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(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

IN THE MATTER OF J (CARE ORDER)

GILLEN J

Introduction

[1] This judgment is being handed down on Friday 1 August 2008. It consists of 22 pages and has been signed and dated by the Judge. I hereby give leave for it to be reported. The judgment is being distributed on the strict understanding that no person may reveal by name or location the identity of the children and the adult members of their family in any report. No person other than the advocates or solicitors instructing them (or any other persons identified by name in the judgment) may be identified by name or location and that in particular the anonymity of the children and the adult members of this family must be strictly preserved. This prohibition shall operate until the child becomes 18.

[2] I have already determined in this matter a threshold hearing under the Children Order (Northern Ireland) 1995 ("the 1995 Order") (see unreported GILF5668 Gillen J 18 January 2007).That judgment should be read with this current determination and accordingly it is unnecessary for me to set out the background facts. It is sufficient to say that I determined that the threshold criteria as contained in Article 50(2) of the 1995 Order were satisfied.

[3] I pause to extract from that judgment factual conclusions I arrived at which were set out at paragraph 13B (i) - (iv) as follows

> "(i) I am satisfied that C suffered two fractures which were inflicted at different times prior to death. I accept the submission of the Trust that there is no legitimate or innocent explanation for either of these such as clumsy handling. ……. I am therefore satisfied that both fractures occurred at different times and that in each instance the

fracture would have been sufficient to cause the child to scream, to be irritable for a period of days and thereafter tender for several days.

(ii) …… Accordingly I am persuaded that the position remains that in my view F and O, had they been appropriately attentive in their parental duties, would have noticed the upset and distress occasioned to this child. I make no finding that they inflicted these injuries – I simply do not know who was the perpetrator – but they had a great deal of contact with this child and I do not accept that they were unaware of the pain and irritation that this child must have suffered. Notwithstanding this they chose not to refer the child to an appropriate GP or health visitor. Given therefore that this child was subjected to non-accidental injury, there was at the very least a failure on the part of both F and O to protect C or to provide care for her by getting treatment at an appropriate stage. That finding persuades me that J, if returned to the care of the respondents, would be likely to suffer significant harm. This child would not be afforded appropriate care or protection. Whilst therefore I am conscious of the principle that the focus of this case must be on J and not C, nonetheless I am satisfied that the lack of care exhibited to C by F and O is highly relevant in considering the likelihood of harm to J in the future.

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

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

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

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

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

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

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

(g) Her mental health vulnerability.

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

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

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

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

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

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

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

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

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

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

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

The Care Order Application

[4] I must now turn to determine the second stage of the application by the Trust for a Care Order and determine whether a Care Order or some other Order or no Order should be made. I invoke the principle that the child's welfare is the paramount consideration. I must have particular regard to the matters set out in the statutory welfare checklist contained at Article 3(3)of the 1995 Order. I must not make any Order unless I consider that doing so would be better for the child than making no Order at all. Before making a Care Order with respect to any child, the court must consider the arrangements which the Trust has made or proposes to make for affording any person contact with a child who is in the care of the local authority and invite the parties to comment on those arrangements. Moreover I cannot make a Care Order until I have considered a care plan with respect to the child. Finally I must consider the terms of the European Convention on Human rights and Fundamental Freedoms ("the Convention ").

[5] This stage of the application has had a protracted history. Since the threshold hearing in September 2006, there have been a number of hearings and several disparate options pursued to investigate the possibility of a family reunion or kinship placement. A hearing in April 2007 was adjourned to permit Dr Dale on behalf of F and O to explore a further assessment of the possibility of J returning to F. That proved unacceptable.

[6] I pause at this stage to record briefly why a care plan with F as the primary carer was unacceptable. At the outset I note that such a proposition was no longer put forward by any party in the current hearing. F clearly did not demonstrate sufficient insight into the impact of her behaviour and beliefs on the wellbeing of her child. While she may have made some positive changes in recent months she continues to lack insight into her failure to prioritise J's needs above her own. Her inadequacies in looking after C cannot be overlooked in this context.

[7] Moreover she still in my view essentially rejects the need for input from the professionals involved in J's case.

[8] It is clear that without input at least from her mother she is unable to manage her reactions and her emotions in a manner which would be compatible with J's best interests. She is far too volatile and unpredictable being absorbed in her own feelings. When her problems are discussed she tries to deflect them away from herself and onto another person finding a fault with somewhere beyond herself.

[9] The volatile and at times violent relationship which she currently enjoys with her partner is further indication that she has not matured sufficiently (see paragraph 72 of this judgment).

[10] A further hearing in September 2007 was adjourned to consider the possibility for change within the mother/daughter dynamic of F and O and to allow investigation of the possibility of O being the primary carer or in concert with F. Another adjournment was granted in November 2007 to further explore this possibility.

