Childrens Court
New South Wales

Medium Neutral Citation:	**Department of Family and Community Services (NSW) and the Bell-Collins Children [2014] NSWChC 5**
Hearing Dates:	18 and 19 June 2014 at Woy Woy
Decision Date:	09/10/2014
Jurisdiction:	Care and protection
Before:	Judge Peter Johnstone, President of the Children's Court of New South Wales
Decision:	There is no realistic possibility of restoration of the children to the parents; placement with the maternal great-grandparents would give rise to unacceptable risk of harm; the permanency planning has been appropriately and adequately addressed; parental responsibility for the children allocated to the Minister until age 18
Catchwords:	CHILDREN - Care and Protection - realistic possibility of restoration - permanent placement in out-of-home care - contact - permanency planning - allocation of parental responsibility
Legislation Cited:	Children and Young Persons (Care and Protection Act) 1998
Cases Cited:	Briginshaw v Briginshaw [1938] HCA 34 Director-General of Department of Community Services; Re "Sophie" [2008] NSWCA 250 DFaCS re Oscar [2013] ChC 1 In the matter of Campbell [2011] NSWSC 761 Johnson v Page [2007] Fam CA 1235 M v M [1988] HCA Re: Tracey [2011] NSWCA 43
Category:	Principal judgment
Parties:	Secretary of the Department of Family and Community Services (DFaCS) The Children The Mother and the Father
Representation:	Mr D Menser, solicitor, for the Secretary Mr D Kennard, solicitor, for the Children Mr D Chapman, solicitor, for the Parents
File Number(s):	2013/102 - 103
Publication Restriction:	Pseudonyms have been used in order to anonymise the children and parties

JUDGMENT

The nature of the proceedings and the principal issues

1 These proceedings concern two very young children, Timothy (2) and Stephen (1), who were removed from their parents and assumed into care on 18 July 2013 pursuant to the *Children and Young Persons (Care and Protection) Act* 1998 (the *Care Act*) due to serious injuries sustained by them.

2 The children have since been in foster care, under the interim parental responsibility of the Minister.

3 The mother is Kylie Bell (now aged 20). Her mother is Rose, the daughter of Mr and Mrs Dark (the maternal great-grandparents).

4 The father is Chris Collins (now aged 22).

5 The proceedings are brought by the Secretary of the Department of Family and Community Services (DFaCS) under

the *Care Act*. Decisions in the proceedings are to be made consistently with the objects, provisions and principles provided for in that Act and with the United Nations Convention on the Rights of the Child 1989 (CROC).

6 The Secretary seeks final Care orders in respect of the children and approval from the Court of the permanency planning proposed for them, as set out in Care Plans put before the Court: s 83(7). The Secretary has made an assessment that there is no realistic possibility of restoration of the children to their parents: s 83(2). The Secretary proposes that the children be placed in long-term out-of-home care with the current carers until the age of 18: s 78A; and that all aspects of parental responsibility for them be allocated to the Minister: s 79.

7 The Secretary proposes contact for the children with their parents for a minimum of 6 occasions per year, to be supervised by a delegate of the Minister.

8 The parents oppose the proposed permanency planning and seek restoration of the children to them.

9 Alternatively, the parents seek permanent placement of the children with the maternal great-grandparents.

10 The maternal great-grandparents sought unsuccessfully to be joined to the proceedings as parties. They did, however, file affidavits, were present at the final hearing, and gave evidence. They have also provided separate, independent written submissions. It is not suggested that they have not been given adequate opportunity to be heard: s 87(1). They seek placement of the children into their care in the event that the children are not restored to the parents.

11 The Secretary opposes a placement with the maternal great-grandparents and has also rejected the possibility of them supervising contact between the children and the parents.

12 The primary issue for determination is, therefore, whether there is a realistic possibility of restoration of the children to the parents.

13 If not, the next issue for determination is whether the children should be placed with the maternal great-grandparents in preference to a permanent long-term out-of-home care placement with the current carers.

14 There are secondary issues, depending upon the outcome of the determination of the issues of restoration and placement, surrounding the nature and amount of contact between the children and others significant to them, including the parents and the maternal great-grandparents.

Some factual background

15 The mother, Kylie Bell, spent most of her life growing up in the home of her grandparents, Mr and Mrs Dark. The material before me about Kylie Bell's childhood is sketchy, but it appears that they played the major role in her upbringing, although for part of this time her mother, Rose, the Dark's eldest daughter, also resided in the house with a de facto partner.

16 Kylie Bell was diagnosed with a bi-polar condition at the age of 13, for which she continues to have treatment and medication. There was a suggestion that she also suffered from schizophrenia, but she has not been treated for such a condition and the suggestion may be discounted.

17 She became known to Community Services due to a turbulent period after she ran away at or about the age of 13 and lived for a period with an older man who had a criminal history and abused drugs and alcohol, and who physically and verbally abused her. There is also a history of her having a miscarriage due to being punched by him in the stomach. Kylie Bell was hospitalised in 2009 following a heroin overdose.

18 She returned to live with her grandparents at their home and commenced recovery from the traumas of that period. There is no evidence of any further drug use or alcohol abuse since that time.

19 In 2010 when she was about 16, Kylie Bell commenced a relationship with the father, Chris Collins, who was then 18. How and where they met is not recorded, but they began living together in Mr and Mrs Dark's home and shortly thereafter Mr and Mrs Dark moved out into a self-contained granny flat above the garage, next to the house.

20 I could find very little in the evidence about Chris Collins, his history, his family or his upbringing.

21 There is only one record of any untoward history, being an episode when he was beaten up at a party, the details of which are not recorded, but which gave rise to feelings of anxiety, particularly about leaving home. He states that he has managed this anxiety better since commencing his relationship with Kylie Bell. He described himself as having obsessive compulsive behaviours, but has no diagnosable psychological condition, and does not drink or smoke.

22 The relationship between Kylie Bell and Chris Collins appears to have been loving and supportive, unattended by any domestic violence or other major disharmony.

23 Kylie Bell became pregnant in 2011 and the child Timothy was born on 5 January 2012. There were no reported incidents concerning the parents or their care for Timothy for the most part of 2012.

24 In the second half of 2012 Kylie Bell became pregnant again. It appears that she ceased taking the medication for her bi-polar condition, as a precaution against possible harm to the unborn baby, but began to experience severe mood swings.

25 On 1 December 2012 there was an incident in which Kylie Bell shaved off all her hair. She described this as a coping mechanism.

