acknowledge some positives about JW he too encountered difficulties in securing contact, such that he resorted to taking legal advice with a view to securing a private law order to assist. Each Father told me of the difficulties encountered with the Mother post separation. None of these fathers knew each other prior to these proceedings. I am satisfied that they are not collectively concocting similar cases. The evidence each gave was independent of the others. I am satisfied that the Mother compromised the emotional and developmental welfare of the children by failing to promote regular contact with their fathers.

209. Having listened to each of K's parents' give evidence I prefer the evidence of TT to the Mother in respect of K's conception and the events that followed. I am satisfied that he did not know about K's birth until told by GA in 2013. I am satisfied that GA and RG assisted him to see K and that, but for their intervention, without the Mother's knowledge, he would not have known about her or met her. I am satisfied that he took up all offers of contact from GA and RG and that he dropped off birthday and Christmas presents for K. I am satisfied that when the Mother discovered that they had done this she was unhappy about it. K is extremely

loyal to the Mother. The Mother had told K very negative things about her father. I am satisfied that K only agreed to see her father as a consequence of the support of her aunt and great grandmother. I consider that TT found himself in an extremely difficult position in which he had no choice but accept contact with K only when it was offered in this way. GA was offering contact without the Mother's knowledge. K spends the majority of her free time with the Mother. This contact must have been very difficult to arrange and promote. The incentive for K at birthdays and Christmas was presents. I am satisfied that the Mother was not happy about K seeing her father and accept TT's account that his contact around Christmas 2016 ended abruptly as a result of the Mother shouting and swearing at him and taking down his vehicle registration number plate. TT may not have been the most proactive of fathers but in these circumstances I am not prepared to make a finding that he failed to take reasonable steps to ensure that contact took place. He was attempting to establish contact with a child he did not know about until she was around 8 years old, in the face of hostility from the Mother. Those who were offering him contact had no legal right to do so and were doing it altruistically. He could hardly insist that they arrange more contact for him. Had he attempted to press for more contact, either from the Mother directly, or via a solicitor, this could well have backfired for him. He ran the risk of K refusing to see him at all.

210. Having heard the evidence of MS I was troubled to hear that he left the Mother to live in Birmingham when she was 6 months pregnant and offered very limited financial support to her thereafter. At the time he left they had not separated and their relationship continued albeit at a distance. He told me that she would telephone and ask him to return to see her. He did not accede to her requests, only returning on the day of C's birth when he told me he took a train back to Birmingham the same day. I accept his evidence that initially he returned to see C every two to three months and that the Mother was happy to promote contact whilst they remained in a relationship. I find that the Mother promoted this contact until it was clear to her that there was no chance that the relationship would continue, whereupon I accept his evidence that she threatened to phone the Police if he turned

up to see C or if he called him by the name he wanted to call him, ('S'). On one occasion when he arrived to see C the Mother did call the Police and he was warned and advised by the Police to see a solicitor if he wanted contact. The Mother's attitude to MS had clearly evolved into a negative one and he too had to rely upon the good offices of GA and RG to covertly promote contact to him. He retained a familial link since GA remains married to his cousin. He has always been aware of C and had the opportunity to push for more contact either through the family or through a legal route. He had the benefit of a solicitor for immigration purposes and could have asked for a recommendation for a family solicitor to seek advice and pursue an application for contact. However I accept his evidence that he hoped that the Mother would change her mind and that when asked neither GA nor RG could give him a reason why the Mother opposed him having contact. Prior to these proceedings he last had contact with C in 2013 when the mother was admitted to hospital to give birth to D. He accepted in oral evidence that he failed to give C any gifts, save for some money on his second birthday. I accept that he had limited funds but presents for a child do not need to be expensive. The giving of a card and an inexpensive gift each year as a minimum would have been significant to C and could have been facilitated by GA. I am satisfied that after that last contact session took place in 2013 he failed to take reasonable steps to secure contact.

211. I am not satisfied that JW failed to take reasonable steps to secure contact with D. JW suffers from a learning disability. He is a vulnerable adult. His relationship with the maternal family was strained. Unlike K and C's fathers he did not have the advantage of GA and RG assisting him to see his son, probably as a result of the historical discord between the two families. His relationship with LH was particularly difficult and was one of the key reasons why his relationship with the Mother broke down. He separated from the Mother in February 2016. Having heard his evidence I am satisfied that he is likely to have found the maternal family intimidating in the weeks and months that followed the separation. He continued to live in the same community as them. I accept his evidence that he was waiting for the Mother to offer him contact and expected that she would calm down and

become more amenable in time. He is not a confrontational character. I do not consider that his approach was unreasonable in light of his limitations and the wider circumstances. He went to a solicitor with a view to securing contact in July 2016. I consider that in light of his vulnerabilities he took reasonable steps to secure contact.

212. The Mother and/or JW have physically and severely chastised the children.

213. The Mother denies this.

214. JW gave evidence that the Mother slapped D and K around their head and legs to chastise them and that the children were afraid of her. MS also independently provided evidence that he had seen the Mother hit K. Both described her doing this with an open hand. I accept their evidence about this. I found their descriptions of these incidents to be detailed and compelling. I acknowledge that MS was not thought to be open and honest with the social worker during his parenting assessment and that JW assisted JA to deceive professionals about the continuation of her relationship with Mr Foster. I have given myself an R v Lucas direction in respect of their evidence. Neither of them was unduly critical of the Mother in their evidence. JW described her as “a good mother”. Whilst they may not have been open and honest about issues which they considered may have damaged their prospects of successfully having their respective children in their care, or in the care of their family, I do not consider that they were untruthful witnesses in respect of issues of fact relating to the Mother. The Mother accepts that she has a short temper. I have already found that she was increasingly rough in her handling of D, and that she inflicted his fractured femur. I am satisfied that at times she has physically and severely chastised K and C.

215. In the position statement filed on behalf of JW dated 29th September 2016 he states, “I do not accept that I have over chastised the children. I was not

responsible for chastising M's older two children and she dealt with any issues relating to them. I do accept however that on 4th September I did roughly handle C. This was at the Queen Elizabeth Hospital in Gateshead. He had been naughty and I do accept that I grabbed him by the arms and asked him to calm down. I also accept that this behaviour was unacceptable."

