Neutral Citation: [2024] EWFC 153 **Case No: LS 22 C 50687**

IN THE FAMILY COURT **Leeds Family Court**

SITTING AT LEEDS **Westgate, Leeds**

Date: 16 February 2024

IN THE MATTER OF THE CHILDREN ACT 1989

AND IN THE MATTER OF: P and Q (Minors

Before : **Mr. W. J. Tyler KC, sitting as a Deputy High Court Judge**

- -

RE: P AND Q (MINORS) (NO. 2) (INADEQUATE LOCAL AUTHORITY ASSESSMENT)

Between :

KIRKLEES METROPOLITAN BOROUGH COUNCIL **Applicant**

- and -

(1) A MOTHER, M

(2) A FATHER, F

(3) P and (4) Q (Minors) **Respondents**

Hearing dates: 29 January and 5 & 6 February 2024
Judgment circulated in draft on 8 February 2024
Final judgment handed down on 16 February 2024

JUDGMENT

Hannah Bramley of counsel (instructed by the legal department) for the local authority

Huw Lippiatt of counsel (instructed by JWP Solicitors) for the mother, M

Semaab Shaikh of counsel (instructed by Nadat Solicitors) for the father, F

Guy Swiffen of counsel (instructed by Wilkinson Woodward Bearders) for the children, P and Q, through their Children's Guardian

Parties, Applications & the Purpose of this Hearing

1. I am concerned with the interests and future of two children, P, born in June 2020, so aged three years and eight months, and Q, born in January 2022, so just two years old. The children are represented by their Children's Guardian (hereinafter "the CG"), represented at this hearing by Guy Swiffen of Counsel.

2. P and Q are the children of M, their mother, born in 1998, so 25 years old, and F, their father, born in 1996, so 27 years old. M is represented at this hearing by Huw Lippiatt of Counsel, F by Semaab Shaikh of Counsel.

3. These proceedings are already depressingly aged. The applicant local authority, Kirklees Metropolitan Borough Council ("the LA") applied on 3 November 2022 for public law orders pursuant to Part IV of the Children Act 1989 (hereinafter "CA 1989") in relation to these children and also, in proceedings which were consolidated with these proceedings, in relation to their cousins in their maternal aunt's family. The LA is represented at this hearing by Hannah Bramley of Counsel.

4. On 5 January 2024, at an IRH, I listed this case before myself for a three-day final hearing. This was perhaps a rather unusual decision, given that listing a 'contested' final hearing flew in the face of (at the time) complete agreement between the parties as to the appropriate final outcome, with which unanimity I did not agree and to the conclusions emanating from which I did not feel able to give judicial imprimatur without hearing the evidence.

Precipitating Event

5. During the afternoon of Saturday 8 October 2022, M presented Q, then aged 9 months old, at A and E. The boggy swelling on the left-hand side of his head, which had prompted taking him, transpired to be a subgaleal haematoma overlying a branching left parietal skull fracture and with underlying subdural haematoma.

6. No explanation was given at the point of presentation which satisfied treating medics as plausibly explaining the injury. Given that Q's maternal aunt and uncle had looked after Q and P for a few hours the evening before presentation at hospital and in light of the inability to pinpoint exactly when the injury was likely to have occurred, the LA intervened, removed into extended family placements both P and Q but also the children of the aunt and uncle. Part IV proceedings were issued in relation to the children of both families, which were, for obvious reasons, consolidated.

Summary of the Proceedings

Issue of proceedings and case management

7. The LA issued its Part IV CA 1989 proceedings in relation to the children of both families on 3 November 2022.

8. The cases were appropriately case-managed. Given the seriousness of the issues, HHJ Hillier, the Designated Family Judge for West Yorkshire, directed expert medical instruction and the collation of material from the police and various medical institutions.

9. The local authority reduced its allegations to schedular form in the usual way, the parents responded and evidence was prepared on behalf of the parties, including assessment by the LA.

Initial parenting assessment

10. A parenting assessment was undertaken in relation to both couples by the social worker, *[being the same social worker to whom I referred in the fact-finding judgment, published as Re P & Q And Others (Minors) (No. 1) (Skull Fracture: Fact-Finding Hearing) [2023] EWFC 319, and referred to in that judgment, as in this judgment, as "SW"]*, who has been allocated since 10 October 2022. The assessment is dated 10 March 2023 and was signed off by Team Manager ("TM"). In relation to M and F, positive engagement was noted, good basic parenting was observed and healthy and positive relationships and attachments with P and Q were apparent. The assessment identified that the expert evidence clearly pointed to the likelihood of a non-accidental cause for the injuries and noted the parents' denial of this, effectively contending that somehow an unwitnessed accident must have befallen the non-ambulant nine-month-old. The single-paragraph *'Analysis'* highlighted the juxtaposition between the *'relatively positive'* parenting assessment, M and F showing good understanding of meeting basic needs, and the LA's *'primary concerns […] surrounding the lack of explanation as to how [Q] sustained the injury'* meaning that *'throughout this assessment professionals are no closer to understanding what actually occurred'*. The recommendation of the assessment was that *'due to the lack of explanation and understanding to how [Q] sustained the injury, the LA is of the view that final care plans cannot be determined for [P] and [Q]'*. While recognising that *'this is a single issue case of physical harm'*, the

assessment concluded with a recommendation that there needed to be fact-finding hearing to determine the cause of the serious injuries to Q.