26 On 4 December 2012 Kylie Bell had a consultation with her general practitioner, Dr R Metcalfe, in which she told the doctor she had been feeling flat for several weeks leading up to the head shaving incident, when she was "feeling a bit numb". She also told Dr Metcalfe she was worried about having a blackout when she might become aggressive. She declined an offer of mental health service supports, stating that she had sufficient support from her older sister, who was living in the house, her mother, who was visiting the home on a frequent basis, and from Mrs Dark, who was available daily.

27 The idea of her partner, Chris Collins, becoming her full-time carer was discussed. Subsequently, Chris Collims officially became the full-time Centrelink approved carer for Kylie Bell; and from 18 January 2013 Community Services allocated a caseworker to work with the family.

28 On 6 February 2013 the couple's second son, Stephen, was born, delivered by elective C section, following which mother and baby returned home from hospital after a few days.

29 About a month after he was born, however, it was discovered that Stephen had been born without a thyroid. The hospital referred the baby to a specialist consultant paediatrician, Dr Adam Buckmaster, owing to a newborn screen which showed a raised TSH. (A TSH test measures the amount of thyroid stimulating hormone in the blood. TSH is produced by the pituitary gland. It tells the thyroid gland to make and release thyroid hormones into the blood.)

30 Dr Buckmaster saw the baby, Stephen, on 20 March 2013, and arranged for various other investigations and tests, which revealed the absence of the thyroid gland. This condition was addressed on an ongoing basis with thyroxine replacement therapy. This treatment resulted in the baby becoming clinically and biochemically "euthyroid", meaning normal thyroid functioning with an appropriate range of TSH. Stephen's prognosis was for normal functioning subject to daily medication.

31 In the meantime, the Community Services caseworker was monitoring Stephen's progress at home. She noted nothing of concern, apart from a report in late February from the father indicating he had issues with anxiety.

32 Over the next few months, however, the caseworker conducted a number of safety assessments in relation to Stephen, determining that he was not at risk of any significant harm.

33 The parents claim that Stephen suffered injuries in early May 2013 when the father had a fall while holding the baby, the detail of which is varyingly described, and the exact date of which is also unclear.

34 The caseworker paid a visit to the home on 7 May 2013, when she was shown minor facial injuries including cuts to the nose and a graze under Stephen's left eye. She was told that the injuries were caused in a fall on the previous day, 6 May 2013, which occurred when the father tripped over some clothes while holding Stephen on his right shoulder. Her file note (Exhibit D) records:

> "Stephen had an injury on his nose and under his left eye. The nose had two cuts approximately an inch long each on the right side of his nose and slightly left of centre. They were not deep and looked clean. There was a small graze under Stephen's left eye. There was no bruising or swelling and Stephen's breathing did not appear to be affected, he was breathing normally...
>
> The father said he had fallen over some clothes that were at the end of the bed when he was returning Stephen to his cot yesterday morning. He was carrying Stephen in an upright position on his right shoulder. Stephen had his dummy in his mouth. As he felt himself fall he brought out his left hand to take the impact of the fall and lifted his elbow of his right arm to help keep Stephen in his arm...Stephen bumped against his arm a couple of times as the father rebounded on the bed from the fall. Stephen began to cry and there was blood on his nose. Chris Collins and Kylie Bell said they put gauze on his nose and settled him down again...They decided not to take Stephen to the GP as the cuts were not deep, his breathing was fine and there was no bruising or swelling. Stephen is seeing specialist Professor Buckmaster tomorrow and Dr Metcalfe, as Kylie Bell is requesting to be medicated as her sleep patterns are getting worse.

Stephen's injuries were consistent with the father's explanation of how the injury occurred..."

35 Later, in various affidavits, the father suggested that he in fact tripped over the leg of the bassinette, that the incident occurred on 7 May 2013, and that he was holding Stephen in his left arm on his left shoulder, and he gave increasingly specific, but inconsistent detail about the occurrence.

36 The mother recorded that she was in the shower at the time of this incident. The father came into the bathroom carrying Stephen, who had blood coming from his nose and a cut under his eye. The father told her he had tripped over the bassinette. The mother noticed fresh red blood on the baby's dummy.

37 There was no suggestion, at the time, that the incident had resulted in anything other than the cuts to the nose and the graze to the cheek. No bruising or tenderness was observed to other parts of the baby's body.

38 The next day, 8 May 2013, Chris Collins and Kylie Bell took Stephen to see Dr Buckmaster for a routine follow-up in relation to the baby's thyroid condition. The father told the doctor about the incident in which he tripped over the bassinette, when Stephen's dummy came out, scratching him.

39 The doctor examined the baby and noted a superficial skin loss over the bridge of the nose and a small sub-conjunctival haemorrhage, but no bruising anywhere. The doctor concluded that the physical examination was in keeping with the event described.

40 But the father told the doctor that he felt Stephen's right leg wasn't quite moving as much as he'd noticed over the last couple of weeks. On examination, Dr Buckmaster found the baby had a full range of movement of the leg, with full abduction, no focal tenderness, no bruising, lower limb reflexes brisk bilaterally and equal, and the tone equal and symmetrical. Nonetheless, the doctor considered that there did seem to be a bit of reduced movement "on that side", being the right leg, and arranged an X-ray. There was no indication of any need for other tests, such as a rib X-ray or a skull X-ray.

41 The leg X-ray was not undertaken until 15 May 2013, but in any event it revealed no abnormality in the right leg (Exhibit 3).

42 On 26 June Dr Buckmaster reviewed Stephen and found him to be a healthy and happy boy, who was growing well and developing nicely. He continued to be euthyroid both clinically and biochemically. He did not observe any injuries to Stephen at that examination.

43 At an unspecified date towards the end of June 2013, the older child, Timothy, suffered a black eye. The mother stated that she woke up one morning and discovered the black eye. Timothy was a "climber" and she believes the black eye occurred when he tried to climb out of his cot. She also stated that at about this time Timothy's eczema was playing up, resulting in grazes to his cheek and chin.

44 On 5 July 2013 the parents took Stephen to the Medical Centre where he had routine vaccinations, when injections were administered into the upper part of his right leg. The baby started to cry and his leg was tender to touch.

45 The father claims that there were two incidents in early July 2013 that involved Timothy falling on Stephen. It was first suggested the date of these incidents was 5 July 2013, but the father revised this in a later affidavit to 7 July 2013, which accords with the mother's version of events and the date specified by her in her affidavit, and which distances the incidents from the date of Stephen's vaccinations.