216. In oral evidence JW said that he did not understand what the words "over chastise" means but did accept that an incident occurred when the Mother was with K at the Queen Elizabeth Hospital and he was waiting for them with C. He was not able to describe to me what he did or demonstrate it but he accepted that what he did was wrong. He told me that this was the only time he had had the care of C on his own. I am satisfied having listened to this evidence that this amounted to rough handling and that this is what C has been referring to when he has made disclosures about JW "pulling him all over" to his foster carer. I am satisfied that this was an isolated incident. I accept JW'sevidence in respect of this issue. My assessment of him is that he is a gentle and vulnerable man. The Mother makes no complaint that he was ever violent to her or towards any of the children or that he physically or verbally abused her or them in any way. I am satisfied that he left the chastisement of the older two children to the Mother. I am not satisfied that he physically or severely chastised any of the children.

217. The Mother has prevented the children from speaking to professionals by chastising them.

218. The Mother denies this.

219. Helen McArthur gave evidence that C appeared to be scared of the Mother when he lived at home. JW shared this opinion.

220. Kate Matheson, health visitor gave evidence that on 25th July 2016, she visited the family home. The Mother and all three children were present. She asked

them if they had had a nice holiday. C did not speak but instead "repeatedly motioned with his lips tightly closed moving his thumb and index finger across his mouth demonstrating keeping his mouth closed." He continued to do this and did the same to D and K's mouths. When the Mother returned to the room she told K and C to go upstairs, shouting at C to "get lost" and telling K to take him upstairs as "he had far too much to say and had heard far too many adult conversations." Ms Matheson's account did not alter under cross-examination. She described C "doing a zipped lips motion" repeatedly. She said, "C was wanting to speak and was not able to in my opinion." She did not alter her account that this was a significant incident and was not merely an example of a child misbehaving and being punished. She said that "[The Mother] was quite agitated during this incident" and that the visit had had to be rescheduled from the morning to the afternoon as the Mother had cancelled the morning appointment saying that she had housework to do. She told me that Sarah Davies had visited that morning and the Mother had been quite upset. I accept her account and find that the Mother had chastised C on this occasion by sending him to bed in order to prevent him telling the health visitor whatever it was he had "overheard". I make this finding in respect of C only, limited to this occasion.

221. The children were exposed to the volatile and conflictual relationship between the Mother and JW both prior to separation and since.

The Mother denies this finding.

In his statement dated 3rd May 2017 JW states "I would accept that towards the end of our relationship, there were a lot of arguments between us and these did take place in the home where the children were. There was no physical violence. I accept that the allegation is therefore made out."

Having heard the evidence of JW I find him to be a credible witness in respect of issues relating to the relationship he had with the Mother. I accept that his admission is accurate and I am satisfied that this finding is made out.

222. The Mother continued to behave in a volatile, argumentative and aggressive fashion after her separation from JW.

223. The Mother denies this.

224. Although reference was repeatedly made to "discord" between the Mother and JW after their separation, JW did not give direct evidence about this, either in written form or in oral evidence. I do not have sufficient evidence about this to make a finding about it.

225. K suffered four separate arm injuries over the space of a month while she was in the overall care of the Mother.

226. The Mother accepts that K suffered these injuries but asserts that they were caused accidentally. The Mother was not questioned about these injuries in her oral evidence. I do not have sufficient evidence about these injuries to be satisfied that they are relevant to the threshold criteria. K was a mobile child at the time she suffered these injuries. I know little about the circumstances which led to them and I am not satisfied that they constitute evidence that she has suffered significant harm attributable to the acts or omissions of the Mother.

"The Mother was neglected as a child and this has emotionally disadvantaged her into the neglectful parenting of her own children."

227. In the Mother's response document she "accepts that she has had a poor childhood, but denies that it has affected her parenting ability."

228. I am satisfied that the Mother's childhood of significant abuse and trauma is linked to her current mental health difficulties and that those difficulties have had a negative impact upon her ability to be emotionally available to the children. Examples include the occasions in which she told me she had lost her temper and smashed the kitchen and dismantled the Christmas tree – without any thought on the impact on the children of seeing the aftermath of these incidents. The episode near Christmas 2016 when she accepts she went out walking in her dressing gown and ended up on the flyover of the A1 following an argument with K about tights, which resulted in her contemplating suicide, is another such example. At these times and others I am satisfied that she is simply unable to consider the emotional needs of the children. Those emotional needs are therefore neglected as the Mother's focus is upon her own mood.

229. I am satisfied that the Mother's own childhood left her ill equipped to meet the emotional and psychological needs of the children and that as a consequence the Mother has suffered from low mood and significant mood swings which have negatively impacted upon the children and rendered her unable to meet their emotional needs. Their emotional needs have therefore been neglected.

230. The Mother is not able to make the link between the harmful experiences that she has suffered as a child and the way that she has parented her own children but I am satisfied that there is a clear connection between her own tragic childhood and the neglectful and harmful parenting that she has given to them. I make the finding sought.

231. In making the findings that I have, I am satisfied that the threshold criteria for the making of public law orders is crossed.

Welfare analysis

K

232. K attends FD primary school where she is receives extra emotional support in the form of weekly counselling sessions, together with support through the primary behaviour support team, to address her behaviour, which has included angry outbursts and a failure to follow adults' instructions. She is said to be very protective towards her mother and brothers and at times has not wanted to leave them to go to school. K is due to attend CH School in September 2017. K has been described as acting as a young carer for younger brothers D and C. She is said to be fiercely loyal and protective towards her family, particularly her mother, and did not cope at all well when temporarily removed to foster care in August 2016. She wishes to remain in the care of the Mother.

233. There are two realistic placement options for K: (1) with the Mother (2) in local authority foster care.

C

234. C attends FD Primary School. He has received "Early Talk Boost" intervention to assist him to develop his speaking and listening skills. C's wishes have been reported as being to remain with his current carer and have contact with his mother and his siblings, although at times he has said he would like to live with the Mother. C is said to be extremely happy in his placement and have good relationships with the staff and other children in school.

235. There are two realistic placement options for C: (1) with the Mother (2) in local authority foster care.

D

236. D remains a very unwell child. He is currently in hospital. His seizures are

managed by medication. He is continuously fed by tube. He has impaired vision, no head control, limited movement and presents as being "floppy". He is a very challenging child to care for. He requires an extremely high level of continuous care and supervision. His health can deteriorate with alarming rapidity. He is frequently hospitalised. He is susceptible to infection. He has had periods of time when he continuously screams and doesn't sleep. He can stop breathing in the night. His previous foster carers said that he needed to be held for long periods of time when he is uncomfortable. They struggled so much with his care that ultimately they reached the view that they were unable to continue to care for him. That was despite the fact that he was placed alone, that there were two carers and that one of the carers gave up work so that each of them cared for him on a full time basis. D requires intensive professional involvement from a whole team of clinical staff. His condition is likely to be life limiting and he is on an end of life plan.