[11] That option too has also proved unacceptable for the following reasons. Whilst I recognise that O is very committed to looking after J, even Ms Leonard who was reporting on her behalf discerned an inability on her part to understand parenting. I fear that there is strength in the assertion by Ms Leonard that in fact O fundamentally does not want the sole care for J with all the demands that this brings. Her underlying motivation is more to show that she cares rather than to demonstrate that she wants sole care of him.

[12] O did not identify that J could be at risk from within the family. The significant parenting deficits that she revealed in her parenting of F have not been sufficiently repaired to allow her to parent J either alone or in concert with F. In fact she has become an advocate for F without really recognising her frailties as a parent. Her level of honesty with social workers and the guardian ad litem was so suspect that I could not rely on her to adequately afford J the protection he requires with appropriate professional input. On the contrary she promotes F as a mother to J by encouraging his responses to her. Far from asserting her authority over F, she advocates her case.

[13] Dr Dale in terms accepted that the return of the child to F or to O and F were no longer feasible options. Consequently yet a further kinship possibility was explored and assessment made of F's aunt and uncle Mr and Mrs M. A Fostering Panel had already turned them down largely on grounds of age and health in 2006. In March 2008 the case was yet again adjourned to allow this to be revisited and for a complete kinship assessment of JK a maternal uncle as backup for Mr and Mrs M. The Ms and JK were represented at this hearing by Ms Walsh QC and Ms Gallagher. F was represented by Ms McGrenara QC and Ms Callaghan, O by Ms Keegan and Ms McHugh, the Trust by Mr Toner QC and Ms Smith and the Guardian ad litem by Mr O'Hara and Ms Anyadike Danes. Since the Ms, F and O were in the event all pursuing precisely the same case before me I have described them jointly as "the Respondents " in this judgment.

[14] Perhaps the key issue in this case around which all other matters revolved, was whether the Trust had on the balance of probabilities satisfied the court that the Care plan which envisaged adoption outside the family circle and excluded Mr and Mrs M as carers had been established as an acceptable plan or whether I should reject the care plan on the basis it was flawed by rejecting the Ms as primary carers within a family context .

The Trust case

[15] In essence the Trust case was that, having satisfied the court that the threshold criteria had been proven, this child required a secure attachment for the future which could only be found outside the current family circle. Essentially relying on Dr Bentovin, Ms Faith Senior Social Worker and Systemic Psychotherapist, Ms Lafferty Senior Social Worker in the Family Placement Team of the Trust, Mr Dickson senior social worker who spoke to the proposed care plan and Marcella Leonard the independent social worker it was its case that Mr and Mrs M could not provide a placement of stability without real risk of placement disruption by F and O.

[16] The Trust contended that Mr and Mrs M had an inability to set rules or appropriate boundaries within the family network and would be unable to stand up to pressures from F or O. They failed to see that F or O represented individually or collectively a threat or risk to J. They were inadequately inquisitive about the history surrounding the death of C or F's current relationship with her present boyfriend to satisfy the Trust that they were appropriate carers.

[17] It was the Trust case that JK, a young man who was a maternal uncle who now resided with Mr and Mrs M, was inadequate backup to the couple because of his antisocial behaviour and drinking habits. Once again it was the trust's case that the Ms had been inadequately inquisitive about these behaviours and habits.

[18] In addition it was the Trust's contention that the age and health of Mr and Mrs M militated against their capability to care for J.

The Respondents' Case

[19] Apart from the evidence of Mr and Mrs M who both gave evidence before me, JK and F, who also gave evidence before me, the Respondents largely relied upon the evidence of Dr Dale and to some extent upon the evidence of Marcella Leonard an independent consultant retained by the Respondents with reference to the assessment of O.

[20] It was Dr Dale's contention, contained in his latest report of 30 May 2008 (Dr Dale had made three previous reports namely on 30 April 2007, 11 June 2007 and 14 December 2007), that there was sufficient strength in the extended family especially Mr and Mrs M together with JK to lead him to conclude that there was a reasonable possibility of success if this child resided in the home of Mr and Mrs M with JK. Dr Dale considered that the strategy was not risk free but with a reasonable prospect of success, he suggested the

court should adjourn again this time for six months to see how J progressed in the home of Mr and Mrs M.

[21] He described the Ms as respectable people with a good relationship for over 40 years whilst at the same time recognising they were older and not in perfect health.

[22] He asserted that there was no significant physical or sexual risk to J simply because of the experience of C. He recognised the risk was in the complexity of the extended family relationship. In particular he was concerned to deal with F's ability to adapt and adjust to Mr and Mrs M having primary responsibility and setting the rules to which J and the rest of the family had to adhere. He felt that the adjournment would allow F's ability to accept and adjust to be reviewed. Since J had to move from his current placement in any event, he felt this did beg the question whether a trial placement of J with Mr and Mrs M with the support of JK should not be considered as the next step.

[23] On the issue of the alleged failure of F and O and the whole extended family to acknowledge the cause of C's death, Dr Dale asserted that it was not necessary for family members to accept findings of fact in relation to how a child was harmed (and who was responsible) as long as the family members behaved in responsible ways with regard to risk management and family support programmes.