46 Again, the detail of the incidents is increasingly specific but varyingly described in subsequent affidavits made by the father.

47 It was claimed that in the first incident, which occurred in the kitchen, Timothy fell backwards onto Stephen, onto his lower torso, causing Stephen to cry. The father said that later the same day he saw Timothy fall face forward directly onto the lower waist/upper leg area of Stephen, who immediately screamed out and started to cry again. In a later affidavit he added that this occurred while holding a stuffed toy.

48 The father later asserted, in a subsequent affidavit, that the two incidents occurred within a short space of time, in the evening, in the living room.

49 The mother stated that on 7 July 2013 Stephen was still upset when his nappy was being changed, and that she observed him favouring his right leg. She went to the gym. On her return, the father told her that Timothy had fallen on Stephen, who was more upset than usual.

50 On 12 July 2013, the parents took Stephen to see Dr George at the Medical Centre citing continuing discomfort in his right leg. The father told the doctor the baby was crying every time his right leg was touched. Dr George examined Stephen and observed swelling and tenderness in his right hip and knee. He forthwith referred the baby to the Emergency Department at the District Hospital for "urgent assessment and screening for non-accidental injuries." He even telephoned a doctor in the Emergency Department to inform him of the referral and about his "concerns" concerning the baby.

51 Later that day both children were admitted to the District Hospital. It was noted that Stephen had bruises to the left thigh, hip, knee, elbow and shoulder. Timothy had a black eye and linear bruises to the back. The boys were examined by the paediatrician on call, Dr D Shorter, a consultant paediatrician. He noted that Stephen presented with reduced spontaneous movement in his right leg. A radiograph identified a "spiral" fracture of the mid-shaft of the femur, an injury usually associated with a high energy twisting force of the leg.

52 Dr Shorter described this as a particularly unusual fracture in a 5 month old boy, it being an injury that required a high degree of external pressure, usually from twisting involving considerable force.

53 Generally a pivot point is involved, the implication being that some part of the body is held while either the upper or the lower limb is forcibly rotated.

54 As for Timothy, he presented at the hospital with a black eye and grazes to his cheek and chin. Dr Shorter found numerous bruises on his body and skin lesions that were unusual, including 3 linear and well-circumscribed areas of damage to the mid-back.

55 A few days later, a full skeletal survey was carried out on Stephen as a result of which it was discovered that he had suffered two further unusual fractures.

56 First, a skull fracture involving the right parietal bone was detected.

57 The second discovery was an older fracture to one of Stephen's left posterior ribs, with callus formation.

58 Dr Shorter stated:

> "Whenever unusual fractures are found in children we arrange investigations looking for evidence of unusual bone conditions associated with bone weakness or brittleness. Investigations in Stephen (serum calcium, parathyroid hormone, vitamin D, procalcitonin and alkaline phosphatise) were all normal....Stephen's functional thyroid hormone level was slightly above the normal range...I would not expect this minor anomaly in his thyroid function to cause any significant bone damage..."

59 Dr Shorter was concerned that, taken together, the injuries to the two boys were inconsistent with the explanations offered by the parents, and it was his suspicion that the injuries were non-accidental.

60 A JIRT investigation ensued, involving interviews of both parents.

61 The children were assumed into care and removed from the care of their parents on 18 July 2013.

62 These proceedings were commenced in the Children's Court on 23 July 2013, pursuant to which the Secretary now seeks final Care orders.

The applicable legal framework

63 The objects of the *Care Act*, as set out in s 8, are to provide:

(a) that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them, and

(b) that all institutions, services and facilities responsible for the care and protection of children and young persons provide an environment for them that is free of violence and exploitation and provide services that foster their health, developmental needs, spirituality, self-respect and dignity, and

(c) that appropriate assistance is rendered to parents and other persons responsible for children and young persons in the performance of their child-rearing responsibilities in order to promote a safe and nurturing environment.

64 The provisions of the United Nations Convention on the Rights of the Child 1989 (CROC) are capable of being relevant to the exercise of discretions under the *Care Act*: *Re Tracey* [2011] NSWCA 43. Most, if not all, of the provisions in CROC have been incorporated into or are reflected in the *Care Act*. The circumstances in *Re Tracey* were unusual

and unique. The parties in the present matter made no submissions based on the Convention. There was, therefore, no suggestion that this Court needed to take into account any provision in CROC such that there was some different requirement, some additional principle, or some gloss that required the Court to have particular regard to in determining this case, such that I was required to go beyond the *Care Act* and the case law interpreting that Act and the relevant provisions, or in the consideration of the permanency planning proposed.

65 The *Care Act* is to be administered under the principle that the safety, welfare, and well-being of the children are paramount (the paramount concern): s 9(1) of the *Care Act*.

66 Subject to that, the *Care Act* sets out other, particular principles to be applied in the administration of the Act. These are set out in ss 9(2), 10, 11, 12 and 13. Principles of potential relevance to the present matter include the following. I paraphrase the provisions concerned:

- Any action to be taken to protect the children from harm must be the least intrusive intervention in the life of the children and their family that is consistent with the paramount concern to protect them from harm and promote their development: s 9(2)(c).

- That any out-of-home care arrangements are to be made in a timely manner, to ensure the provision of a safe, nurturing, stable, and secure environment, recognising the children's circumstances and that, the younger the age of the child, the greater the need for early decisions to be made s 9(2)(e).

67 Care and protection proceedings are not to be conducted in an adversarial manner, and are to be conducted with as little formality and legal technicality and form as the circumstances permit: s 93.

68 The Court is not bound by the rules of evidence, unless it so determines, and in this matter it did not make such a determination.

69 The standard of proof is on the balance of probabilities: s 93(4) of the *Care Act*. The High Court decision in *Briginshaw v Briginshaw* [1938] HCA 34 is relevant in determining whether the burden of proof, on the balance of probabilities, has been achieved: *Director-General of Department of Community Services; Re "Sophie"* [2008] NSWCA 250.

70 It is now well settled law that in all decisions under the *Care Act* 1998 involving the paramount concern for the safety, welfare and well-being of a child, including issues of removal, restoration, contact, custody and placement, the proper test to be applied is that of "unacceptable risk to the child": *M v M* [1988] HCA 68 at [25]. The High Court held that in applying the unacceptable risk of harm test it is necessary to determine firstly whether a risk of harm exists and, secondly, the magnitude of that risk.