Change in local authority's position

11. There followed, on 13 April 2023, just a month after the parenting assessment, a statement from SW which substantially repeated the contents of the assessment. However, in the section dealing with the s.1(3) CA 1989 welfare checklist factors, under the heading, *'Any harm the child has suffered or is at risk of suffering,'* the following was written:

> *'The harm that [Q] has experienced has been outlined above. [Q] sustained a skull fracture and this was deemed to be non-accidental either from a direct blow to [Q]'s head or due to lack of supervision. Professionals are no closer to understanding the cause of injury, therefore a finding of fact was initially considered. However, the Local Authority has been informed by a high court judgment from Mrs Justice Leiven* [sic] *dated 5th December 2022, which informed of a similar single-issue case where a child sustained a significant injury and parents had a positive parenting assessment. The judgment outlined that a finding of fact was not proportionate as it is unlikely that parents would accept the findings or that a 9 day finding of fact hearing would be proportionate so the children can know the 'truth'. Therefore, The Local Authority did not deem this plan to be appropriate as it would simply delay care planning for the children.*
>
> *Further, [F] and [M] have also had a positive parenting assessment and there have been no concerns identified around their ability to meet the needs of [P] and [Q]. It can also be highlighted that [F] and [M] will continue to receive support from Maternal Grandma, paternal grandparents and other family and friends, who will report of any safeguarding concerns to The Local Authority or the Police.*
>
> *When considering information, it can be highlighted that whilst there has been a positive parenting assessment in respect of [F] and [M], the risk to*

both [P] and [Q] remains, as professionals are no closer to understanding how the injury occurred. It has been recognised that this is a single issue case meaning that aside from the significant injury, there have been no other concerns. However, while this may be true the risk cannot be disregarded. Therefore, during the assessment process conversations were had with parents regarding appropriate supervision as Dr Elias Jones had noted that the injury may have been sustained through a 'blow to the head' or 'through lack of supervision'.

It has been considered that at times the children may be present in environments that may be chaotic due to the number of Maternal Cousins who get together when visiting Maternal Grandma. However, there have been conversations undertaken with both [F] and [M] to ensure proper supervision takes place following the proceedings. They have both shared that supervision of [P] and [Q] following the proceedings will be prioritised and shared that it is likely that they will not leave their children anywhere due to the injury [Q] has sustained.

When acknowledging this information, it can be highlighted that the Local Authority recognises that there may still be some risk to [P] and [Q] sustaining a significant injury as the cause of the injury is unknown, however it is felt that this is not proportionate reasoning for the children to remain Looked After. Both [F] and [M] have evidenced throughout these proceedings that they will willingly engage in any support and advice offered. In addition to this, there has also been a positive assessment of parents.

Therefore, the Local Authority is of the view that should parents continue to willingly engage with professionals and support then the risk of [P] and [Q] returning home can be appropriately managed under a Child in Need Plan with continued support from Maternal Grandma, paternal grandparents and other family and friends, who will report of any safeguarding concerns to the Local Authority or the Police.'

12. As well as indicating its intention to return all of the children to their respective parents' care, the LA, by application dated 18 April 2023, sought permission to withdraw the Part IV CA 1989 proceedings on the basis that any ongoing risk for any of the children, in both of the families, could adequately be dealt with by a Child in Need ("CIN" Plan). At a hearing before HHJ Hillier on 27 April 2023, the learned judge noted the LA's intention to begin to transition both sets of children from their extended family placements back to their parents' care, and that this was within the LA's discretion pursuant to its holding parental responsibility. However, in relation to the application to withdraw the underlying proceedings, a matter over which the court does hold jurisdiction, HHJ Hillier noted the *'very serious circumstances'* in which the proceedings were brought, clearly had in mind that a CIN plan's success entirely relies on the voluntary compliance with it by the parents of the children involved, and listed the application before her on 7 June 2023.

Further change in local authority's position

13. At that hearing on 7 June, HHJ Hillier indicated that she was concerned about *'the robustness and adequacy of the local authority's risk assessment'*. The learned judge pointed, in particular, to two further aspects of the respective couples' current circumstances which had not featured adequately in the assessment process. While I do not have a transcript of that hearing, it seems very likely to me that the judge was concerned about the speed with which the LA had so fundamentally changed its stance and absence of any real reasoning or intelligible assessment of risk. It seems from the order from that hearing that, on indicating her concerns, the judge stood the matter for advice to be given and instructions taken. The LA changed its stance again, returning to its position that there should be a fact-finding hearing. The

Children's Guardian ("the CG"), who had initially supported the LA's withdrawal application, also changed her mind. Clearly HHJ Hillier also considered that there should be adjudication of the relevant contested facts as she listed the case before me for a pre-hearing review on 21 June 2023 and a composite final hearing for five days beginning on 7 August 2023.

The pre-hearing review

14. At the pre-hearing review, I dealt with the usual case management issues, including the management of the expert evidence, and I stressed to the four parents then still involved that it was in everyone's interests for me to be given a genuine and truthful account of the incident – as there must have been some significant and memorable incident – which led to the fractured skull.

15. I was also concerned that careful thought was given to the various possible findings which could emanate from a case where the spectrum of findings ranged from pure accident, through negligent lack of supervision, to possible deliberate / inflicted injuries, and where I might identify an individual perpetrator, or two or more members of a (so-called) pool of possible perpetrators, possibly across two different families. I directed the LA to provide a full written opening, setting out with particularity how it put its case and how it will assess risk differently depending on the findings made.