237. There are two realistic placement options for D: (1) with the Mother (2) in local authority foster care.

The Mother

Advantages

238. There are obvious advantages to placing all three children together in the Mother's care: they would be placed in one sibling group; they would be raised by their natural parent in their natural family, thereby retaining their family identity. As the Guardian puts it in her report dated 12th May 2017, "The benefits of a placement with M would preserve family relationships and enable the children to grow up feeling that they belong in their birth family." A placement with the Mother is the only placement option which provides for the children to be raised with their siblings, since the care plans provide for the separation of all three into solo placements. I remind myself that sibling relationships are life long and are often the longest relationships that any person can have. The Mother has been each

child's primary carer from birth until August 2016.

239. This placement option accords with K's wishes and feelings – she wants to stay at home with the Mother and wants her brothers to live at home as well. In her letter to me dated 2nd May 2017 she writes, "Dear Judge, My Name is K and I would like to talk about my brothers being in foster care. I know that they are in foster care but I really want them home."

240. The Mother has at times divided professionals. Many positive interactions between the Mother and the children have been noted. Kate Matheson described her interactions with D during early health visitor appointments and his 3-4 month check as "good" or "excellent". Staff nurses at the RVI formed a very positive impression of the Mother, as did members of the Family Intervention Team who had a high level of involvement with her. Previous social work assessments have noted that the Mother "promotes her children's school attendance and works as a volunteer at the schools breakfast club. She encourages her children to go on school trips, engage in family holidays and community sporting activities. There are plenty of age appropriate toys in the family home." These previous local authority assessments have reached positive conclusions and have described the Mother as "a caring and emotionally warm parent". The Child in Need assessment dated 10th May 2016 notes the following positives: that K and C enjoy social and peer relationships within family home and local clubs and present as bright sociable and polite young children, the same assessment identified no concerns regarding the basic care of the children. The children have been described as well presented when attending school, and "always clean and well kept".

241. Staff nurses from the RVI were very positive about the Mother's interactions with the children in their report for the Initial Child Protection Conference dated 16th August 2016, and include descriptions of the Mother providing cuddles to all of the children and comforting them. Her interactions led to observations that she "often plays in an age appropriate way and gives cuddles".

242. The Mother loves all three children and they love her. The Mother is clearly committed to the children. Her commitment to attending contact sessions for C and D is not in dispute. Her contact sessions with D have many positives. The Mother has co operated with local authority assessments and with the Guardian's enquiries. She has demonstrated her commitment to the children through her attendance at court hearings and local authority care team meetings. The Mother has attended parenting capacity courses as recently as January 2017.

243. The Mother has a positive relationship with K's school and has positively engaged with teaching staff.

244. The Mother's home is adequate for the children and is able to manage her finances adequately. Sarah Davies accepted when cross-examined on behalf of the Mother that she is the type of parent who would go without herself to ensure that her children had what they needed materially.

Disadvantages:

245. In making the findings that I have I am satisfied that not only have the children suffered significant harm but that they continue to be a risk of significant harm in the care of the Mother.

246. There have been safeguarding referrals about the Mother's care of the children since 2007 when K aged just 2 years old. The Mother is unable or unwilling to accept that there are any concerns about her care of the children. She has refused to accept that the threshold criteria is crossed and refutes each finding pleaded against her despite a plethora of professional evidence to the contrary. Without any admission of past failing on her part I can have no confidence that she is able and willing to effect change for the children.

247. In the Guardian's report dated 12.5.17 she points to the Mother's mental health difficulties as being a source of concern "There are a number of examples provided by Ms McArthur in respect of M's fluctuating mood. I note that on 13 December 2016 Ms McArthur contacted M's GP with her concerns in relation to the recent events when she went missing from her flat. The GP raised concerns that M may be presenting some traits of Bi Polar. M's emotional presentation again deteriorated around March 2017 with thoughts of suicide and extreme mood swings witnessed by professionals. M in her self-report accepts this. I also note that M's behaviour in contact is described as "hostile and aggressive" with D being exposed to this. The most recent information provided is that at a meeting on 27th April 2017 Ms McArthur contacted the Crisis Team for support when M was very upset but M went missing, didn't answer her phone or attend the appointment with the Crisis Team; she also failed to return home until midnight." Clearly at such times, the Mother is simply unable to meet the needs of the children. I remind myself that these events have occurred notwithstanding the fact that K was in her care.

248. During the Mother's evidence she displayed a worrying lack of appreciation as to the importance of promoting a relationship between each child and its father. She repeatedly said that this was "up to" the child. Her focus was to attempt to apportion blame to each Father and trawl through historical arguments about past conduct. Her ability to focus on the present and future was limited. I agree with Mr O'Sullivan that there is little basis for confidence that the Mother will permit the children to have consistent and meaningful contact with their respective fathers or otherwise promote paternal identity in a positive way. I am satisfied that should any of the children remain in the care of the Mother, she will fail to adequately and properly promote a relationship with their father and paternal family.

249. I do not accept the Mother's evidence that she does not know how K's birth certificate came to be registered in the name of the wrong father. Only the Mother could have caused this to come about. The Mother's actions in registering the wrong man as K's father are indicative of her lack of regard for K's natural father

and of K's right to know about him. If this were an innocent mistake the Mother would have admitted that by now. The fact that the Mother maintains her opposition to the birth certificate being rectified by opposing an appropriate declaration being made only serves to underline her failure to understand and be able to support K's emotional needs.

250. The position adopted by the Mother in this case has been to steadfastly oppose a placement of any of her children in its paternal family. On 30th March 2017 at a hearing before HHJ S Wood the Mother had made clear that she would prefer permanence for D, even by way of adoption, above any placement within his paternal family. Mr Ainsley on behalf of JW, putting forward the interests of JA, had sought to advance a case that relations between the Mother, JW and JA had improved. Whilst that may well have been the case as far as civilities around the Court building are concerned, the Mother made plain her opposition to JA's quest to care for D, not in her words in evidence, but in her deeds thereafter by trawling social media for entries to destroy JA's case.