71 Whether there is an unacceptable risk of harm to the child is to be assessed from the accumulation of factors proved according to the relevant civil standard: see *Johnson v Page* [2007] Fam CA 1235.

72 The Secretary, will not fail to satisfy the burden of proof on the balance of probabilities simply because hypotheses cannot be excluded which, although consistent with innocence, are highly improbable: *Director-General of Department of Community Services; Re "Sophie"* [2008] NSWCA 250 at [67] - [68], per Sackville AJA. His Honour said in that decision:

"The reasoning process I have outlined involves an error of law. The primary Judge, although stating the principles governing the burden of proof correctly did not apply them correctly. It was appropriate to take into account the gravity of the allegation of sexual misconduct made against the father, as required by s 140(2) of the Evidence Act.

It was not appropriate to find that the Director-General had failed to satisfy the burden of proof on the balance of probabilities simply because his Honour could not exclude a hypothesis that, although consistent with innocence, was highly improbable. (Emphasis added)

To approach the fact-finding task in that way was to apply a standard of proof higher than the balance of probabilities, even taking into account the gravity of the allegation made against the father": [67].

"As the High Court pointed out in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* at 171, statements to the effect that clear and cogent proof is necessary where a serious allegation is made are not directed to the standard of proof to be applied, but merely reflect the conventional perception that members of society do not ordinarily engage in serious misconduct and that, accordingly, a finding of such misconduct should not be made lightly. In the end, however, as Ipp JA observed in *Dolman v Palmer* at [47], the enquiry is simply whether the allegation has been proved on the balance

of probabilities": [68].

73 I turn now to discuss the concept of "a realistic possibility of restoration".

74 The phrase involves an important threshold construct, which informs the permanency planning that is to be undertaken in respect of any child that has been removed or assumed into Care.

75 It is for the Secretary to make the assessment: s 83(1). It is for the Court to decide whether to accept that assessment: s 83(5). If the Court does not accept the assessment it may direct the Secretary to prepare a different permanency plan: s 83(6).

76 Regard must be had to two matters:

a) the circumstances of the child or young person, and

b) the evidence, if any, that the child or young person's parents are likely to be able to satisfactorily address the issues that have led to the removal of the child or young person from their care.

77 There is no statutory definition of the phrase 'realistic possibility of restoration'. And, until recently, there had been no judicial consideration of what it entailed. The leading superior court decision in respect of the phrase "realistic possibility of restoration" is *In the matter of Campbell* [2011] NSWSC 761, a decision by Justice Slattery.

78 I have discussed the relevant principles in a number of judgments including *DFaCS re Oscar* [2013] ChC 1 at [29] - [34]. The principles may be summarised as follows:

- A possibility is something less than a probability; that is, something that it is likely to happen. A possibility is something that may or may not happen. That said, it must be something that is not impossible.

- The concept of realistic possibility of restoration is not to be confused with the mere hope that a parent's situation may improve.

- The possibility must be 'realistic', that is, it must be real or practical. The possibility must not be fanciful, sentimental or idealistic, or based upon 'unlikely hopes for the future'. It needs to be 'sensible' and 'commonsensical'.

- It is at the time of the determination that the Court must make the assessment. It must be a realistic possibility at that time, not merely a future possibility.

- It is going too far to read into the expression a requirement that a parent must always at the time of hearing have demonstrated participation in a program with some significant "runs on the board": *In the matter of Campbell* [2011] NSWSC 761 at [56].

- There are two limbs to the requirements for assessing whether there is a realistic possibility of restoration. The first requires a consideration of the circumstances of the child or young person. The second requires a consideration of whether the parent(s) are likely to be able to satisfactorily address the issues that have led to the removal of the child or young person from their care.

- The determination must be undertaken in the context of the totality of the *Care Act*, in particular the objects set out in s 8 and other principles to be applied in its administration, including the notion of unacceptable risk of harm.

79 Having made the assessment as to restoration, the Secretary is then required to address the permanency planning for the child: s 78. The permanency plan is then placed before the Children's Court for its consideration: s 83(2) and s 83(3). Permanency planning means the making of a plan that aims to provide a child with a stable, preferably permanent, placement that offers long-term security and meets their needs.

80 Permanency planning must:

(a) have regard, in particular, to the principle that if a child is placed in out-of-home care, arrangements should be made, in a timely manner, to ensure the provision of a safe, nurturing, stable and secure environment, recognising the

child's circumstances and that, the younger the age of the child, the greater the need for early decisions to be made in relation to a permanent placement s 9(2)(e), and

(b) meet the needs of the child: s 78A(1)(b), and

(c) avoid the instability and uncertainty arising through a succession of different placements or temporary care arrangements: s 78A(1)(c).

81 The permanency plan will generally consist of any Care Plan that has been prepared by the Secretary or on his or her behalf, together with details of other matters about which the Court is required to be satisfied: s 80. It may also include other documents, such as undertakings to be given to the Court by a parent or a proposed carer.

82 The plan must set out the proposed allocation of parental responsibility, the kind of placement proposed and how it relates in general terms to permanency planning, proposed arrangements for contact between the child and his or her parents, relatives, friends and other persons of significance, the services that need to be provided to the child or young person and the agency designated to supervise the placement in out-of-home care.

83 The permanency plan need not provide details as to the exact placement but must provide sufficient detail to enable the Court to have a reasonably clear understanding of the plan: s 83(7A).

84 In addition to setting out the kind of placement proposed, the permanency planning must set out the allocation of parental responsibility.

85 The term parental responsibility means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children: s 3.

86 The Court must not make an order allocating parental responsibility unless it has given particular consideration to the principle in s 9(2)(c) of the *Care Act* and is satisfied that any other order would be insufficient to meet the needs of the child(ren): s 79(3).

87 The principle in s 9(2)(c) of the *Care Act* is:

"In deciding what action it is necessary to take (whether by legal or administrative process) in order to protect a child or young person from harm, the course to be followed must be the least intrusive intervention in the life of the child or young person and his or her family that is consistent with the paramount concern to protect the child or young person from harm and promote the child's or young person's development."

The parents' explanations for the injuries to the children

88 The parents have continuously and consistently denied deliberately causing the injuries sustained by the children.

89 They have at various times proffered a variety of suggested explanations for the injuries to their children.

90 During the course of the JIRT investigation it was suggested by the father that the leg injury to Stephen could have resulted from Timothy falling on him in July 2013. The skull fracture could have been caused by Timothy head-butting him when trying to give him a kiss. The rib fracture could have been caused by the hypothyroidism, or during the birth by C section; the bruises from rough play with Timothy, or when trying to roll over, or from the injections. Timothy's bruising was a result of him being an active kid wanting to explore his environment.