[24] In Dr Dale's view it would be a much more natural and constructive thing to leave the thinking as to how F's role in the future with J should be clarified, supported and monitored to the extended family as a whole. The Trust should be in the position of facilitating and responding to the constructive thinking of the family as to how this could best be managed for J's benefit.

[25] In relation to adoption generally, Dr Dale asserted that research has highlighted that adoptive placements are by no means always entirely successful. Approximately 20% break down at some stage (although this is more likely with those placed at an older age than J) and a significant proportion of adopted adults report various degrees of dissatisfaction with their experience of having been adopted. Dr Dale highlighted the strength of commitment of the extended family to J and his significant place with them as evidenced by the enjoyment of contact visits. He suggested that the contact reports continue to illustrate the strong mutually loving relationship between O and J.

[26] In short Dr Dale suggested that J should be placed in the care of Mr and Mrs M with the support of JK on a trial basis following a period of skilful preparation and a closely designed professional support package. This would

be subject to continuing assessment on the basis of J remaining on an Interim Care Order with updated progress reports being provided to the court for a rearranged final hearing in about 6 months' time.

[27] He criticised the current Trust for not having a separate kinship care process emphasising that kinship assessment has different criteria from foster parent or adoptive parent criteria. Kinship carers tend to be older, in poorer health, poorer financially and have complex family relationships.

[28] In terms of post adoption contact if adoption is granted, he felt there should be post adoption contact with O, F and JK. He would also like to see the Ms have some direct contact albeit more distant.

[29] The Respondents called Dr Moles who was the General Practitioner for Mr and Mrs M for over 20 years. In relation to Mr M's health, she did not dispute that he had difficulties with low blood pressure, high cholesterol, diabetes, obesity and degenerative disc disease. She expressed concerns about his physical limitations to be able to look after a 3 year old due to his back and leg pain. She felt however he could be an emotional support.

[30] So far as Mrs M was concerned, Dr Moles felt that currently ,despite her high cholesterol, obesity and blood pressure which were all risk factors, she could look after a 3 year old on a full-time basis but she shares concerns with Dr Bailie that over time it may prove more difficult.

[31] Mr M gave evidence before me. He struck me as a well intentioned well meaning man who wants only the best for J. He felt there was no doubt that he could look after J with help from JK.

[32] Mr M said that he had a guarantee from F and O that they would not disrupt the return of J. He asserted that if J was living with him and his wife, they would take the decisions and not F and O. So far as his health is concerned, he said he only rarely uses his wheelchair if for example he is in the shops for a long day. He still does have bad arthritis but usually gets by using a stick.

[33] Mrs M gave evidence. I found her a quiet self-effacing decent woman who again satisfied me that she had nothing but J's best interests at heart. She felt she could provide a stable home for J and asserted that O and F had both said they would take a "back seat". She agreed that she would call in the Social Services if they interfered unacceptably.

[34] F also gave evidence before me. She accepted that she had made mistakes in the past and had been a "terrible teenager". She said she realised that J was never going to be returned to her. However she wanted him to

return to someone in the family so that he could be cared for and her choice was Mr and Mrs M.

[35] JK testified before me and I shall deal with his evidence where relevant later in this judgment .

[36] The Evidence of Marcella Leonard

Marcella Leonard, an independent Social Work Consultant, had been instructed on behalf of O and F to undertake an independent social work assessment of the case. She was in the event called on behalf of the Trust I had read two reports produced by her of March 2008 and of 16 May 2008. In March 2008 she concluded that O was neither ready nor suitable to undertake the parenting role for J. She was aware that there had been a reassessment of Mr and Mrs M with JK being considered alongside him as part of the assessment.

[37] It was her view that the Ms and JK were well aware of the positive nature of the assessment but she pointed to their lack of judgment in relation to the non disclosure of JK's medical history. They entered into the family meeting defensively rather than constructively seeking to demonstrate how this family will collectively manage crisis and stress.

[38] Ms Leonard recognised that throughout the assessment of O, her lack of engagement and preparedness to discuss the family history, the family problems and challenge family views was very evident

[39] This difficulty, in her view, mirrored similar difficulties with Mr and Mrs M and JK. In the penultimate paragraph of her later report she stated:

> "This is not to doubt their love for J and a desire to care for him but their inability to openly deal with their individual and family group deficits which require review is significant. It is my opinion that the family have extensive historical issues which appear to impact on their ability to really confront each other and therefore in respect of safety and maintenance of the family and individual family member status they become defensive against others."

[40] Ms Leonard concluded:

> "It is my opinion that the kinship assessment has raised continuous questions as to how the family as a whole has functioned in the past and

> currently. In order to address these issues extensive family systemic work would need to be undertaken, where the family really opened up their family history but it is my concern that this would not fit within a reasonable timescale in relation to J."

[41] In essence Ms Leonard said that there was no real understanding of the need to hold each other to account within the family. There is no evidence of this so far. She also found no actual evidence of the Ms positively asserting that what they would protect J against F and O come what may .