251. The local authority seeks the following welfare finding in respect of D:

252. D's complex health and care needs require a level of parenting that is good enough to fulfil his assessed needs. His parents and wider family are unable to meet those needs, whether caring for him as part of a sibling group or alone and despite significant professional support.

253. D's Father accepts this finding in so far as it relates to him.

254. The Mother "accepts that D has complex care needs, but feels able to meet his needs with support from professionals and her family."

255. Dr Morrell's substantive report is dated 12th January 2017. It is his opinion that D's condition is unlikely to be as a consequence of trauma and that it is most

likely that he developed one of the epileptic encephalopathies of infancy, although the precise nature of this remains unclear. In his opinion it is likely that D's condition is genetic in origin but a precise diagnosis is unclear at this stage. It is likely that D will continue to exhibit significant developmental delay and that he will require regular monitoring by a Paediatrician with expertise in neuro-disability and a Paediatric Neurologist with regards to his epilepsy. Dr Morrell's second addendum report is dated 26th April 2017 within it he confirms that D continues to present with severe global developmental delay and epilepsy, the cause of his condition remains unclear. A muscle biopsy displayed no evidence of any metabolic disorder.

256. Dr Wolny, Consultant Paediatrician and D's lead treating clinician describes D's medical condition in her letter dated 9th March 2017, in the following way: D has global developmental delay. He is unable to communicate verbally or via gestures; he has eye contact, he is fully dependent on carers for feeding and personal care. He has severe epilepsy and spasms; he has been admitted to hospital to treat his irritability. It is impossible to settle him at times, even with painkillers. This distress has led him to suffer severe sleep difficulties. Dr Wolny's opinion is that it is likely that D's condition will either deteriorate or not significantly improve. He is a child with "extremely high care needs who will need a very experienced carer at all times".

257. In her oral evidence Dr Wolny explained the extent of D's disabilities. She confirmed that the extent of his care needs are "extremely high" and said that they will remain very high for the foreseeable future. Whilst she could not give a precise life expectancy she said that his condition was more likely to be life limiting with the burden of care that he requires being set to increase. In her opinion any single carer would need another carer to help them, they would require respite care and support in the community. In her opinion, a single carer would find it difficult to care for him given his very high level of need. Any carer would need a good support network.

258. I accept the evidence of Dr Morrell and Dr Wolny with regards to D's diagnosis, prognosis and symptomology. The evidence of the local authority and Guardian that D's level of care need is simply too high for the Mother to meet. She is a single carer and has a very limited support network, especially so since the sad death of RG. I agree. I am satisfied that as a consequence of the extraordinary demands placed upon the Mother as a result of caring for D, coupled with the lack of support she had and her underlying mental health difficulties, she inflicted a serious injury to him. I am satisfied that she is unable to cope with his care needs and that to allow her to attempt to do so again would place him at risk of further physical harm and neglect. I accept the Guardian's opinion that "foster care remains the only option which can meet D's care requirements". I make the finding sought.

259. I am satisfied that the Mother is unable to meet D's exceptionally high level of care needs, even if he were to be placed with her without any other children. I am satisfied that the understandable stress and strain of caring for D is one of the triggers that resulted in her injuring his leg. The mother is not emotionally equipped to care for D. He needs a vigilant carer who is able to always put his needs first. His need for immediate medical care at times is such that a failure to obtain it could be life threatening. The Mother has demonstrated an inability to ensure that urgent medical care is obtained for him. The risk of that happening in future is high and could have catastrophic consequences for D. Quite apart from urgent medical attention, D requires regular physiotherapy and speech and language therapy to ensure that he maximises his potential. He needs a carer who will always co-operate and engage with medical and health care professionals and who will prioritise his appointments above other commitments. The Mother missed many of D's appointments, failing to ensure that he accessed vital physiotherapy appointments. She also failed to follow his feeding regime resulting in persistent weight loss. I am not satisfied that the Mother will follow professional advice to ensure that D's care needs are met in future.

260. I am satisfied that D's care needs at the current time would be overwhelming for one carer and that he needs to be the only child in placement to permit his carers to totally devote their efforts to meeting his needs.

261. I am satisfied that K has suffered emotional harm whilst in the Mother's care. I am satisfied that the Mother is not able to protect her from the risk of on going emotional, physical and sexual harm posed by adult members of her family. I am satisfied that should C be returned to the Mother's care, he too would be at risk of the same harm that K has suffered and is at risk of suffering.

262. I am conscious that a decision to remove K from the care of the Mother would be contrary to her express wishes and feelings. I accept that those wishes and feelings are genuinely held. Not only would a removal to foster care be contrary to K's express wishes and feelings, the attempt to place in her foster care last year was disastrous. Her behaviour was extreme and involved screaming and begging to be returned to the Mother for prolonged periods of time. She tried to prise C from the arms of the foster care and expressed a desire to walk home with him. Her level of distress was alarming and manifested in an equally disastrous supervised contact session with the Mother in which she clung to the Mother and became hysterical as the session came to an end. K's behaviour was so extreme that four social workers, a foster carer, a family support worker and two police officers were involved in attempting to calm her down to enable her to return to her foster carer's home. This took place over the course of two hours. She had to be physically restrained to prevent her hurting herself or others. Not even the Police could succeed in getting K into the car to transport her back to placement. Ultimately a decision was reached that K would have to be returned to the Mother's care as a result of her violent behaviour and threats to run away.

263. During her oral evidence Sarah Davies described the Mother's behaviour towards K when she was placed in foster care last year in the following graphic

terms, “When K was placed in foster care with C she had choked him. The foster carer thought that she had done it deliberately to make him cry so that she could call the Mother and say he was crying for her. We took the view that it was not safe to allow them to continue to be placed together. K needed to be placed alone. I told the Mother before her next contact session. She immediately rang K and told her so that K attended the contact session very distressed. I had to explain to K it wasn’t her fault. K continually sought comfort from the Mother in contact – at one stage she picked the Mother’s arm up and put it around her shoulders. She got nothing back from the Mother, not a smile, no physical affection. K clung to the Mother so hard that she ripped the Mother’s clothes. The Mother said, “Get off”. It was horrendous to watch. It took four contact supervisors and the Police to calm K down. Her distress went on for two hours. The Police had to restrain her. The Police were seriously concerned about how a move to another foster care placement would be safely managed. The Mother switched off her phone so we couldn’t contact her and she never asked how K was. It took two hours in total. K was screaming and shouting, “I’m going to kill myself.””