The final / fact-finding hearing

16. In the event, I was not provided with any analysis as to how different findings would impact on the assessment of risk (or the appropriate calibration of a safe response to that risk). The updating social work statement simply included this:

> *'A plan has been considered by The Local Authority if findings are made, the Local Authority would look to wider familial support such as Maternal Grandmother, who has had a positive full connected persons assessment and has been approved as a foster carer to support the family to reduce the risk.*
>
> *[…]*
>
> *Conclusion/ Recommendation:*
>
> *Therefore, the recommendation is that as a result of a positive initial parenting assessment and also a positive addendum parenting assessment, should findings be made in regard to how [Q] sustained his injury, the Local Authority would consider at that point any further orders which may be required to safeguard the children and would work alongside the family support network to safeguard the children in their parents care.'*

17. The LA written opening, such as it was, contained this exposition of the LA's position:

> *'18.1 The local authority acknowledges that there are ongoing risks in respect of both sets of parents in the absence of any findings/conclusion of how [Q] sustained his injury. Its position however is that on balance, subject to any finding being made, when looking at the whole picture, including the parenting assessments, those risks can be managed at home for all five children.*
>
> *18.2 The local authority has considered all evidence filed to date, the engagement of the parents throughout proceedings and their willingness to work effectively with professionals.*
>
> *18.3 The final statement of [M] in respect of [Q] and [P] (10.07.23) updates the position from her statement of the 13th April 2023. It concludes as a result of a positive initial parenting assessment and also a positive addendum parenting assessment, should findings be made in regard to how [Q] sustained*

his injury, the local authority would consider at that point any further order which may be required to safeguard the children and would work alongside the family support network to safeguard the children in their parent's [sic] care.'

18. The CG's position statement for the composite final hearing in August agreed, in principle, with the LA's care planning, but indicated that there would need to be further risk assessment in the event that the court were to make a finding of infliction (i.e. deliberate, or non-accidental, perpetration), in particular against a single individual.

19. The social worker, SW, initially held to the LA line, when asked questions during the hearing, indicating that even with a finding of inflicted injury being made against an identified individual, the LA would not consider further risk assessment necessary. Reflecting on this position, however, she later agreed with the propositions put to her on behalf of the CG, first, that there was not, as at that point, a comprehensive analysis of risk, and secondly, that, after finding were made further assessment, in particular risk assessment, would be required.

Findings of Fact

20. In the event, the evidence, as it was laid out, explored and tested, enabled me to make fairly precise findings, as follows (and as summarised in the schedule to the order from that hearing):

1. *[Q] suffered a branching fracture of the left parietal bone of his skull, with an associated extensive haematoma within the subgaleal space and associated subdural bleeding.*
2. *[M] inflicted those injuries on [Q] either on Thursday 6th or Friday 7th October 2022 whilst he was in her sole care.*

3. *The court cannot say how the injuries were caused as no honest explanation has been provided.*
4. *When [Q] was injured, this was obvious to [M] and she deliberately and culpably did not seek medical attention and withheld the truth of what happened despite the catastrophic consequences for her and her family.*
5. *[The aunt] and [the uncle] did not and could not have caused the injuries to [Q].*

21. It was clear from and explicit within my judgment that I accepted the medical evidence from the jointly instructed experts, Dr Elias Jones, Consultant Paediatrician, and Dr Oates, Consultant Radiologist, that the injuries must have been caused by a significant traumatic event, comprising a fall onto a hard surface, the head striking a hard surface or a blow from an object or fist. It was also apparent from my judgment that I had considered and rejected various posited possible explanations, including an accidental fall he was said to have sustained at a hospital and a late-raised, non-witnessed possibility involving his then two-and-a-half-year-old sister and a heavy metal bowl.

22. Despite being asked to do so by the LA and the CG, I made no findings against F.

Proceedings after fact-finding

23. I dismissed the proceedings against the aunt and uncle in relation to their children.

24. I adjourned the instant proceedings to a Case Management Hearing to take place a few weeks later, directing responses from the parents to my judgment and findings and an assessment plan from the LA. The order includes this curiously, but accurately, worded recital:

> *'And upon the local authority through the social worker's evidence conceding that further assessment is required before the court can conclude the proceedings in relation to [Q] and [P] including but not limited to a further risk assessment.'*

25. An assessment plan was duly filed. At the CMH before me on 18 September 2024, evidence was timetabled through to an Issues Resolution Hearing / Early Final Hearing before me on 5 January 2024.

Issues resolution hearing

26. By the point of that hearing, the LA had undertaken its updated parenting assessment. This had been a joint piece of work between SW and an Advanced Practitioner *[whose identity has been redacted, hereinafter "SW-AP"]*. There was also another final statement from SW. The LA was, again, proposing that there was no need for any order, and that the proceedings should conclude on the basis of no order and a CIN plan. This was the third time that the LA had proposed that there need be no order, and that a CIN plan could adequately protect the children from the risk of harm.

27. I was presented by agreement across the board to this proposal. The parents, perhaps not surprisingly, agreed. More surprisingly, to my mind, so did the CG.

28. I was troubled by the proposal and, more perhaps even than the proposal, by the seemingly poor quality of the risk assessment undertaken by the LA (on which I will expand below) and, at that stage, supported by the CG. It seemed to me that, if the

poor quality of the written assessment and supporting statement was truly reflective of the absence of depth, rigour and thoroughness in the underlying work and analysis which had taken place, then I was unable to give my judicial blessing to the proposals. I adjourned the case – reluctantly given its age – to a three-day final hearing, at which the evidence would be heard. I indicated that I would ask my own questions in order to assess the quality of the assessments if no other party did so. I made it clear, in some detail, which aspects of the assessment, and which seeming omissions from the assessment, caused me particular anxiety.

This Hearing

29. The evening before this three-day hearing was due to begin in front of me, Mr Swiffen, on behalf of the CG, circulated a brief Position Statement. It included this:

> 3. *The Guardian has now received feedback from her legal team following the last hearing.*
>
> 4. *She recognises the quality and integrity of [SW-AP]'s assessment is pivotal when determining planning for the children, particularly given the serious nature of the injury suffered by [Q]. In the circumstances she wishes the assessment and its conclusions to be tested through cross examination on her behalf, so as to assist her in considering whether the children should be the subject of a more robust plan as well as them being made the subject of a public law order.*

The parenting and risk assessment

30. Accordingly, when the hearing began on the morning of Monday 29 January, the LA led the evidence of *[SW-AP]*, the parents' counsel had limited cross-examination (given that the parents accepted the conclusions), and Mr Swiffen subjected the evidence to the scrutiny through cross-examination which the CG had wholly appropriately sought. Notwithstanding Mr Swiffen's expertise and thoroughness, I had a fair number of questions of my own to put to *[SW-AP]*.