[42] F's learning disabilities have been a major factor in her inability to allow others to take over. Ms Leonard entertains concerns about this particularly as the child moves into adolescence. Whilst the family assert that they will step back and allow Mr and Mrs M to control matters, it was Ms Leonard's contention that there is no concrete evidence of this having happened. The failure of the M's to hold JK to account over his alcoholic past and antisocial behaviour was an instance of this. In particular Ms Leonard said that she felt unable to indicate how JK's future would unfold in the absence a career path or some indication from him as to what his intentions were .

Foster Care Panel

[43] Before turning to my conclusions in this matter I pause to make some comments about the foster care panel who reassessed the Ms in 2008.

[44] I commence by drawing attention to the European Convention. Article 8 provides:

> "(1) Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> (2) There shall be no interference by a public authority with the exercise of this right except as is in accordance with the law and is necessary for a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of crime and disorder, for the protection of health or morals or for the protection of the rights and freedoms of others."

[45] Both the Trust and the court are constituted public authorities for the purpose of this article. In Re S (minors) (care order implementation of care plan): Re W (minors) (care order: adequacy of care plan) (2002) 1 FLR per Lord Nicholls at paragraph 99:

> "Although Article 8 contains no explicit procedural requirements, the decision-making process leading to a care order must be fair and such as to afford due respect to the interests safeguarded by Article 8."

[46] I am not satisfied that the procedures currently adopted by this panel comply with Article 8. It was clear to me that the Ms were excluded during part of the discussions/representations made by the social workers to that panel and medical evidence from Dr Bailie was provided to that panel to which the Ms were not privy. This occurred in circumstances where the personnel present at the meeting were largely well known to each other and the form of address was in Christian name terms. No memoranda of the meeting were circulated thereafter to the Ms and other than a perfunctory reference to the proceedings they were not informed in any detail of what had occurred when they were permitted to enter the meeting. This was an inadequate process for ensuring inclusive involvement in the decision making process. I consider that it is imperative that this Trust forthwith re-examine the procedures adopted by this panel to ensure compliance with the Convention.

[47] In the event, as both Ms Walsh and Mr O'Hara expressly recognised, I was now looking at the process in greater detail than the Panel did, hearing witnesses and exploring all the issues that were before the Panel. Moreover I do not consider that the determination by the Panel has had any irreversible impact on the overall decision making process as a whole. All parties have had an opportunity by virtue of this court hearing to fully ventilate all the point that they wished to raise. Moreover, in my view, given the facts of this case and my conclusions to which I shall shortly turn there is no benefit in returning the matter for reconsideration by the Panel. I emphasise however that this might not always be the conclusion in future cases if these unacceptable procedures continue.

Conclusions

[48] I commence my deliberations by recognising the strength of the jurisprudence in the European Court of Human Rights ("ECHR") to the effect that it is a guiding principle that a care order should be regarded as a temporary measure, to be discontinued as soon as circumstances permitted and its implementation should be consistent with the ultimate aim of reuniting parent and child. The minimum to be expected from the authorities in relation to parental rights of access is an examination of the family

situation anew from time to time to see whether there had been any improvement. (See R v Finland (Application No 34141/96)).

[49] The positive duty to take measures to facilitate family reunification as soon as reasonably feasible will begin to weigh on the responsible authorities with progressively increasing force as from the commencement of the period of care, subject always to its being balanced against the duty to consider the best interests of the child. After a considerable period of time has passed since the child was originally taken into public care, the interest of a child not to have his or her de facto family situation changed again may override the interests of the parents to have their family reunited (see K A v Finland (2003) 1 FLR 696 at p 721 para 138).

[50] Thus Trusts must be vigilant in keeping the objective of rehabilitation in mind and be serious in implementing periodic reviews of any given situation.

[51] With reference to the European Convention and in particular Article 8 and its relevance to this case, I respectfully adopt the comments of Baroness Hale at paragraph 33 of Down Lisburn Health and Social Services Trust and Another (AP) v H (2006) UKHL36.

> "Article 8 of the Convention guarantees …. respect for family life. A public authority must not interfere with that right unless three conditions are fulfilled: first that it is in accordance with the law; second that it is for a legitimate aim, in this case safeguarding the best interests of the child; and finally, that it is 'necessary in a democratic society' – that is, that the interference is for relevant and sufficient reasons and proportionate to the legitimate aim pursued."

[52] Factual Conclusions

Against that legal background the following are the factual conclusions at which I have arrived:

[53] I have no doubt that Mr and Mrs M are a well intentioned couple with a good home who love J. However I am not satisfied that they could yet afford a placement of stability without real risk of placement disruption. I accept the evidence of Ms Faith, senior social worker and systemic psychotherapist who gave evidence in this regard. She had carried out seven sessions of approximately 1 ½ hours each in 2007 and 2008 to establish whether or not if J was not returned to F or O's care, a family option was possible with Mr and Mrs M being the primary carers.