264. I am acutely aware that in sanctioning a removal to foster care for K, there is a very real risk that history will repeat itself and that she will once again demonstrate extreme behaviour. Helen McArthur accepted in evidence that it is “a high risk strategy”. I acknowledge that a removal from her mother’s care will cause K distress, anxiety and short term emotional harm. In deciding whether to remove K from the Mother’s care I must balance that short term emotional harm against the significant emotional harm that she has already suffered in the care of the Mother and is at risk of continuing to suffer, together with the risk of sexual and physical abuse at the hands of the Mother’s extended family.

265. There are a number of factors which in my view exacerbated K’s reaction to foster care last August. Firstly, she was removed by strangers in an unplanned way and without warning. She told her Guardian that she “didn’t expect to be taken into care at 1am”. Secondly she was permitted to have unmonitored, unplanned

and often late night telephone calls with the Mother and other family members. Thirdly the removal closely followed the discovery of D's injury and K appeared to feel responsible for advocating her Mother's innocence. Fourthly K was placed with C and appeared determined to ensure that C expressed the view that he too wanted to go home and was missing the Mother – so much so that her efforts resulted in the placement of both of them together breaking down. Fifthly I am satisfied that the extreme distress that she exhibited was in consequence of the Mother informing her that as a result of her behaviour she had to be separated from C. This resulted in a situation in which K felt that she was being punished. The crescendo of this series of events was a contact session, immediately following news of the planned separation, in which the Mother refused to give K any comfort or reassurance.

Long-term foster care

Advantages

266. In her report dated 12.5.17 the Guardian notes some of the general positives of long term foster care namely "the relationship between the children and their family of origin will be protected, which will assist with the development of identity and sense of self. Most particularly in this matter the children will not have their sibling relationship permanently severed, as contact will be promoted. A significant number of children who become looked after want a family who can look after them until they are ready to move to independence and who will continue to be their family and a resource to them beyond that point and need another choice that is of equal value to those options. Children can feel that they belong, have a sense of family membership and are able to develop relationships that are expected by all concerned will last after they have moved on into independence. It can provide permanence in a stable environment, where children and young people can live safely in the knowledge that this is their home until such time as they are ready to move on. At least until they are 18. (Ref The Fostering Network) If a parent

does not undermine this outcome and is able to place the children's needs before their own the children could grow up in foster care with a secure upbringing."

267. Foster care will allow the children an opportunity to have on going contact with each other, with their parents and with their extended families. It is the best option to ensure that each child is able to build, maintain and enjoy a relationship with its father and paternal family.

268. For K, a long term foster care placement with experienced carers will allow her to enjoy a childhood in which she can have her complex needs met as a child on her own. She will be free from the responsibilities of acting as a carer for her siblings and protected from emotional abuse as a consequence of the Mother's behaviour and protected from physical, emotional and sexual abuse being perpetrated by adult members of the maternal family.

269. C is very happy and settled in his placement, where he can remain long term. I am satisfied that he is thriving in his current placement.

270. D moved placements in the week before this final hearing began, to a foster care placement that could be a long-term placement for him. He has two professional foster carers and is the only child in placement. His carers previously fostered a disabled child with complex needs over a ten-year period. They are only approved to care for one child. The local authority contends that, due to his exceptionally high care requirements, D should be placed alone in a placement with two full time carers. D's parents have each separately met his carers, as has JA. I was told that these meetings went well. It is proposed that D will continue to reside in this specialist long-term foster placement, to allow him to receive a very high level of care and that he will continue to be the only child within the placement. D currently has supervised contact with his father once per week and supervised contact with the Mother three times per week. It is proposed that contact with each parent will reduce to take place on a monthly basis.

Disadvantages

271. The local authority care plans are to separate all three siblings. During these proceedings they have lived separately, as the Guardian observes in her report dated 23.09.16, "K, C and D's relationship with each other has been fragmented through the Local Authority case management of their care. When sibling groups are separated in this way it invariably leads to the severing of sibling ties becoming permanent, without any real consideration of how this will impact upon the children's long term emotional needs." In her report dated 12.05.17 the Guardian goes on to observe, "Studies make findings that the separation of siblings is not a minor issue and can inflict pain, sadness and feelings of injustice which may remain throughout life".

272. As the Guardian recognises in her report dated 12.05.17, foster placements do not always provide security. Children may find themselves moved from one home to another. A long-term foster child does not always have the same and enduring sense of belonging within a family as does a child who has been adopted." Or, I would add, as a child who is safely cared for by its natural family. She goes on to note, "A long term foster child does not always experience the permanency, predictability and enduring quality of placement." The Guardian recognises in that report that "A planned and supported move to long term foster care could be a plan which, if managed correctly and with support from parents, could have positive benefits to the children by ensuring that they are provided with safe and consistent care. However, foster care does not always provide the improvements sought, particularly for older children, if they are not 'matched' adequately by the Local Authority who must resource this issue to a good enough standard if it is deemed appropriate by the Court."

273. Local Authority foster care carries with it associated stigma for children. As subjects of Care Orders they have continued social work involvement

throughout their minorities and have the intrusion of requiring local authority approval before they can stay overnight at friend's homes and go on school outings.

Discussion and conclusion

274. In balancing these competing placement options I have reached a clear decision that none of the children can be safely placed with the Mother and that foster care is the only safe option for them.

275. Notwithstanding that the Mother refuses to accept any of the findings sought against her, or that the threshold criteria is crossed, she argues that the children can be placed with her under a Supervision Order with a written agreement and professional assistance and monitoring. That package of support and safeguards has already been tested during these proceedings in respect of K. It failed. K was returned to the Mother under an Interim Supervision Order, together with a written agreement. Children North East visited the home twice per week and saw K at school. This was in addition to the support given to K and the Mother by the social worker, by the school and by the rest of the care team. I take the view that the support that was offered was the highest level that could have been delivered. Despite this package of support and monitoring, the Mother breached the written agreement and K and the Mother managed to conceal from all professionals the alleged abuse that LH was perpetrating to K. K and the Mother have now disclosed that K suffered significant emotional and physical abuse, which ultimately resulted in her refusing to attend school after the Easter holidays in 2017 and informing professionals that she had attempted to commit suicide on two occasions.