31. The concerns which I had with the assessment as written, and which I had explained to the parties at the hearing on 5 January were as follows:

    a. My clearly expressed finding of fact was that M had inflicted the injuries on Q, explicitly ruling out an unreported (or unknown) accident whether caused by a culpable lack of supervision or otherwise.

    b. As to M's motivation in so acting, or the factors predisposing or precipitating her so to act, I had said this:

> *'As for the motivation, again, I am in the dark due to not having been told the truth. I doubt that this mother would have acted in any premeditated or deliberately cruel way. It seems more consistent with what I know about her, that she was struggling, for whatever reason, more than she has let on, and that she has momentarily lost control. This is not a finding, more of a judicial musing, recognising that many parents, including otherwise very good parents, come before these courts having acted violently – but out of character* – in extremis*.'*

    c. The injuries, for whatever constellation of reasons M had been driven to inflict them, were of the utmost gravity. Bitter experience teaches the more seasoned among us that it seems largely a matter of chance whether the child who sustains

a serious inflicted head injury makes a full recovery (as Q, happily, seems to have done), suffers ongoing, often lifelong disability or impairment, or dies.

d. The fact of the assessment process created a period of 3 or so months in which the parents and other, wider family members could reflect on my judgment, my findings and my essential, underlying reasoning (which were, of course, well known to the parents, who have had the benefit of the highest quality representation throughout, and which were conveyed to other family members in whatever ways the assessors thought best). However, clear at the time of the assessment sessions and the assessment being written up, and, two or so months on, at the hearing, were the following facts:

- M continued entirely to deny the infliction of the injuries; she revived and somewhat embellished (compared to previous recounting) an account of Q falling at a hospital a day or so before the injuries were discovered, and she told, for the first time, of a supposed incident involving Q falling from a bed in the period leading up to the discovery of the injuries. Her acknowledgment of fault seemed to be entirely confined to an acknowledgment that something must have happened to Q while in her care, without her being aware of it or of its significance, and so greater vigilance and supervision in her parenting is the change which is needed.

- F, who was present throughout the fact-finding hearing (as it turned out to be), who heard all of the evidence, including from the expert medics, and who has had the benefit of expert legal advice after receipt of my judgment, continues absolutely to deny even the remote possibility that M could be responsible, in the sense of being in any way to blame, for his son's injuries.

- Each member of the wider family to whom the assessing social workers spoke maintains the same stance, that none of them can accept even the possibility of M being in any way to blame (beyond, possibly, a momentary lapse of supervision). They would prefer to believe (variously) that a non-ambulant 9-month-old could somehow have fallen under his own steam, or that his two-and-a-half-year-old sister could somehow have caused such an injury, than to contemplate that M could be responsible.

- Thus, the support network on whom total reliance would be placed to ensure Q's safety once both active supervision lapses and social work visits all but cease is comprised entirely of those who do not, at any level, accept the validity of the underlying risk (*viz.* a repetition of an act of serious physical violence to a young child).

e. The assessment seemed to proceed on the basis of encouraging M to explore further possible accidental or non-culpable explanations for the injuries.

f. The assessment seemed then to put these alternative explanations forward as somehow relevant to an assessment that ongoing risk is low, given that the parents had indicated that they would be more vigilant to prevent accidents from occurring.

g. Nowhere in the assessment is there any acknowledgment that – regardless of whatever other positive, or risk-mitigating factors may be present – the harm, against the risk of which any plan must act, is of potentially grave injury, even death.

h. Equally absent from the assessment is any analysis of the difficulties of safe rehabilitation in the context of a perpetrator of serious abuse in complete denial, and, as a potentially compounding feature, the impact on this of a protective network none of whom accepts the facts (as found) giving rise to the index risk.

32. Prompted, I imagine, by my having expressed at the IRH in January some provisional views about the quality of the assessment, *[SW-AP]* acknowledged, even in her evidence-in-chief, that her assessment contained some *'vulnerabilities'*. *[SW-AP]* acknowledged first that she could have given the parental relationship *'more consideration and thought'*, secondly, that she *'didn't really explore'* with M that, while she says that she accepts *'that the findings were made'*, she does not in fact accept the truth of those findings, and thirdly, that she could have undertaken greater exploration around the extended family, their acceptance of risk and what this means. Somewhat confusingly, while these admitted *'vulnerabilities'* seem on their face to represent substantive omissions from the process of assessment, when pressed by Mr Swiffen for the CG, *[SW-AP]* summarised her critique of her own work by saying that the assessment document *'could have been a lot more robust in terms of the write-up'*, with *'more detail given to the paragraphs'*. I sought several times to understand what, then, was meant by the notion of *'vulnerabilities'* in the assessment, but I remained throughout unable to discern if this was intended to describe: (a) a deficit or flaw in the process of assessment itself, (b) weakness or lack of thoroughness in the process of writing up the assessment, or (c) an identifiable risk factor in the household in which the children are living or in the network and plan intended to protect them.