[54] Sadly her conclusion, which I accept , was that Mr & Mrs M were, as she described them, "benignly naive" about the risks attending on a return by J to the family network. It is this witness' view that neither of them had enough capacity to impose rules and boundaries on F and O or for that matter to stand up to them. They were almost too sympathetic to F. The witness saw no evidence of a challenge to F or O in this regard.

[55] I share Dr Bentovin's view, as assessed in April 2006, that as O was unable to prioritise C's needs within the context of the priority she gave to F, so she, and for that matter F, are unable to prioritise J's needs. J's permanent carers must be able to stand up to this conceptually and practically. I was struck by how strong an allegiance O had with her daughter and particularly her need to represent F. I consider that it will be a major struggle for any carer, particularly within the family network, to assert the rules by which this child must be brought up in the face of what I consider is likely to be criticism and opposition from O and F. As I have said, I am concerned that O does not appreciate the impact of F's learning disability and her capacity to provide consistent emotionally attuned care giving and she acts as an advocate for her daughter. It will need a very strong carer, particularly within the family network to resist this pressure. I am not satisfied that Mr & Mrs M have got the capacity to deal with this in the best interests of J.

[56] I am satisfied that in the absence of the capacity of Mr and Mrs M to resist the influence of F and O, this child will be confused as to who is setting boundaries for him. That will not lend itself to consistent parenting which this child so desperately needs.

[57] As Dr Bentovin has pointed out, this is a child who has made basic core attachments and has lived the whole of his life with his foster carer and family members. Wherever he is placed, he is going to be a vulnerable child as a result of the disruption of his core attachment. He has to move from his present carer. The current foster carer is his primary attachment and O is the secondary attachment at the moment. J needs an emotional climate particularly stable to build up a secure attachment. He does have a potential for building up secure attachments provided the level of stability within the family is such as to permit this to happen. Whoever now takes care of this child must see him through maturity. A delay of yet another 6 months as advocated by Dr Daly in starting this process will simply prolong the uncertainty as his future in circumstances where I am satisfied there is no realistic prospect of resolution within the family context.

[58] The observations made by the Guardian ad litem lend weight to these propositions. In particular the Guardian said at paragraph 5.173 of her recent report concerning the presence of the Respondents at contacts:

> "On those occasions when I have observed J's contact with his family members, my accounts indicate that J responds to O as a significant adult and then to F. I have not observed a similar level of interactions between J and (Mr or Mrs M). Mr M is delighted with J, he smiles when the child approaches him and speaks warmly about him, but during those sessions which I have observed, I did not observe him to represent a significant figure to J during the contact. I have observed (Mrs M) assist O and F in practical tasks and remove objects from J when it appeared he was going to throw them or hit someone. I did not observe interactions with the family contact to suggest that there had been a reorganisation of roles or responsibilities within the family. The interactions between O and J in my view were central to the contact."

[59] The Guardian continues at paragraph 5.175:

> "I am concerned that should J be placed with Mr & Mrs M that F and O could undermine the placement and this would create uncertainty for J in terms of who was responsible for him and who has authority to set boundaries for him. There are historical concerns about O's capacity to set boundaries in respect of F and significantly of her capacity to assert herself to do so.
>
> 5.176 J needs an attachment figure, someone who he can transfer his trust to and who he can rely on to provide safe and consistent care giving. R, his foster carer provides this role to J currently, but in the context of family contact I see O as the most significant adult. Given that (Mrs M) considers that O could see J whenever she wants to, I query whether O could relinquish this primary role to her sister and whether her sister has the capacity to assume it. There are reports of (Mrs M) being not very vocal and a very quiet person, her husband being the more vocal and confident and this is also my assessment. I am concerned there is a risk for J that there is confusion/conflict, explicit or implicit disagreement over who has primary

> responsibility for him, authority over him and this would result in uncertainty for J."

[60] I am bound to say that having watched Mr & Mrs M, this echoes my own concerns and assessment of the situation.

[61] I consider that one of the real difficulties in the case is that this is a closely knit family within the network of which there has been no attempt to challenge the lifestyle of F and O in the past. In addition to the parties already mentioned I have heard mention of a number of other uncles who also attend contact sessions. Indeed during the hearing I was presented with a statement signed by eight adult members of the family circle indicating that they would support Mr and Mrs M in every way possible and that J would be brought up in Christian and loving family circle. In that document F recorded, as she stated in her evidence before me, that she was behind the proposal to return J to her aunt and uncle. However there appears to have been an absence of rules or appropriate boundaries within that network. Hence Mr and Mrs M made no attempt to intervene in or make adverse comment on the wholly unacceptable position in which two 14 year old children - F and W - were living and sleeping together within O's household. It is not merely a question of O not appreciating the impact of F's learning disability on her capacity to provide consistent emotionally attuned care giving. The rest of the family, including the Ms, seem similarly unaware of the risk presented by F or O to J in the context of the harm suffered by C and the historical circumstances in which O permitted F and another child to live together under their roof while sharing a bed.