276. The Mother now argues that she is estranged from LH and will now be able to keep the children safe. Sadly I do not have confidence that the Mother will be able to maintain a distance from her mother. The sad passing of RG has rendered the Mother to be effectively isolated. LH has been a source of support to her for many years, notwithstanding her behaviour and notwithstanding professional

advice about the need to distance herself from her. LH's behaviour towards K has been going on for a protracted period of time, during which time the Mother allowed LH to stay at her address. I am satisfied that it is likely that the Mother will continue to gravitate towards LH for support in the future and moreover that even if she is able to maintain a distance for a period of time, she is unable to protect the children from LH or AM as a consequence of her inability or unwillingness to prevent the risk of chance encounters. Taking K to RG' wake was a clear example of the Mother exposing K to the risk significant harm. This was an entirely avoidable occurrence, which took place contrary to professional advice as recently as June 2017. The Mother appeared unable to grasp why this would cause professionals concern. She was unable to consider the effect on her 10-year-old niece of being present in the same room as AM, the man she had recently accused of sexually abusing her. AM sexually abused the Mother and her sister GA as children as well, and yet they also shared a room with him and allowed their daughters to do so. I agree with the Guardian that this is revealing of the family dynamics within the Mother's family. I have no confidence that the Mother will accept professional advice about this issue in future and agree with the Guardian that the Mother lacks insight with regards to how to protect K from LH. I have no confidence that the Mother will be able to take steps to prevent LH or AM from having contact with the children in future. I echo the Guardian's comments that the Mother is unable to adequately assess risk and protect from it. I am satisfied that as a consequence of the Mother's inability to protect the children, they are at risk of significant physical, emotional, psychological and sexual harm in her care.

277. I am satisfied that there is no order, written agreement or package of support that could keep any of the children safe in the Mother's care. The risks are far too great and she is incapable of working openly and honestly with professionals. The fact that K is alleged to have suffered abuse at the hands of LH during the proceedings, at a time when all professionals and the Court were scrutinising K's placement at home to see if it could succeed long term, the alternative being removal to foster care, and that the Mother was aware of that, is clear evidence that

even the deterrent of permanent removal was insufficient to ensure the Mother's compliance with a safety plan.

278. I acknowledge that in approving the local authority's care plans I am sanctioning the making of not only the most draconian orders available to the Court but also the separation of all three siblings. I entirely agree with the Guardian's observations in her report dated 12.5.17 that "the separation of siblings is not a minor issue and can inflict pain, sadness and feelings of injustice which may remain throughout life. If children have to be separated, contact is crucial. Separation can involve great sadness for children and their grief aggravated by worry and guilt about siblings. It will be vital that the issue of contact is kept central to all decision making so there is a balance between the children maintaining a relationship and spending time with their family, but this should not be detrimental to the security of their long term placement."

279. In evidence, the Guardian said that it is in C's welfare interests to be placed without K, but sadly it is in K's welfare interests to be placed with C. I accept that K would wish to be placed with C but I do not accept that it is in her best interests to be placed with him. The evidence before the Court is that when they were placed together K continued to play a parenting role for C and that she posed a risk of physical and emotional harm to him by attempting to "choke" him and by trying to make him cry. I am satisfied that it is in each child's interest to be placed separately. The high level of care that C is receiving should not now be compromised by the introduction of K to his placement. I accept the submissions made on behalf of the Guardian that "K deserves the right to be parented and cared for in her own right as an 11 year old." I am satisfied that to attempt to place them together now would risk K continuing to attempt to parent C which is in neither child's best interests.

280. I am satisfied that K cannot remain in the care of the mother. The risks are simply too great. I am satisfied that there are no proper or reasonable supports that could be put in place to reduce these risk to a manageable level. I agree with the

Children's Guardian that the management of risk in respect of K is a significant challenge for professionals and that even with the considerable intervention provided by the local authority and other agencies and professionals during these proceedings her welfare remains at risk. Notwithstanding an interim supervision order, written agreements, a very high level of professional monitoring and the existence of care proceedings, K is alleged to have suffered emotional and physical harm whilst in the care of the Mother perpetrated by LH.

281. The success of removal to foster care for K this time will be dictated by whether the local authority can learn from its past mistakes and ensure that K's removal is dealt with in a planned way, without un monitored telephone calls to her family, especially late at night, and to a placement with highly skilled and experienced carers. K's removal will need to be handled with real care and sensitivity. It has a far greater prospect of success if the Mother can support K through the process. Understandably, this is likely to prove extremely difficult for the Mother. I agree with the Guardian that there are steps that the local authority can take to ensure that the transition is as smooth as possible, to minimise the distress to K. By the time that this judgment is handed down, I hope that the local authority has heeded the advice of the Guardian and sourced an appropriate placement for K so that when my decision is shared with her, she can be told precisely where it is that she will be going to live and with whom.

282. In the letter from the Mother's GP dated 15th June 2017 it states "This lady's mental health remains of a concern. She has a recent history of depression and self harm episodes. She took an overdose of Paracetamol in April 2017. She has also had 2 episodes contemplating suicide by throwing herself off a bridge. She had been seen by the Primary Care Mental Health Team in March. They were concerned that the complexity of her mental health problems required more specialist intervention and she was referred onto the Community Mental Health Team. They were concerned that she had significant mood swings and a mix (sic) presentation. They were also concerned about that she was not being honest with

regards to risk and possible hidden agendas. I note a significant background of sexual abuse in her childhood as well as a fall out of a third floor bedroom window in 1993 when she landed onto a mattress. As you are aware she is under significant stress following 2 of her children being taken into care last year…With regards to your third question of prognosis, this lady's mental health problems are unlikely to resolve in the near future as they are evidently significant and not responding to supportive measures over the last few months."

283. The Mother accepted in her evidence that this letter's content was accurate and that she has now been referred to see a psychiatrist, her medication is set to change as it is not helping her. She told me she "needs something stronger" as "the way I've been feeling hasn't changed". I note that the Mother is currently taking 200mg Sertraline daily and that this is said to be the highest dose of that drug that she could be on. She is due to have continuing involvement from a CPN. There is an open-ended timescale for this support. The GP's letter considers that the Mother's childhood is significant when considering her present mental health difficulties. In so far as the Mother's explanation that she only felt this way after the two younger children were taken and wouldn't be like this if they were returned, I cannot accept this. K has been placed in her care during the period of time in which she has attempted and contemplated suicide. The Mother told me in oral evidence "I've not always been honest about my health. I was worried about professionals finding out – health professionals and the local authority."