33. Two aspects of *[SW-AP]*'s assessment and oral evidence were of particular concern to me.

34. The first was the near total absence of any real or meaningful assessment of the risk to the children. I would have expected the starting point of the analysis to be the confluence of two hugely important factors, first, that, by my finding, M inflicted an extremely serious injury, which could easily have been fatal, to her own nine-month-old baby, and second, that she continues absolutely to deny doing so. The combination of these two factors must equate to the ongoing existence of a real risk to the children of serious physical harm, a risk which is substantive but not exactly quantifiable as the denial prevents exploration of the triggers to the assault. Rather, *[SW-AP]*'s reasoning seemed to move immediately from identification of the injury and denial to exposition of the various positive factors which, in her opinion, all but eliminate any ongoing risk.

35. The second problem flowed from the first. Meaningful consideration of the actual risk would lead to an explicit acknowledgement that the danger against which the children must be protected is the repeated infliction on one or both of them by their mother of very serious physical injury. Only once the possible harm is identified, can thought be given to possible triggers, what appropriate monitoring or supervision might look like, which positive factors could properly be said to lessen the likelihood of repetition, etcetera. However, the non-identification of the index risk led *[SW-AP]* to spend what seems to have been a significant part of the assessment indulging M in propounding alternative non-culpable mechanisms for the injury. One of these was an embellished version of an event which I rejected at the fact-finding hearing as being a possible cause of the injuries. The second was an account of a fall from a

bed which was not raised at the fact-finding hearing, M now saying that she was advised by a friend not to raise it.

36. *[SW-AP]* was at pains to emphasise on several occasions in her oral evidence that she absolutely accepted and was working at all times within the findings. It is difficult, though, to reconcile this with the prominence given in the assessment to exploring supposed protective factors or other issues which flow from M's account rather than from the findings. For example, the fact that both parents are said to be hypervigilant to prevent any further accident arising from poor supervision of the children seemed to be relied on by *[SW-AP]* as a future protective factor. Of course, given my finding was of an inflicted injury, future vigilant supervision is all but irrelevant to possible recurrence. In the same vein, *[SW-AP]* explored with M and presented in her assessment possible reasons for M's not having earlier volunteered the new account, given *'the implications that her not sharing this information may have on her'*. I was left with the clear impression that, having asked M about the circumstances in which Q's injuries were inflicted and not been given the true, now long supressed, account, *[SW-AP]* proceeded on the basis of M's accounts, as though they were accurate.

37. A further deficit in the assessment process flows from the assessors' treatment of an extremely sensitive issue which arose during the process. During one of the assessment sessions, M told *[SW-AP]* and SW for the first time that she had been the victim of sexual abuse as a child. No doubt it was extremely difficult for M to raise and discuss this, as it was for her to hear the issue discussed during the hearing. The relevance of the issue to the assessment derives from the fact that M described her abuser as having been a male person within her family and that, as she grew older

and recognised that her experiences constituted sexual abuse, she informed a cousin, who raised it within the family, but that no protective steps were taken by the family, rather she was told by family members not to tell anyone the information *'due to the impact that this would have on the family'*. It seems that M complied with the exhortation *'not [to] share anything and to remain quiet'* right up until she felt able to raise her experiences with the social workers last autumn. Perhaps because of the sensitivity of the issue, which M understandably did not want disseminating more widely than absolutely necessary, or perhaps due to oversight, it seems that *[SW-AP]* did not appreciate until it was put to her in cross-examination that it is highly relevant to the assessment of risk in this case that there is evidence to suggest that some of the family members whose absolute commitment to putting the children's interests first in the event of any future concerns have previously done exactly the opposite when confronted with a choice between child protection and preservation of reputation. From the scant information available to me, I am not in a position to say more than *'there is evidence to suggest'* that this is the case. It is difficult to understand, however, why *[SW-AP]* did not immediately identify this as a matter of importance which demanded closer investigation.

38. The assessment focussed in some detail on the positive factors, of which there are certainly a number. Among these are:

a. The quality of the parents' basic care is beyond question.

b. There is a very warm relationship between parents and children.

c. There has been no repetition of harm or even any single professional concern for the children's welfare or about the M and F's parenting during the long life of these proceedings.

d. The parents have been welcoming, have complied with everything asked of them and have engaged with all professionals and all assessments.

e. There are few, if any, of the risk factors or *'red flags'* identified by Peter Jackson J in *Re BR (Proof of Facts)* [2015] EWFC 41.

f. The parental relationship seems to be on a stronger and healthier footing than had been the case around the time of Q's injuries.

g. F has recently changed his working hours, and so is more present in the family home than had been the case, and is reported as being more 'hands-on' with the children more supportive to M, practically and emotionally, than hitherto.

The social worker's evidence

39. The allocated social worker, SW, gave evidence. She too accepted that the parenting assessment had its *'vulnerabilities'*. However, like *[SW-AP]*, she did not seem to accept that these flaws in any way undermined the assessment's conclusions. In particular, it does not seem to her relevant to the confidence which can safely be reposed in the support network of extended family members that none of them in any way accepts my findings, as *'they are still prepared to put the children first; that was made very clear'*.

40. If the case were to conclude now, with no statutory order, but an agreement that a Child in Need plan would be put in place, she, SW, would undertake the customary Child and Family Assessment in order *'to identify any support needs'*.

41. SW pointed out a number of times that the family had fully engaged with her over the fifteen months of her involvement. She did not seem meaningfully to accept my

suggestion that the engagement has not been full, open and honest in circumstances in which M continues to deny the pivotal finding against her. Nor did SW seem to accept that the combination of that denial and the corollary that professionals have no way of understanding the triggers for the assault should lead to concern that there remains a substantive but unquantifiable risk of really serious, possibly catastrophic, harm.

42. SW was able to confirm that none of the family members spoken to in any way accept even the possibility that M inflicted Q's injuries. She was unable to explain why she and *[SW-AP]* had not spoken to the maternal aunt and uncle who were, until the end of the fact-finding hearing, parties to these proceedings, who heard all of the evidence, and had the benefit of expert legal advice throughout. Of all of the family members, it seems logical to suppose that these two are the more likely to accept the validity of my findings, and so represent important component parts of an ongoing protection plan.