91 The mother told the JIRT investigators that Stephen's leg could have been injured by the GP, Dr George, when he bent the leg up into a "lotus position". The skull fractures and bruises must have been caused by Timothy. The rib fracture could have been caused by the C section. Timothy's bruises were a result of him being an active kid and a climber, and the other marks on his body were due to eczema, and scratching.

92 Other, subsequent explanations have included the possibility that Stephen's injuries could have been caused when the father fell after tripping on the leg of the bassinette while carrying the baby on one of his shoulders on 6 or 7 May 2013, or by Dr Buckmaster when he examined the baby on 8 May 2013, or were a result of hypothyroidism

93 In the final written submissions, the parents appear to be blaming the fall on 6 or 7 May 2013 for the skull and rib fractures suffered by Stephen and suggest that the spiral fracture to his right leg was caused when Timothy fell on Stephen on the evening of 7 July 2013 (at p 27).

The evidence of Dr Moran

94 The parents retained and qualified Dr Kieran Moran, an experienced and highly regarded consultant paediatrician, to

provide an independent expert opinion in the proceedings. He was provided with a large amount of material by the solicitor for the parents, Mr D Chapman, and additional material by the independent legal representative for the children, Mr D Kennard. Specific questions were posed for his consideration, which he addressed in a written report dated 11 April 2014 (Exhibit 5).

95 The doctor turned first to consider the postulation that the skull and rib fractures suffered by Stephen occurred during the father's fall on 6 or 7 May 2013. He carefully analysed the discrepancies in the various versions of the incident and then, assuming the father's version that involved him holding the baby on his right shoulder with his right arm was correct, gave the following carefully qualified expression of opinion:

> "My opinion is that such a scenario could cause a skull fracture such as the one seen in this case...I think it would be an unlikely outcome but it would not be possible to say it could not occur. Usually, a linear parietal skull fracture occurs after impact with a broad, flat surface. However, I can't rule out that impact against the bony shoulder, even though it is padded with muscle, might cause enough force to result in a fracture.
>
> The rib fracture is more difficult to account for. Normally, inflicted rib fractures in infants are caused by compression, as happens when the chest is encircled by both hands and compressed.
>
> In this case the single fracture is postero-laterally placed (more towards the side of the chest, away from the spine), and is more likely to be due to direct impact from an external force, such as when a child hits an object, or is hit by an object, with force..
>
> From the description of the fall I can't see how the child's chest came into contact with any object. Consequently, I don't think we have a convincing story from the fall to explain the rib fracture."

96 Dr Moran goes on to exclude the C section birth as an explanation for the rib injury.

97 Dr Moran then turned to consider the spiral fracture of Stephen's femur, and the postulation that the cause had been the occasion(s) on which Timothy fell on him. Again, he discussed the evidence surrounding the incidents, and concluded:

> "Stephen had a spiral fracture of the junction of the upper/middle 1/3rd of the right femur. The mechanism of production of such a fracture is a twisting one, and twisting with considerable force, even in a 5 month old.
>
> I can't discount a twisting mechanism causing the undisplaced spiral fracture of the femur could occur from the events described, even though it would be unusual.
>
> I can also understand that it's difficult to be certain about whether a child has a fracture when the fracture is undisplaced and in a baby who is not independently ambulant.
>
> However, it seems that 5 days is a long time to wait when an infant seems to be in pain, has swelling and loss of function of the limb...However, in mitigation, the effects of the vaccination appear to have clouded thinking on the family's part and this is understandable."

98 The doctor went on to discount hypothyroidism as having any bearing on the baby's propensity to fracture.

99 As to the bruising to Stephen, Dr Moran was not able to postulate an exact mechanism of injury for any of the bruising, but stated that their significance should not be underestimated in a child of his age in the absence of a good explanation: "Such bruising is often a sentinel for more severe injuries, such as fractures and internal injury".

100 Turning to Timothy, Dr Moran again carefully analysed the evidence as to the explanations relied upon by the parents and expressed a guarded view about his bruises, and the linear marks on his back, concluding as follows:

> "In summary, the explanations given...do not seem adequate to me to explain most of the bruising seen on Timothy and this raises the possibility that they may be inflicted."

101 Dr Moran was required to attend the hearing for cross-examination. The hearing being at Woy Woy, I allowed his evidence to be given by telephone.

102 As it turned out, the solicitor for the parents had sent a video to the doctor with certain re-enactments involving movements by Stephen, with Timothy falling on him, which, it was postulated, could have contributed to the fracture of his femur (Exhibit 7). This was not dealt with in his written report, and the DVD was only recently sent to the doctor. The solicitor had given no notice of his intention to use this material at the hearing, in my view unfairly. Nevertheless, the doctor had viewed the video, and had even gone to the trouble of consulting various orthopaedic specialists. Opinion on the question was divided, and ultimately the parents derived no evidentiary benefit in their case from the video.

103 Dr Moran was asked about the thyroid condition as a contributing factor to the fractures and he told the Court he had

discussed this issue with endocrinologist colleagues, who all said the baby's thyroid condition could have nothing to do with his propensity to suffer fractures, and that there was no credible literature to support the proposition.

104 He was also cross-examined about the rib fractures and skull fractures, but confirmed his view that the mechanisms postulated by the parents for those injuries, whilst not impossible, were unlikely to have caused them.

105 Overall, I found Dr Moran to be a most impressive witness. He was thorough, he was logical and in my view, objective. He made concessions where appropriate, but his overall view remained one of scepticism about the likelihood of the scenarios put to him as being causative of the injuries sustained by the children, in particular Stephen. His opinions were tested, but unshaken in cross-examination, when if anything he was more forceful in his overall view and cynicism as to the proffered explanations.

The other medical evidence

106 For the sake of completeness, I turn briefly to discuss the evidence of the other medical witnesses, lest it be suggested that the parents could derive any comfort from their evidence.

107 Dr Buckmaster, in summary, discounted Stephen's thyroid condition as having any causative role in the fractures he suffered. He also discounted the possibility of the fall on 6 or 7 May 2013 described by the father as having any causative role in the baby's skull fracture, there being nothing resulting from his thorough examination on 18 May 2013 to give any indication of such an injury. He was also categorical in his view that as at that date, Stephen was not suffering from the spiral fracture to the femur discovered later, in July 2013, although he was unable to exclude the possibility that the rib fracture had occurred by that date, because a fractured rib could be present without any external symptomatology to indicate it. He doubted, however, that the mechanism for the rib fracture was that proffered by the parents.