[62] The fact of the matter is that I fully endorse the view of the Guardian ad Litem in her report of 9 June 2008 that Mr and Mrs M do not consider that F or O represent a threat or a risk to J. They both see F as having matured significantly and they consider that she and O would abide by the rules should J return to their care. They claimed that they were not really involved during C's life as they were both working and were unaware of any difficulties that were ongoing in O's home. However they were familiar with the fact that F was living another child. I consider that the extract of the Guardian ad Litem at paragraph 5.97 of her report is extremely revealing:

> "I asked Mr and Mrs M for their view about the professional concern that has existed about the inappropriateness of two 14 year olds being involved in a sexual relationship. Mr M advised that they don't like to intervene, although they probably should have, and he commented that there are 14 year olds, running around with babies."

I regard this as a very telling response which fills me with concern.

[63] Although the Ms and JK, to whom I will shortly turn, all apparently understand the concern that C suffered two fractures, they are quite adamant that O and F did not represent a threat to C and so do not represent any risk to J. Fundamentally they do not appreciate the limitations on F's capacity to parent J.

[64] Hence I agree with the fears expressed by the guardian ad litem in her report of 9 June 2008 at paragraph 5.16 where she observes ;

> "The issue of the impact upon F's capacity to parent has been one of the core assessments in this case and has been commented on by Dr Galbraith and by Dr Bentovin. It is my view that Mr & Mrs M and JK have a limited understanding of the impact of F's learning disability on her capacity to parent and that this contributes to their lack of understanding of professional concerns about her parenting ability. This resonates with concerns which existed at the outset of these proceedings related to O placing C in the care of F and W and promoting F as primary carer for J.

[65] How then could the Ms possibly comply with a protection plan which restricts contact and requires collaborative working with the Trust in circumstances where they might have to align themselves against O and F when they consider neither O nor F to present a threat to C in the past or to J in the future?

[66] In February 2006 a kinship assessment was carried out on the Ms by two social workers. One of the concerns that arose was the family dynamics and the influence on Mr & Mrs M in the face of assertive behaviour by F and O. I share the view of Ms Lafferty, senior social worker in the family placement team for this Trust, that although some shift in the thinking of Mr & Mrs M has occurred from 2006, it has not been sufficient. They now accept that C died from non accidental injuries. Formerly they had been wedded to the notion that it had been a cot death. However although they now accept that it was a non accidental injury ("NAI"), they still do not accept that F or O pose any risk to J. If they are unable to accept the risks posed I am bound to question their ability to protect J. Without such an acceptance, they will not be able to put appropriate strategies into effect to protect J. What is to happen to this child if F appears at their door and indicates that she wishes to take the child out of the house on her own? I believe that there is evidence to substantiate the assertion by both Ms Faith and Ms Lafferty that whilst saying they would abide by the rules and stick to contact arrangements, there is

insufficient evidence to substantiate that they would be robust enough to stand up to the members of the extended family.

[67] These concerns are shared by the guardian ad litem. At paragraph 5.166 of her report filed on 9 June 2008 she stated:

> "Given the interconnected nature of the family living – this raises concerns for me that within the context of kinship placement, it may not be possible to establish with veracity and clarity, family composition. This adds to my concern about who would be having contact with J, who will be assuming a care giving role and potential difficulties about responsibility/authority for J".

[68] Dr Daley is of the view that the Ms and indeed the whole extended family, do not need to accept the court findings about the circumstances of the death of C or indeed my conclusions on this part of the case as set out in paragraph 3 of this judgment. However he adds the vital rider that they must be able to behave in a responsible way with regard to risk management and support programmes. I do not believe the Ms, F, O, JK or the rest of the family accept there is any real need for risk management or supportive programmes and accordingly are unlikely to implement them effectively.

[69] In these circumstances it did not therefore surprise me that the Ms seem to be unaware of the extent of the problems in JK's life notwithstanding that they regard him as an appropriate backup. They seem to be unaware of the extent of his drinking and antisocial behaviour in circumstances where I consider they ought to have been extremely inquisitive for the sake of J. Just as they see no apparent risk to J in the behaviour of F and O, similarly they perceive no risk to J in the behaviour of JK or inadequacies in his capacity to provide backup.

[70] In short I do not accept that Mr & Mrs M understand the risks present to this child. They do not fully accept that any risk accrue will to him from F and O, they do not appreciate that F and O failed in their responsibilities to observe the pain and suffering that occurred to C, they do not appreciate the impact of their health problems (to which I will later advert) and they do not recognise the frailty of the support that would come from JK (again to which I will later advert).

[71] I am satisfied with the evidence given by Ms Faith that the literature reveals that when kinship care placements are appropriate the kinship carers must understand the risks presented to a child from the carers and that their understanding corresponds with the assessment of the Trust. I am not satisfied that this criterion is met in this instance. Whilst Dr Daley is correct to

note that kinship carers may often be older , poorer or even less healthy than the conventional adoptive parents, they must nonetheless be able to recognise the need to manage and control risks .