43. SW was asked about the passage in her statement suggesting that she too seemed to have been working on the basis that the new explanations put forward by M might explain the injuries, despite my findings. Despite her protestations that she absolutely accepted the court's findings, it is difficult to read her statement in any other way. The *'risk factors'* are analysed in that statement just two short paragraphs as follows:

> *'There have been findings made against [M] of inflicted injury following written evidence and verbal evidence provided to the Court.*
>
> *Despite a 5-day finding of fact hearing and the further assessment period, the Local Authority still do not have a confirmed explanation for the injury [Q]*

sustained in October 2022. There have been other explanations highlighted by [M], however these are possible explanations.'

The issue of risk is briefly touched on again under the s.1(3) CA 1989 factor, *'Any harm that the child has suffered of is at risk of suffering'*:

[Q] sustained a significant injury October 2022 and despite the finding of fact hearing, the explanation for this remains unknown. However, findings of inflicted injury have been found against [M].

Therefore, as a result of this unknown, it has been considered that there remains some risk to the children. However, both the risk and protective factors have been considered earlier in this statement. Therefore, I respectfully refer The Court to this part of the statement to avoid repetition.'

44. SW relies significantly on the fact that when P suffered a witnessed, accidental injury over a weekend during proceedings, the parents were proactive in bringing this to her attention. From this, she infers that any future concerns will equally be reported. It was not until she was asked questions by Mr Swiffen that she contemplated the difference between open and frank reporting of innocent incidents and the deliberate suppression of culpable and consequential incidents

'Q: The mother tried to cover it up when [Q] had a fractured skull. How are you confident that she wouldn't do that again?

A: I guess that risk remains.

Q: Where in your statement has that risk been considered?

A: It hasn't been.

Q: Is that a significant gap [in your assessment]?

A: Yes.'

45. I am told by SW that the Independent Reviewing Officer, *[name redacted]*, has indicated her agreement with the LA's actions, plans and proposals, and that, most recently, in her absence from work, her manager, *[name redacted]*, is also in agreement, and has *'identified that the level of oversight and intervention in proposed Child in Need Plans that have been circulated is appropriate to meet [the children's] needs'.*

46. SW repeatedly referred to the LA's plan (of no order and CIN plan) to be *'proportionate'*. I concluded that by this she really meant *'least interventionist'*, as, until I explored the issue with her, it was not clear to me that she had ever truly considered what it is to which the plan was *'proportionate'*, i.e. the harm against which the proposed intervention is designed to protect, measured with reference to the gravity of that harm and the likelihood of its occurrence.

The parents' evidence

47. The parents gave only brief oral evidence at this hearing.

48. From M's evidence, it was clear that she continues to deny the truth of the findings, and she was frank with me when I asked her in terms: we should not expect anything else from her by way of truthful explanation for Q's injuries. It was equally clear that she is desperate for her children to remain in her care and will – in all other ways – cooperate in any way asked of her. Mindful of the dangers of judicial attempts at assessment of a person's mental state from their demeanour in the witness box, everything I saw confirmed the descriptions elsewhere in the evidence, that M is finding these proceedings, the ongoing scrutiny and the current high-level supervision of her time with her children hugely stressful.

49. F's presentation was concerning to me. While he is clearly devoted and as intent as M on maintaining the integrity of his family unit, he mirrors M's complete denial with a near-total absence of curiosity into how his infant son sustained life-threatening injuries. His refusal to believe that M played any culpable part in their infliction was not backed up by any reasonable alternative hypothesis. He could not explain why he had not discussed with M in any depth the facts surrounding the injuries or my findings about them:

> *'I guess I should have, but I didn't; that's my failure. I should have tried to get to the bottom of it, but from my understanding, I still can't see [M] doing something like this.'*

50. Given how the very striking, almost jaw-dropping, casualness of F's approach to an incident which could easily have cost his son his life, and which may have been (on my finding, was) caused abusively, it is surprising and not a little concerning that neither of the assessing social workers have considered this a potential weakness in their protection plan.

The Children's Guardian

51. The CG gave brief evidence. Overnight between the second and third days of the hearing, she had issued a Part 25 application for the instruction of an independent social worker ('ISW') to undertake a risk assessment and of a psychologist to undertake an assessment of both parents.

52. The CG indicated that, while she had not initially been troubled by the written assessment, she had formed the view during the exploration of that assessment in oral evidence that it was significantly flawed. In particular, she considered that the assessment simply does not match the court's findings.

53. Given that she and the court had been assured that a senior social worker in the local authority (*[SW-AP]*) would undertake the assessment, and that the product of that task had been so wholly inadequate, the CG was of the view that there would have to be outsourcing to an ISW for a thorough and robust 'Resolutions-style' assessment to be undertaken.

54. The requirement for the psychological assessment derived, the CG said, from the need to understand the likely triggers to M's having inflicted the injuries, her support needs to help her maintain emotional regulation, and her therapeutic needs. While she had initially contemplated only M being assessed, F's evidence, and in particular the striking lack of curiosity into his son's injuries, caused her to reconsider and to recommend an assessment of both parents, F's ability to protect having been put squarely in issue by his evidence.

55. Troubled by the imposition of yet more delay, the CG thought this necessary in order to achieve a sound evidence base from which to make final decisions.

The Parties' Positions

56. Ms Bramley for the LA urges me to conclude these proceedings now, with no statutory order, placing confidence in the LA's ability to protect these children through the Child in Need process. The assessments proposed by the CG, she said, were not necessary in light of the fact that the social worker would be conducting a Child and Family Assessment under the CIN process. The social worker, I was told, even after the evidence had been heard *'considers that the chances of [M] injuring [Q] again are remote'*, and, as this is a single-issue case, with no other features of

concern, such as substance misuse or neglect, it can and should conclude now without orders.