108 Dr Shorter was similarly dismissive of the parents' explanations as being likely causes of Stephen's injuries.

109 Finally, Dr George disputed the proposition that he had rotated Stephen's leg in the extreme manner described by the parents, or that his examination on 12 July 2013 in any way contributed to the injuries discovered. Mr Chapman, the solicitor for the parents, even put to the doctor that he had held the baby's leg and twisted it. The doctor clearly rebutted this proposition, stating that the baby was screaming with pain and to have moved the leg in the way suggested, or even to check for a full range of movement, was far too risky. Rather, he was so suspicious of the injury, given its unusual nature, and his scepticism about the explanation given by the father as to the cause, that he immediately referred the child to the Emergency Department of the hospital, and even rang the doctor there to voice his concerns.

The submissions

110 The Secretary submitted that the children experienced non-accidental injuries while in the care of the parents absent any suitable explanation. In the circumstances the children would continue to be at an unacceptable risk of harm if restored to their parents.

111 The submissions for the parents sought to advance a proposition that because the explanations proffered by the parents for the children's injuries had not been excluded as possibilities, the Secretary had failed to "rebut" the explanations given by the father, who it was submitted, was an impressive witness (at p 27).

112 The independent legal representative for the children submitted that the Court must accept the Secretary's assessment that there is no realistic possibly of restoration because, in the absence of a viable explanation for the injuries sustained to the children whilst in the exclusive care of the parents, the parents were unable to demonstrate how they have addressed the issues that led to the children being assumed into care. "Simply put, if injuries cannot be explained then any children in the care of the parents are at risk of injury because without knowing the cause of the injuries there is no way to mitigate the risk."

The parents

113 As the independent legal representative for the children submitted, the parents could have conducted a case in which they accepted that the conduct (either through an act or an omission) of one or both parents was a causative factor in the injuries sustained by their children, but that they have implemented strategies to ameliorate or mitigate the risk of any future recurrence. As such, the Court could be confident that the causative conduct was unlikely to recur and the children's safety could be reasonably assured, such that restoration would not pose an unacceptable risk of harm to

them.

114 But this was not the case run by the parents. Rather, the parents did not accept that their conduct was a factor in any of the injuries suffered by the children that was suggestive of any future risk of harm.

115 As the independent legal representative submitted, the mother's position was that that she does not know how Stephen sustained his injuries. Her evidence was that she was not present, either because she was out of the home or because she was in the shower, on the two critical occasions when the father suggests the injuries were sustained. She knows that she did not cause the injuries, and accepts the father's explanation. As to Timothy, the mother's evidence was that his injuries were either a result of his eczema or were self inflicted due to his energetic behaviour.

116 The father's position was, as the independent legal representative submitted, that he does not know how the injuries were caused, but that he was not responsible through an act of intent. The mother was not responsible for the injuries and, therefore, the only possible explanation for the injuries is that:

"On 7 May 2013 he tripped and fell whilst carrying Stephen and in the process of that fall Stephen sustained a fractured skull, a broken rib and other minor injuries including a cut to the nose and under the eye. No bruising resulted from this incident;

In the alternative, the skull fracture is the result of Timothy head-butting Stephen when attempting to give him a kiss;

Stephen could be particularly susceptible to broken bones as a result of hypothyroidism which affects bone density and that the fractures to the skull and ribs should be considered as secondary to this medical condition;

In early July 2014 Timothy fell on Stephen two times, whereby Stephen sustained the injury to his femur.

The father notes the leg troubled Stephen over the next few days but no bruising or swelling was observed. The child was displaying symptoms similar to the symptoms he had displayed earlier in the year following his inoculations;

In the alternative, the injury may have been sustained on 12 July 2014 when Dr George twisted Stephen's leg in the process of examining him;

In the alternative the broken femur could have been the result of Stephen suffering from brittle bones or a lack of bone density arising from his endocrinological condition or the lack of a thyroid gland."

117 The Secretary formally conceded on the record that this matter is not about the mother's mental health. That is, in the absence of the injuries to the children, the mother's mental health and other matters that may impact on the capacity of both parents to parent are not sufficient to ground a finding that there is no realistic possibility of restoration to the parents.

118 There were, however, a number of troubling aspects about the mother's history, and the evidence of her mood swings when she failed to take her medication. Her evidence about eczema being the likely cause of Timothy's injuries was tendentious, and her refusal to make any concession about Dr Moran's conclusions was unsatisfactory.

119 The father, for his part, was a most unimpressive witness, whose evidence was inconsistent in many important respects, having given varying dates and differing accounts of the critical incidents, tailored progressively in an attempt to accommodate the medical evidence as it emerged.

120 He was similarly dismissive of the medical evidence, in particular the evidence that his son's thyroid condition could not have contributed to his injuries. I was also disturbed by the attempts to lay blame upon Dr Buckmaster and Dr George for his son's injuries.

Findings and conclusions in respect of the children's injuries

121 I turn to consider the appropriate findings and conclusions in respect of the children's injuries, and the cause or causes of those injuries.

122 I am comfortably satisfied that neither Dr Buckmaster nor Dr George caused or in any way contributed to or exacerbated Stephen's injuries.

123 Similarly, the uncontradicted medical evidence refutes the suggestion that Stephen's injuries could be attributed to hypothyroidism or some other genetic bone condition leading to bone brittleness.

124 Taken on their own the bruises to the two boys and the other minor injuries might well be reasonably explained away by the history of boisterous activity. But I am comfortably satisfied that Timothy's eczema played no role in the injuries

observed on his body at the hospital on 12 July 2013.

125 Each of the fractures sustained by Stephen required the application of considerable external force. Each was to a different part of the body and was the type of injury that was unusual in the case of a baby of that age.

126 So far as the fractured skull is concerned, I am comfortably satisfied that it did not occur in the alleged fall by the father on 6 or 7 May 2013. If it had, there would have been signs observable by the caseworker on 7 May 2013 and by Dr Buckmaster in his examination of the baby on 8 May 2013. The evidence of Dr Moran that the fracture was an unlikely outcome of the episode described by the father, even accepting his amended version of it, leads to the conclusion that more probably than not, that episode does not adequately or satisfactorily explain that injury. The idea that the skull fracture might have been caused by Timothy head-butting him is particularly tendentious. The possibility was raised as a last resort, and never put to any of the medical witnesses. There was, therefore no independent support for this as a potential mechanism for the injury.