[72] A further troubling concern I have about the Ms is that they seem to be unaware of the difficulties that have arisen in the relationship between F and her current boyfriend. The social work report cites a number of important pieces of information obtained from the local Domestic Violence Officer concerning the relationship of F and her current boyfriend. In April 2007 F called the PSNI because she had been assaulted by him. Alcohol was involved. She refused to make a complaint. In May 2007 police responded to a call from F, saying G had assaulted her. F claimed to have taken an overdose of alcohol and sleeping tablets. Both were taken to Accident and Emergency. F again withdrew her complaint.

[73] In June 2007 F reported that her boyfriend had assaulted her by slapping her twice in the face and urinating on her leg. She reported a swollen hand. Again she withdrew her complaint.

[74] In September 2007 F telephoned the police to the effect that she and her boyfriend had had a verbal argument over a Sky viewing card. F shouted at the police that she shouldn't "call out as (her boyfriend) would knife himself and blame her".

[75] The boyfriend has been referred for a full assessment in relation to Probation Board Northern Ireland, Men Overcoming Domestic Violence. This has to be seen in the context of the earlier history in which it had been suggested that F had been the subject of violence by the child boyfriend W she was then living with.

[76] The Guardian ad litem dealt with this problem at paragraph 5.169 of her report when she said:

> 5.169. I am also concerned that Mr & Mrs M have told me that while they understand F has a capacity for volatility that she has matured. Mr & Mrs M provided very little information about F's relationship with (her current boyfriend) and JK said that he did not know him. I have said previously that I am concerned that (the current boyfriend) and F's relationship has been punctuated by aggressive outbursts that have come to the attention of the police. This does not indicate to me that F has matured and I continue to have concern that F, despite her assertiveness is a vulnerable young woman and the relationship she

> is involved in currently raises concern about the potential for aggressive incidents and volatility and highly charged emotional interchanges."

[77] I find it extremely concerning that Mr and Mrs M seemed uninquisitive about this history given that should J be given into their care, they will have to deal with F and her boyfriend. It is another example where I fear that Mr and Mrs M simply do not understand the possible risk to J that F and her relationships represent .

[78] The proposed backup to the Ms in the form of JK fits the same concerning pattern. For a young man of only 29 he has a very depressing history of drinking from an early age leading to admission to hospital with alcohol problems in 2001.

[79] On 7 June 2003 he had been arrested outside a bar for disorderly behaviour. He has been banned from that bar as the result of an unsavoury incident, which I believe to be a drunken one, in which he threw a stool and a glass at someone with whom he was having a dispute but in the event struck a bar person.

[80] On 22 May 2006 he had been involved in a drunken escapade outside a bar which led to him being charged with disorderly behaviour, resisting arrest and obstructing traffic.

[81] In November 2006 he had been admitted to hospital in France with what his General Practitioner believed to have been an incident connected with drink. He had also been involved in an earlier incident when a bus had driven over his foot again when he had drink taken.

[82] Although he denied it in evidence before me, I have no doubt that he told social workers during the assessment of him in 2008 that "he enjoys having a few beers during the day on a Saturday while the racing is on, about 10 x 330ml bottles". I found him to be less than candid when indicating to me the amount of drink that he consumes when he regularly attends football games in Scotland with a supporters club. I formed the clear impression watching this young man that he still drinks to excess and that the incidents which have punctuated his history are harbingers of future behaviour by him.

[83] I formed the conclusion that he is but one member of this network of family members who fail to see the risk that F and O present to J. He freely admitted in cross-examination that in his view neither of them represent any risk to J. He indicated that if J was returned to her, F could look after him perfectly well. He does not fully accept the nature of the circumstances in which C died. Hence he sees no risk whatsoever to J.

[84] As part of this family network, he told the Guardian ad Litem that he was not aware of any difficulties in the relationship between F and O, O and W, F's current boyfriend and F and between F and W. "He said he could not say that he had concerns about W and F's relationship at that time because he had not".

[85] I am satisfied that he was being disingenuous when he told the Guardian ad Litem that he thought F and W were 16 years of age. I am satisfied that he knew that they were both 14 and involved sexually with each other. He did visit their home every morning (at that time he was staying with Mr and Mrs M) but said he did not take an active role being involved in his own life.

[86] Regretfully I was very unimpressed with this young man .I was left with the clear impression that JK would not be an adequate backup for any inadequacies on the part of Mr and Mrs M .He certainly does not represent the robust backup carer which the social workers and experts in this case have properly indicated would be necessary for Mr and Mrs M.

[87] These concerns are in the context of circumstances where Mr & Mrs M are 60 and 58 respectively. That in itself would not be sufficient to deter me from a kinship assessment but it must be coupled with their health problems . J is now almost 3; he has been in foster care for 2 years and 7 months and will be obliged to forge new relationships with Mr and Mrs M. The health needs of Mr M in particular are a major matter of concern to me.