57. Mr Lippiatt, realistically, did not seek to defend the LA's risk assessment, conceding that it was flawed, even *'not fit for purpose'*. He asked me, on M's behalf, to end the proceedings if at all possible, indicating that M would prefer their earlier conclusion, with a Supervision Order, or even a Care Order (with placement at home), than to adjourn further. That said, M, I am told, will cooperate with whatever is directed, including further assessments.

58. Ms Shaikh's submissions on F's behalf were similarly restrained and realistic. F would prefer that the proceedings end sooner rather than later. Ms Shaikh made the point that it is beyond the parents' control that the LA's assessments should be as they are. With my understanding of the strengths and other positive factors in this family, and reassured by a now significant period with no professional concerns, Ms Shaikh submits that I can conclude the proceedings now, perhaps seeking an assurance from the LA that they commission similar assessments outside proceedings to those suggested by the CG within the proceedings.

59. Mr Swiffen, for the CG, acknowledged that any court would instinctively want to bring long-running proceedings to a conclusion, but cautioned against it. In short, he contended that the assessments have simply failed to *'fit the findings'*, and thus that it would be dangerous to use them to inform final welfare planning. Of particular concern to the CG is the complete denial by not only the perpetrator of serious abuse, but also by the other adult who would be present in the home and by every member of the protective network, and particularly when this is considered in combination

with evidence to suggest that members of the family have *'closed ranks'* before in order to prevent investigation of possible abuse.

Discussion

60. This has been a troubling case. At its heart are two young children, one of whom, as a nine-month-old baby, sustained a very significant injury, which could easily have been fatal, and which was inflicted on him by his primary care-giver. While there are many positive factors, and while these may in combination provide meaningful protection, sight cannot be lost of the very significant danger from which the court is bound to ensure those children are protected.

61. The actions of this local authority have, in my judgment, repeatedly fallen below acceptable standards.

62. In my fact-finding judgment, I recorded my consternation about the immediate actions of the LA when Q was first admitted to hospital and the likelihood of inflicted head injury was first raised:

> *'[An] issue which has concerned me is Children's Services' immediate response to the injuries when notified of them by the hospital. I took this social worker through a host of references in the medical bundle, to medics expressing real concern that the Local Authority was not imposing any supervision on the parents' access to [Q] in hospital and notwithstanding (a) the unexplained, very serious, and possibly inflicted injury, and (b) the fact that an infant admission to hospital in no way replicates supervision. For example, the social work manager was told in terms by the hospital that there would only be one overnight check on [Q], who was otherwise in the care of the parents who may – it was not, of course, then known – have caused a very serious injury. The medics, wholly professionally, expressed their unease.*

> *One nurse took it upon herself to do "spot checks" which would not otherwise have taken place, such was her consternation. I am baffled by the Local Authority's decision making in this crucial period and particularly in relation to access to and non-supervision of time with [Q].'*

63. I asked for an explanation, and was told, in a statement from a Team Manager, that *'there is learning from what happened'* in relation to the need to ensure effective supervision of children when there is suspected non-accidental injury.

64. Proceedings were then issued. The case took a fairly usual course until the LA suddenly diverted from its stated position that it would need to seek to decide how Q had come by his injuries in order to make decisions relating to the children in the two affected families. I have asked for assistance in relation to the decision-making process, but have not received it. It seems, however, as though the volte face was caused by a misreading of the judgment of Lieven J in *Derbyshire CC v AA, BA, X and others* [2022] EWHC 3404 (Fam). In that case, a baby had sustained rib fractures. The child remained in its parents' care, subject to family supervision. By the point of the decision of Lieven J, a significant period of time had passed, without issue. Lieven J declined to direct a fact-finding hearing, which would have taken some nine days, as, the judge concluded, the factual conclusions of such a hearing would be unlikely to have any impact on placement or welfare decisions. Recognising that no hearing meant that the s.31 CA 1989 threshold criteria would not be satisfied, Lieven J considered that it was disproportionate to hold an expensive nine-day hearing simply to enable the making of a Supervision Order when the evidence suggested that the family would voluntarily comply with the CIN plan which was the alternative. Notably, Lieven J said this:

> *'There is no evidence here to support any finding of deliberately inflicted injury. The overwhelming probability is that if the court did find a non-accidental injury, it would be a single act of significantly inappropriate handling of a very young baby, rather than any deliberate act or any course of conduct.'*

Lieven J also made it clear that there will, of course, be cases in which fact-finding will be necessary:

> *'Understanding the facts and circumstances of an alleged non-accidental injury is often critical to the determination of future risk. But here I do not find that is necessary, and even if I made all the findings it would be unlikely to have any material impact on the ultimate orders for X.'*

65. It seems, in particular from the way in which this is described in the relevant social work statement, as though the LA considered Lieven J's judgment as somehow representing authority for the proposition that in a single-issue case where parenting appears otherwise to be appropriate, the course adopted in that case will always be the correct course. Self-evidently, Lieven J's judgment is not authority for that proposition; rather it is a case-specific example of the faithful application of the binding principles found in the cases of *Oxfordshire County Council v DP, RS and BS* [2005] EWHC 1593 (Fam), [2005] 2 FLR 1031 and *Re H-D-H* [2021] EWCA Civ 1192, [2022] 1 FLR 454 with the additional reminder from the Master of the Rolls at paragraph 66 of the judgment of *K v K* [2022] EWCA Civ 468, [2022] 2 FLR 1064.

66. This case was very different to the *Derbyshire* case. In particular, the injuries, on any view, were far more serious than being the product of *'significantly inappropriate handling of a very young baby'*. Also of real relevance was the fact

that in the current case, without fact-finding it would not even be known in which of two households the injuries may have occurred.