127 I am comfortably satisfied that the fracture to Stephen's skull was caused by some mechanism other than the explanations proffered by the parents, such that it remains unexplained.

128 So far as the spiral fracture to Stephen's leg is concerned, having regard to the expert evidence as to the necessary mechanism and the sort of force required for such an injury, and the medical opinion that it was extremely unlikely to have been caused by his older brother falling on him, the only appropriate conclusion is that more probably than not, that mechanism does not adequately or satisfactorily explain that injury.

129 I am comfortably satisfied that the spiral fracture to Stephen's femur was caused by some mechanism other than the explanation proffered by the parents, such that it remains unexplained.

130 Taken alone, the rib fracture sustained by Stephen, which was separate but older than the other fractures, might not admit of a finding. But having regard to the medical evidence that such an injury to a baby's ribs, given their malleable nature and the force required for a fracture, and that the usual mechanism for such an injury would involve squeezing, I have concluded that more probably than not the father's fall on 6 or 7 May 2013 does not adequately or satisfactorily explain that injury.

131 I am comfortably satisfied that the rib fracture suffered by Stephen was caused by some mechanism other than the explanation proffered by the parents, such that it remains unexplained.

132 It is not necessary to identify the actual perpetrator of the injuries, or to establish the precise mechanisms for their occurrence. It is sufficient to find, as I do in the present case, that the only possible perpetrators were the mother or the father: *M v M* [1998] HCA 88. For these reasons, I find that more probably than not each of the injuries suffered by Stephen and Timothy was caused intentionally by one or other of them, or both.

Is there a realistic possibility of restoration to the parents?

133 It is clear, having regard to the conclusions I have reached, and the findings I have made, that restoration of these children to their parents would give rise to an unacceptable risk of harm to them.

134 As the independent legal representative submitted, any strategies identified by the parents cannot possibly ameliorate or mitigate the risk because, if the Court is unable to accept the parent's explanations of the injuries, then the Court cannot assess whether any future risk is acceptable or unacceptable: "Simply put, if injuries cannot be explained then any children in the care of the parents are at risk because without knowing the cause of the injuries there is no way to mitigate the risk".

135 In these circumstances, the parents are not likely to be able to satisfactorily address the issues that led to the removal of the children from their care.

136 Likewise, the circumstances of the children are such that it is not in their best interest to be restored to these parents unless and until the risk posed to their future safety is appropriately addressed, by identification and a fully informed and transparent assessment.

137 Until that occurs any possibility of restoration will remain fanciful and sentimental.

138 I am comfortably satisfied that there is in the present circumstance no realistic possibility of restoration of these children to their parents, or to either of them.

139 For these reasons, I accept the assessment of the Secretary, as set out in the permanency planning, that there is no

realistic possibility of restoration of the children to the parents.

Placement

140 Given that there is no realistic possibility of restoration of the children to the parents, the next issue for determination is whether they should be placed with the maternal great-grandparents in preference to a permanent long-term out-of-home care placement with the current carers, as proposed by the Secretary in the permanency planning.

141 It was submitted for the parents that if the Court were to find that "restoration is deemed unrealistic", Mr and Mrs Dark should be re-assessed by a different assessor for placement of the two children into their care.

142 Separate written submissions were prepared for the maternal great-grandparents and presented to the Court after the evidence was closed for its consideration. These submissions were prepared by Ms Jane Smith, a solicitor independent of the solicitor acting for the parents.

143 These written submissions state the following:

"The maternal great-grandparents now accept that there is a risk to the children in circumstances where the injuries in question have not been adequately explained and there is a possibility that the parents may have either accidentally or deliberately harmed the children."

144 This is interesting in itself, given that they made some tentative concessions in cross-examination that the children's injuries could have been accidentally inflicted by the parents, but not deliberately.

145 The maternal great-grandparents acknowledge that they have been critical of Community Services in the past but are willing to work with Community Services in the future in a co-operative manner and adhere to any requirements in relation to the children, to protect them from harm, either intentional or accidental.

146 The independent legal representative for the children supported the proposition that the children should be placed with the maternal great-grandparents in preference to a non-family placement with the current carers. He formulated the issue in this way:

"The issue for the Court is whether Mr and Mrs Darks' change in position is sufficient to mitigate any risk to the children if they are to be placed in the great-grandparents' care."

147 He went on to submit that because the great-grandparents changed their views with respect to risk in the light of the medical evidence, the Court can have further comfort that they have the capacity to protect these children from potential harm arising from unsupervised contact with their parents. It would be open to the Court to find that any risk the children may be exposed to in the care of the maternal great-grandparents is not an unacceptable risk, such that children's' placement with them should be excluded.

148 Accordingly, the Court should not accept the permanency planning proposed by the Secretary who should be directed to prepare a permanency plan that includes a risk assessment of the great-grandparents based on their current position and their capacity to comply with any order the Court may impose in the event that the children are placed in their care.

149 The Secretary, however, continues to contend that any placement with the maternal great-grandparents would see the children at an unacceptable risk of harm. It was submitted that the history demonstrates that they remain unwilling to accept or acknowledge that the parents, or one of them, may have intentionally harmed the children. Their belated change in position does not stack up against the amount of objective information they had knowledge of leading up to the hearing.

150 In support of this submission, the Secretary points, in particular, to:

(1) The maternal great-grandmother assisted with attempts to obtain information to support alternative explanations for the injuries. In her affidavit of 21 August 2013 Mrs Dark commented on the perceived negligence of the medical professionals, and, more importantly, said, "I do not suspect that Chris Collins or Kylie Bell have injured Stephen in any way."

(2) The maternal great-grandparents were assessed by Assessments Australia between 23 August 2013 and 12 September 2013. During interviews, they were not willing to accept the possibility that either parent intentionally harmed the children.

(3) On 6 March 2014 they met with the manager casework and caseworker. They maintained their belief the parents did

not harm the children. They would not accept that as a possibility. Mr Dark became agitated and both then walked out of the meeting.

(4) In a joint affidavit dated 15 May 2104 the Mr and Mrs Dark stated, "We do not believe that Kylie Bell or Chris Collins have ever intently (sic) hurt the children."

(5) If Mr and Mrs Dark had any doubt or misunderstanding about the cause of the injuries, the receipt of Dr Moran's report must have left them little room for continuing to accept the parents' explanations.