284. I am satisfied that the Mother's mental health remains precarious. I commend her for her very recent engagement with the Community Psychiatric Nurse Service. She has attended two appointments, both during these proceedings and on days that I have excused her attendance at Court to permit her to go. I sincerely hope that she continues to attend such appointments and that she engages with the psychiatrist that she has been referred to. She has, however, very serious mental health difficulties with an attempt at suicide as recently as April 2017. Her very high dose of medication has not helped her. I fear that she has a long way to

go before her mental health shows any sign of significant and lasting improvement. This is particularly the case in the light of the loss of RG. Whilst I have every sympathy with the Mother and have to acknowledge that the permanent removal of all three children from her care is bound to exacerbate and compound her difficulties, it is their needs that must come first. I accept the Guardian's opinion that "from the children's perspective there is now insufficient time for her to be given further opportunity to demonstrate and maintain the necessary progress within acceptable timescales." The Mother is not presently able to acknowledge the profound effect that her childhood has had upon her and its contribution to her emotional difficulties. Sadly I fear that her therapeutic journey may well be a long one. I wish her well with her therapy and sincerely hope that she engages with the support on offer to her.

Contact arrangements

285. When making care orders in respect of each child I must be satisfied that the contact arrangements provided for in the care plans are appropriate.

Sibling contact

286. I am satisfied that the care plans for the children provide for an adequate level of sibling contact at the current time. The proposal for separate fortnightly sibling contact is endorsed by the Children's Guardian. It will continue to be reviewed as a consequence of the children being "Looked After". There may be times when D is unable to attend due to ill health. In due course it is hoped that the children's foster carers can arrange contact so that it occurs in a natural and relaxed way either in the community or within their placements.

The Mother's contact

287. It is proposed that the Mother's contact with the children will reduce to take place on a monthly basis. It is proposed that this reduction will be gradual and that K will need a higher level of contact whilst she adjusts to her removal to foster care. I accept the evidence of the local authority and the Children's Guardian that the level of contact for K will depend upon how she reacts to my decision, whether she accepts her placement and whether the Mother is able to support her through the process. The local authority is alive to the possibility that it may need to apply for an s.34 (4) order to prevent contact between K and the Mother if the Mother seeks to undermine the plan or if her contact causes disruption. It is hoped that K's transition to foster care can be assisted by contact with the Mother. I accept the Guardian's oral evidence that "Monthly contact may not be sufficient for K. If the Mother can support K's placement and not undermine it hopefully contact could be more frequent." I take the view that it is difficult to be prescriptive about the Mother's contact with K. Too much depends upon whether her transition to foster care is a success. Contact between K and the Mother is a highly complex issue. She is immensely loyal to the Mother and has a strong desire to please her and remain in her care. It will be for the local authority to manage this aspect of the care plan. I am confident that it will do so and that K's social worker, Helen McArthur, is well aware of the need to handle contact with the utmost sensitivity to K's needs and will do her best to ensure that they are met.

288. I accept the Guardian's oral evidence that "an end point of monthly contact for the Mother is appropriate" and "that the reduction should be stepped". The Mother will have additional contact with D at times when he is in ill health – by attending hospital appointments and visiting him in hospital when he is admitted as an inpatient. Sadly, as a consequence of D's condition it is likely that this will be a regular occurrence. He was in hospital during the latter part of the hearing and the Mother was afforded additional contact as a consequence. D's carers have a particularly arduous task head of them and I accept the Children's Guardian's evidence that monthly contact is a good balance. There will be more contact at

times when he is ill. I approve D's care plan in so far as contact with the Mother is concerned. C needs an opportunity to adapt to his placement becoming his long-term home. I am satisfied that an end point of monthly contact is appropriate for him to enable him to make this adjustment.

289. Clearly all of the children's contact will be subject of on going reviewing as a consequence of their "Looked After Children" status and can be increased or reduced in accordance with their wishes and feelings and individual needs. I am content that the care plans are an appropriate starting point and I approve them in so far as the Mother's contact is concerned.

Contact between K and her father

290. I am satisfied that contact between K and her father is a positive experience and that it is in her best interests for it to continue at a frequency appropriate to continuing and developing their relationship. Having heard the evidence of Helen McArthur I am confident that the local authority is committed to promoting K's relationship with her father. The Children's Guardian also supports continued contact with a view to their relationship developing. TT accepted in evidence that his contact may need to be held in abeyance whilst K settles into a foster care placement. I am satisfied that he is sensitive to her predicament. Contact arrangements for K are difficult to prescribe or predict. Much will depend upon the success of her removal to foster care and her ability to accept her placement. The progression of her contact with her father will also depend upon her wishes and feelings. I am satisfied that contact between K and her father has a far greater prospect of success whilst she is placed in foster care than if she were to remain in the care of the Mother and am confident that it will be appropriately promoted by the local authority and reviewed through the "Looked After Child" process.

291. I invite the local authority to amend its care plan to reflect the oral evidence given by Helen McArthur, to include confirmation that it will continue to promote a relationship between K and the father through ongoing direct contact and that it

will assess TT as a potential carer for K throughout the course of its statutory involvement with K. TT accepts that no timescale can be given for this work. Both Helen McArthur and the Children's Guardian are open to the prospect that in time K's contact with her Father could take place on a weekly basis. I am satisfied that their relationship will be supported to develop under the auspices of a care order.

Contact between C and his father

292. MS accepts the local authority's amended care plan, which is endorsed by the Children's Guardian. I am confident that their contact will be appropriately promoted by the local authority and reviewed through the "Looked After Child" process and therefore approve the care plan.

Contact between D and his father

293. The local authority and Children's Guardian are of the view that the quality of JW's contact is enhanced by the presence of JA. JW accepts this and both he and his niece request that she be permitted to continue to attend his contact sessions. The Mother does not oppose this. I approve this part of the care plan.

294. Prior to the penultimate day of the hearing when the Mother produced the Facebook entries, it had been hoped by the local authority and Children's Guardian that JA could be trained to meet D's care needs so that she could support JW to have contact in the community without the need for professional supervision.

295. When JW gave oral evidence he admitted that he had been aware that JA was lying to professionals and to the Court about not being in a relationship with SF. He was aware that contrary to her assertions that she had not had any contact with him for the last two years, she had remained in contact with him. He said that he didn't like SF as he "knew the way he was with his hands" – a reference to the severe domestic violence he had previously perpetrated towards JA. He knew this

because he had seen them together on three occasions this year, one such occasion being at his 40th birthday party. He had not seen the Facebook entries but it was only after they had been produced and after JA had withdrawn as a carer for D that he revealed this information. He accepted that he knew that this was information that the local authority needed to know but that he had not told any of the professionals in the case. He said that he couldn't trust JA and accepted that as a consequence of these issues, she could not be responsible for supervising or supporting his contact in the community and that their contact would need to continue to be professionally supervised. I am satisfied that in light of the JW and JA's sustained deception about her ongoing contact with SF that their contact with D will need to continue to be professionally supervised for the foreseeable future, until such a time that professionals can be confident that she is not with SF and that she can be trusted.