67. HHJ Hillier, as described above, questioned the LA's approach, causing its renewed acceptance that a fact-finding hearing would be appropriate.

68. I set out this part of the proceedings, even though I was not the judge at the time, as it seems to me that it was from this point that the LA's handling of the case started to be characterised by the lack of appropriate rigour.

69. In my fact-finding judgment, I noted the LA's non-delivery of the protective measures it had assured the court would be immediately provided on return of the children:

> *'[A]t the point that the court was asked to sanction the return of all of the children to the care of the two sets of parents without any explanation for the injuries or any fact finding, safety plans were put before the court which involved frequent social work visiting. I cannot say for sure, but it may well have been by a fairly narrow margin, that HHJ Hillier sanctioned the return of the children at that point in the process. […] On any view, this was a risky rehabilitation, the Local Authority being entirely ignorant, at that point, of the true cause of potentially life-threatening injuries to a child. It is shocking then that the Local Authority did not deliver on its promised visiting of the children until the Children's Guardian flagged up their failure.'*

70. I asked for an explanation for this, and was told, in the same statement from the Team Manager, that the reason for the visits not having taken place was, effectively a combination of *'the allocated social worker […] having restrictions on her working abilities and not being able to undertake home visits'*, and *'annual leave and capacity'*.

71. The stance taken by the LA at the *'composite final hearing'* was initially that regardless of my findings, and even if they included a finding of inflicted injury by a named individual, no further risk or other assessment would be needed, the case could simply conclude, preferable with no orders. It was difficult to understand how such a position could be taken. The LA eventually changed its stance, recognising the self-evident fact that further assessment would be necessary, depending on my findings, and in particular if there were a finding of infliction against a named person.

72. There was just such a finding, and it is against that backdrop that the assessment and statements described above were prepared.

73. In my judgment, the process of assessment has been very significantly flawed, for all the reasons set out above. At times it has felt as though a reverse process has been underway, reasoning backwards from an assumed conclusion. I have been particularly struck by the absence of anything resembling robust risk analysis. Parts of the assessment read almost as though there had been no definitive conclusion to the fact-finding process. The perpetrator of a serious injury seems to have been indulged in putting forward further non-culpable explanations, entirely contrary to my findings, and then time has been spent considering what measures could protect against repetition of those fictional explanations.

74. Denial of serious findings is not necessarily a bar to the safe reunification of a child with a parent. However, the fact of denial, and in particular the fact of denial not only by the perpetrator but also by all members of a supposed protective network, makes the need for robust, coherent and focussed risk-assessment the greater. In this case, such risk assessment as has taken place has not fulfilled any of these criteria.

75. I have anxiously considered whether, notwithstanding the obvious deficits in the assessment process, I could proceed effectively to assess the risk myself and to use my conclusions to put in place whatever order I thought necessary and require the imposition of any protective measures required. I have come to the reluctant conclusion that I am not in a position to do so – that is not my function. In order to decide what risk these children face, and how it can safely be protected against, there needs to be the sort of assessment which I had hoped would emanate from my directions after the fact-finding hearing. Without such assessment, I am not in a position to decide whether the LA is correct to assert that the children can appropriately be protected without a Part IV order (although I currently struggle to see how this could be so), or, if a public law order is required, whether this case falls into the exceptional category contemplated by Sir Andrew McFarlane P in *Re JW (A Child)* [2023] EWCA Civ 944, [2024] Fam. 25 as justifying the making of a Care Order while children continue to live at home.

Decision

76. In those circumstances – and all too conscious of the dangers of delay in general and the real and deleterious impact it will have on this mother in particular – I have no choice but to postpone my final decision-making in this case.

77. Bearing fully in mind the requirement that any expert evidence I commission must be *'necessary'* in order to enable me fairly to conclude these proceedings – I am driven to accede to the application by the CG for the instruction of an Independent Social Worker. The ISW proposed has expertise in Resolutions-type assessment. This will include robust work not only with the parents, but also with the extended

family. There will have to be careful and sensitive consideration given to how to handle the information recently given by M of childhood sexual abuse and its reporting having been closed down by the family, but it is not for me to dictate how that should take place.

78. I am also minded to grant the application to instruct a psychologist to undertake an assessment of the parents. It will be evident from the foregoing that an understanding of M's psychological make-up, her ability to regulate her emotions and likely triggers to dysregulated behaviour are important. In light of her recent reports of childhood abuse, the need for that assessment and consideration of appropriate therapeutic intervention is heightened. Given the centrality to my ultimate decision-making of the parental relationship and F's ability to protect, in light of not only his denial but also his current marked lack of curiosity, it is necessary that he too forms part of the assessment.

79. I am asked by the CG to direct that the LA should bear the cost of the ISW assessment. That cost is £2,700 plus travel. While I bear very much in mind the huge financial pressures on local authorities, I consider that it should pay for the assessment. The need arises solely because of the deficits in its own assessment, and I note both that there has been plenty of encouragement from the Bench in this case to consider with appropriate rigour the clearly relevant issues and that, I am told, the assessments, statements and approach in general adopted by the LA has been the subject of full and high-level approval within the service. The cost of the psychologist will be split between the parties in the usual way.

80. I am conscious that my decision will represent a very real disappointment to the parents, and I note that they are not responsible for the quality of the LA's

assessments in this case. I very much hope that the case will conclude with the children remaining in their parents' care. It stands to reason from all I have said above that risks can far more accurately be assessed and so more safely be protected against if M finds herself able to tell the court what actually happened to Q and why. Equally, if F – albeit belatedly – is able to adopt an appropriately questioning stance, he is likely to be better able to protect his children from future harm.