(6) On day two of the hearing the maternal great-grandparents were cross-examined, at which time they had heard the evidence of Dr Shorter, Dr Buckmaster and Dr Moran. Mrs Dark was inconsistent in her evidence. She said that upon reflection she would accept that somehow the parents harmed the babies, but not intentionally. On the other hand, she also said she thinks the Secretary could have come to a different view on the evidence, and should have come to a different view.

(7) Mr Dark took a different position to Mrs Dark and said that it was his opinion all along that the parents could have accidentally hurt the children. This answer was inconsistent with his earlier evidence, particularly paragraph [34] of his affidavit of 15 May 2014, where he stated, "Community Services has concluded that Stephen's injuries are a result of child abuse but we believe this is unsubstantiated as there are no statements to confirm how or when the injuries occurred". Mr Dark also said he did not believe any bruising was caused deliberately. Mr Dark was prepared to accept the parents may have harmed the children, but not intentionally. He could not accept that the parents deliberately harmed the babies.

151 Nothing new was learned at the hearing in relation to the existence of the injuries and the medical opinion as to their cause or as to the implausibility of the parents' explanations. What Mr and Mrs Dark already knew before the hearing was the same information they say informed their sudden decision to state a change in position. Accordingly, the Secretary submits, the change in position does not present as a genuine acceptance or acknowledgement of the risk posed by the parents. This can give no reassurance that they will be a safe ally for the children, and gives Community Services little comfort as to any insight into working co-operatively with any plan for placement of the children with them.

Findings and conclusions in respect of placement

152 Where restoration is not possible, a family placement for children removed from their parent(s) is always preferable to foster care, particularly if it will give rise to the potential for greater contact and some ongoing involvement in the lives of the children on the part of the parents. Accordingly, very careful consideration needs to be given to permanency planning that proposes foster care in preference to a family placement.

153 The test remains that of unacceptable risk of harm, as discussed above.

154 But the history here on the part of these maternal great-grandparents is one of closeness to the mother, and an almost blind faith in her, and a persistent refusal to see that there was a possibility that the parents or one of them had perpetrated the injuries suffered by the children deliberately.

155 I agree with the submissions made on behalf of the Secretary.

156 My duty is to make my assessment today, not at some future time, based on some hope that circumstances might change, or that the maternal great-grandparents might over time develop sufficient insight into the risk posed to these children by these parents such that placement with them is not unacceptable.

157 The presentation of the maternal great-grandparents has been consistently unacceptable. Up till the end they have been critical of the Department and its actions taken to protect the children, even in the face of strong uncontradicted medical evidence, including that of Dr Shorter who was qualified by the parents and whose report was tendered on their behalf. Their change of position came late and in my assessment is insincere, in that what is being said on their behalf does not reflect their belief, irrationally held despite the objective evidence, that these parents could not have hurt these children. In other words, faced with the inevitable, my assessment is that their position pays mere lip-service to the reality of the position, designed to engender a favourable outcome.

158 I have no confidence that the maternal great-grandparents can work co-operatively with Community Services in the future, or that they will provide the necessary and appropriate measures and safeguards that would be required to protect these children from harm by their parents and ensure their ongoing safety. I find that a placement with the maternal great-grandparents would pose unacceptable risk of harm to the children.

Contact

159 The Secretary is not seeking a contact order but, through the evidence presented, suggested that contact should be for the purposes of identity only. He proposes, therefore, that contact with the birth parents should be a minimum of 6 times per year supervised by a delegate of the Minister. The Secretary has rejected the possibility of the maternal great-grandparents supervising contact.

160 It was submitted for the parents that if the Court finds that "restoration is deemed unrealistic", the parents seek a regime of liberal contact, supervised by the maternal great-grandparents.

161 The issue of appropriate contact for children who have been permanently removed from the care of their parents, particularly young children, remains vexed.

162 The Report of the Special Commission of Inquiry into Child Protection Services in NSW (the Wood Report) recommended that evidence based guidelines for contact orders be developed by the Children's Court to assist judicial officers and to achieve a greater degree of consistency in the kinds of matters taken into account when making contact orders in Care proceedings.

163 In response to that recommendation the Children's Court issued Contact Guidelines in 2011 designed to provide assistance to judicial officers, practitioners and parties, which were based upon available research and the Court's "accumulated expertise and experience as a specialist court" in Care proceedings.

164 It is generally accepted that a child benefits from some contact with the family of origin (except in extreme cases). Much depends on the level of trust and co-operation that exists between the carers and the birth family.

165 In some cases the birth family can play a positive and supportive role. In other cases, members of the birth family can put the stability of the placement at risk.

166 There is, however, a strong body of opinion that contact should not interfere with a child's growing attachment to the new family. The younger the child, and the less time the child has been with the birth parents, the less the need for other than minimal contact, for identification purposes.

167 There was no evidence presented in the present proceedings to contradict or counter-suggest these propositions.

168 In these circumstances, contact with the birth family does not need to be any more extensive than that proposed by the Secretary consistent with the permanency planning.

169 I am comfortably satisfied that an order mandating contact in the present case is neither necessary nor appropriate. In my view, questions surrounding contact, including duration, location and frequency, are best left to the judgment of the Minister as the person with parental responsibility, or his delegate, having regard to all the matters I have already discussed.

170 Clearly, contact between the children and their birth parents will need to be supervised. For the reasons already articulated, the maternal great-grandparents are not appropriate persons to safely supervise that contact. Similarly, any separate contact between the maternal great-grandparents and the children will also need to be supervised.

171 All contact for the children with the birth family should, therefore, be supervised by a delegate of the Minister.

Parental responsibility

172 Notwithstanding the principle set out in s 9(2)(c) of the *Care Act* to the effect that the course to be followed must be the least intrusive intervention in the life of a child and his or her family, in the present case the paramount concern to protect a child from harm and promote that child's development dictates that parental responsibility for these children should be allocated to the Minister until they reach the age of 18.

173 I am satisfied that any other order would be insufficient to meet the needs of these children: s 79(3).

Disposition

174 For all these reasons I expressly find that the permanency planning proposed for these children has been appropriately and adequately addressed.

175 I make no order for contact under s 86 of the *Care Act*.

176 I make the following final Care orders:

1. Parental responsibility for Timothy and Stephen is allocated to the Minister until they reach the age of 18.

2. The Secretary is to file within 11 months a report concerning the children prepared in accordance with s 82 of the *Children and Young Persons (Care and Protection) Act* 1998.

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