[88] The medical adviser of the Trust, Dr Bailey, in a report of 9 April 2008 recorded the following of Mr M in the summary:

> "Mr M is clinically obese: has essential hypertension: type II diabetes and is being treated for raised blood cholesterol. Thus there are four risk factors for ischemic heart disease and stroke. However he does not smoke. ... Mr M has arthritis of his lower limb joints, ankles and knees and proven degenerative disc disease as well as prolapsed discs (MRI in January 2008). Although he continues to walk and swim, there is evidence from the medication list that the pain continues to be troublesome and is likely to impact on his mobility and general mental wellbeing – there would appear to have been a deterioration over the intervening 22 months with an apparent height reduction of 5 cm. The extent of the back pain is such that he has been referred to a neurosurgeon. However pain is a very subjective matter. A

> simple comparison of the repeat medication list shows an increase in the number of repeat prescriptions issued from 2006 from eight to a total of fifteen although only thirteen have been prescribed since the start of 2008.
>
> ... The child to be placed with Mr M is currently 3 years of age and assuming he is like most other 3 year olds is likely to have boundless energy and be very dependent on others for many years to come in the activities of daily living ... This is likely to require a considerable amount of energy, stamina and almost certainly flexibility of joints to manage over the forthcoming years.

[89] So far as Mrs M is concerned, she is described as:

> "Clinically obese and appears to be being treated for hypertension and raised blood cholesterol. Thus there are three factors for ischemic heart disease and circulatory disorders eg stroke ... Mrs M has arthritis of her upper limb joints – hands, shoulders and experiences back pain which may well impact on her ability to assist the young child in her care with activities of daily living. If the addition of further medication for the management of the arthritis can be used as a gauge there is a suggestion that perhaps there has been an increase in the amount of pain experienced."

[90] I listened carefully to the evidence of Dr Moles the GP on behalf of the Ms. Certainly, at least in the longer term, she said nothing that I found at fundamental variance with the views of Dr Bailie.

[91] Given the combination of age and health problems, I accept the grave concerns expressed by both social workers in this matter as to the capacity of this couple to care for a child who is not yet 3 years of age. I therefore agree with the view of the Guardian ad litem expressed at paragraph 5.181 of her report where she says:

> "I had previously referred to the Trust medical officer's report which stated – `It would be my opinion that the impact of the combined medical conditions should be considered rather than independent one of the other'. With this in mind I

> am concerned that placing J in the care of the Ms would be to place him in the care of an older couple who both have health needs which could impact on the care and the potential stability that he receives."

[92] I am satisfied that Mr Dickson is currently aware of two couples who have been considered by the pre panel matching meeting. Both couples are in a position to adopt this child and have agreed to post adoption contact. As yet they do not know about the full background of this child but the adoption panel will consider the matter on 30 July 2008, looking for an introduction in August 2008. Mr Dickson also assured me that both families will meet the religious needs of this child being of the Protestant faith and are church goers.

[93] Before making a Care Order it is also necessary for me to afford the opportunity for the parties to address me on the question of contact. At the moment contact occurs three times per week namely Monday for 2 hours, Tuesday for 3 hours and Friday for 1 hour. I agree with Mr Dickson's proposals that it would be necessary to introduce a phased reduction if the care plan is to be implemented successfully. The present arrangement of twice per week for F and O and once for the extended family is simply too much for a child who will have to make a transition from the current primary foster carer to new carers. He cannot meet so many people so often and in any event it will help the family accommodate themselves to the changed circumstances involving J if I decide to make a Care Order. I agree with the care plan which is that contact would be reduced to one hour per week for F and O until the freeing proceedings were instituted with one hour for the extended family per month. In the event of an adoption taking place, the matter will have to be revisited although Mr Dickson was thinking in terms of contact three times per year.

[94] He recognised that any prospective adoptive family would have to take on board the need for ongoing contact with the current primary carer as well as the family. Any post adoption contact would have to be considered in light of the attitude of the birth family to any adoption that would be ordered by the court. I share these views.

[95] I arrive at these conclusions bearing in mind the point elicited by Ms McHugh, on behalf of O, from Mr Dickson that J does regard O as a significant attachment figure.

[96] I have therefore concluded that I should approve the Care Plan advocated by the Trust in this case, namely that adoption outside the family is the appropriate course to be followed in this case. My factual findings make it unnecessary to slavishly rehearse each subsection in article 3(3) of the 1995 Order at this point. Suffice to say that the physical, emotional and

educational needs of this boy, the harm he is at risk of suffering and the lack of capacity in his parents or members of his extended family to care for him, all point to a care order as appropriate for his best interests. I do not believe a supervision order or any other less draconian order would be adequate for his needs. Making a Care Order is manifestly better than making no order at all.

[97] I have considered the principles set out in paragraphs 48-51 of this judgment with reference to the Convention. I have determined that a care order is lawful, necessary and a proportionate response to a legitimate aim in this instance namely the best interests of this boy.

[98] I therefore make a Care Order in this case.