296. JW seeks the frequency of his contact with D to continue to take place on one occasion each week. The amended care plan provides for it to take place on one occasion each month. Helen McArthur accepted that additional contact would need to be promoted at times when D is unwell and in hospital and that his parents are entitled to attend his hospital appointments. I am satisfied that this is appropriate and should be included in an addendum care plan. In so far as the frequency of contact is concerned D remains an unwell child. The reality is that he is likely to see his parents on a far more frequent basis than monthly as a consequence of his hospital admissions and treatment. I am content to approve a care plan that provides for a baseline level of monthly contact at times when D is well to allow him the opportunity to spend as much time as possible forming a primary attachment to his foster carers and to prevent his ordinary routine within his placement from being disrupted. I accept the Children's Guardian's evidence that monthly contact is a good balance. There will be more contact at times when he is ill. I approve D's care plan in so far as contact with the Father is concerned.

297. I am satisfied with the proposed placements and contact proposals within each child's care plan, subject to the amendments that Helen McArthur agreed to make in her oral evidence, and make the care orders sought.

MS's application for Parental Responsibility in respect of C

298. The Mother seeks to establish that MS has not been committed to C during his life either through contact or through financial provision for him. MS's case is that contact was made difficult by the Mother and took place only when covertly organised by the Mother's sister GA and facilitated by RG. MS accepts that he has made limited financial contributions towards C during his life.

299. In determining whether MS is to be granted Parental Responsibility for C I am more interested in the present than the past. MS has demonstrated his commitment to C in these proceedings by attending all court hearings notwithstanding the commute from Birmingham and that he has a new born baby at home, by engaging in assessment work and in the provision of information for life story work and indirect contact. He told me that he "would like his son to be in a safe place, to have good education and to be in good health." He supports C remaining in foster care and has demonstrated an ability to prioritise C's welfare above his own natural desire to see C. He has accepted that matters need to progress at C's pace and that establishing a relationship with C may take some time. I commend his patience in that regard. By accepting that C's best interests lie in his current foster care placement he has demonstrated an ability to put C's needs and welfare above his own wishes. He has resisted the temptation to attempt to unsettle C's placement either by seeking to argue that C should be placed with him or his family members in Birmingham or by pressing for direct contact prematurely.

300. The Guardian indicated in her oral evidence that she was "struck with his view that he just wants C to be happy". The Guardian was "left with the picture that he wants to be involved in his son's life". She supports MS acquiring parental

responsibility to "give him a legal voice which he does not have". She explained in evidence that when children are Looked After only adults with Parental Responsibility are consulted with and so by acquiring parental responsibility he would be included in looked after meetings and reviews and care team meetings.

301. I am satisfied that it is in C's best interests for MS, his birth father, to be granted Parental Responsibility for him and I make that order. I am satisfied that MS has demonstrated commitment to his son during these proceedings and that his motivation for seeking to share parental responsibility is a genuine and positive one. He wants what is best for his son. It is C's right that his father shares parental responsibility for him and is consulted with, and informed about, the decision making for his care and welfare during his time as a looked after child.

Declaration of Non Parentage and Declaration of Parentage in respect of K

302. K's paternity has been established via DNA testing commissioned during these proceedings. The man currently registered on her birth certificate is not her father. It is essential that this situation be rectified as soon as possible. K has a right to have clarity in so far as her paternity is concerned. She has already been told who her father is and has been enjoying positive contact sessions with him during the course of these proceedings. Her birth certificate is an important legal document. It should be an accurate one. K will use it throughout her life. She has every right to have a factually accurate birth certificate. I can see no reason whatsoever to refuse K's father's application for a Declaration of Non Parentage to clarify that MA-H is not K's father and to make a Declaration of Parentage declaring that TT is. I accordingly make those declarations.

TT's application for Parental Responsibility in respect of K

303. The Mother seeks to establish that TT has not been committed to K during her life either through contact or through financial provision for her. TT's case is

that contact was made difficult by the Mother and took place only when covertly organised by the Mother's sister GA and facilitated by RG. In many ways his case echoes that of MS.

304. TT now accepts that K cannot live with him at the current time. He acknowledges that he needs to establish a relationship with her first and be the subject of on-going assessment in the future. Whether K can ever move to live with him will depend on her wishes and feelings, how she settles into foster care, whether they establish a good relationship and whether he can demonstrate the necessary commitment and capacity to safely parent her to a good enough standard. All of those matters are matters for the future. In acknowledging his need to be patient and supporting K by accepting that she needs to move to foster care and that his contact with her will need to take second place for the immediate future whilst she settles, he is demonstrating that he can put her own welfare needs above his own desire to see her.

305. I am satisfied that he has demonstrated his commitment to her in these proceedings by attending court hearings, engaging in the assessment process and attending contact sessions with her. I am satisfied, having heard his evidence and the evidence of Helen McArthur, that those contact sessions have been positive experiences for K. I hope that once K settles into her placement she can enjoy regular and frequent contact with her father, which will support her in understanding her heritage and identity.

306. The Guardian supports TT acquiring parental responsibility for K for the same reasons that she gave for supporting MS acquiring it for C, namely to give him a legal voice and include him in the looked after child process and procedures.

307. I am satisfied that it is in K's best interests for TT, her birth father, to be granted Parental Responsibility for her and I make that order. I am satisfied that TT has demonstrated commitment to his daughter during these proceedings and that

his motivation for seeking to share parental responsibility is a genuine and positive one. It is K's right that her father shares parental responsibility for her and is consulted with, and informed about, the decision making for her care and welfare during her time as a looked after child.

308. I am grateful to Helen McArthur, the children's current social worker and to the Children's Guardian for their assistance in this matter. Both professionals gave helpful, balanced and fair evidence. Helen McArthur made a number of concessions about contact between the children and their parents and family members during the course of her oral evidence, which went beyond the detail in the current care plans. I direct that those details, as incorporated into this judgment, be set out in addendum care plans for each child and that those documents be filed within 7 days of this judgment being handed down.