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Re DH (A Minor) (Child Abuse)

[1994] 1 FLR 679

24/01/1994

Barristers
Catherine Wood KC, MCIArb

Court
Family Division

Facts
D was almost 2 years old. His parents were married. His birth was normal and he appeared to develop normally. His maternal grandmother, Mrs M, took a large part in his daily care and he had a strong bond with her. Towards the end of 1992 the mother began to suffer mood swings. On 4 January 1993 D was admitted to the local hospital, having been diagnosed as having an upper respiratory tract infection. On 5 and 6 January 1993, while he was alone with the mother in a cubicle, he stopped breathing. The consultant paediatrician suspected that the episodes might be the result of Munchausen's syndrome by proxy. On 8 and 9 January 1993 there were further episodes resulting in D having to be given oxygen. These were subsequently acknowledged to have been induced by the mother blocking the child's upper airways. The mother and child were transferred to another hospital where further episodes occurred on 15 and 20 January 1993, both induced by the mother and resulting in D losing consciousness and having to be revived by oxygen. On 25 January 1993 the mother and child were transferred to a specialist unit where covert video surveillance was used without telling the mother or seeking the father's permission. On 27 January 1993 there were two further assaults which were recorded on video. On the second occasion, the mother was clearly seen to place something over D's face. She was arrested and taken to a police station where she was interviewed. Initially, she denied involvement, but having been shown the video she admitted the final incident only. Eventually, she was charged with two counts of cruelty to a child; she pleaded guilty to the second and was placed on probation for 3 years with a condition of psychiatric treatment. Following an emergency protection order, proceedings for a care order were commenced and by consent the local authority was granted a succession of interim care orders. D went to stay with his paternal aunt and in July 1993 returned to live with the father where he thrived. Initially, there was an order that neither the mother nor Mrs M should have contact with D. Mrs M applied for, and was granted, an order for contact, and since April 1993 had seen D once every 2 to 3 weeks supervised by the father; this contact was successful. The mother also made an application for contact, and contact was ordered at fortnightly intervals for one hour supervised by the social worker. These sessions went well and D was not disturbed by the contact. At the hearing, the mother's consultant psychiatrist gave evidence to the effect that the mother suffered from a personality disorder (rather than any formally identifiable psychiatric illness). The disorder was eminently treatable, but the treatment was likely to be a long process. There was also evidence of the mother having a hormonal disorder brought about by her taking the contraceptive pill at three times the dosage level recommended in order to stop her periods as

she had a phobia about menstruation, and menstruation coincided with the onset of her mood swings. The mother was attending regularly for treatment; there was no significant change, but she was motivated and able to start talking about her feelings. The consultant psychiatrist did not consider that supervised contact would pose a risk to D. At the final hearing, there was no dispute that a residence order should be made in the father's favour. The local authority maintained that all contact should be terminated between D and the mother and the mother's side of the family. The father and the guardian ad litem did not believe that there was any benefit to D to be derived from contact with the mother.

Held

Held –

(1) Adopting the recommendations of the child psychiatrist instructed by the mother, contact with the mother should be maintained while further investigation of the mother was undertaken, and there should be six contact visits of not more than 2 hours' duration to be supervised by the local authority. There should be a review by an independent psychiatrist after one year and the case should then be relisted for reconsideration of contact.

(2) There was value in maintaining contact with the mother, not so that she could play a maternal role, but to give D a memory of her so that she did not become a frightening fantasy figure, particularly because D was to remain in his family. It would assist him to come to terms with what she had done to him if he came to know her as a kind and loving figure.

(3) The maternal grandmother, Mrs M, was an important figure in D's life; there was nothing to suggest that she would in any way damage D's interests and she should have contact not less than once every 3 weeks in the presence of the father.

(4) It was appropriate to make a supervision order under s 31. The court cannot make supervision by the local authority a condition of contact under s 11(7) or impose supervision by means of a specific issue order. The court can make a supervision order combined with a residence or contact order where it is satisfied that, but for the supervision order, the child would be likely to suffer significant harm attributable to the care given to him by either of his parents. Although it would usually be preferable to make a family assistance order in a conventional case in which the object is simply to achieve contact supervised by a local authority (see Leeds County Council v C), there was scope for using a supervision order in cases in which the local authority had made an application and the threshold criteria laid down by Children Act 1989, s 31 were satisfied; supervision orders were designed for the more serious cases in which an element of child protection was involved: see The Children Act 1989 Guidance and Regulations, vol 1: Court Orders , para 250.

(5) The case of Oxfordshire County Council v M does not expressly deal with the question whether counsel has a duty to make voluntary disclosure of medical reports even when disclosure would be contrary to the client's interest. But the view (expressed by Thorpe J in Essex County Council v R) that there was a positive duty to make such disclosure was consistent with the approach of the Court of Appeal in the Oxfordshire case, and should be followed unless and until the Court of Appeal ruled otherwise. If no party wished to adopt the maker of a report as their witness, the court could properly treat that person as the witness of the court and allow all parties to cross-examine him or her.

(6) It was desirable in this case for the court to retain its involvement; and the Official Solicitor should be invited to act as D's guardian ad litem and, subject to his consenting, the guardian ad litem would be discharged. The case involved complex issues and the Official Solicitor was best placed to select the independent consultant psychiatrist to advise on the continuation and quantum of contact: see Practice

Note: The Official Solicitor: Best Practice on His Appointment as Guardian ad Litem in Family Proceedings.

(7) (a) Where an expert who has already written a report is asked to write a second report or an update, it should be requested that if he changes his recommendation he should give the earliest warning to the solicitors instructing him, and this information should be immediately communicated to the other parties; (b) time-limits set at directions appointments for the delivery of evidence must be obeyed by everyone involved in the case; (c) realistic time estimates must be given for the length of time an expert is likely to spend in the witness-box; (d) advocates should study and obey Practice Direction: Children Act 1989: Hearings before High Court Judge: Time Estimates .

(8) Evidence produced by covert video surveillance is generally admissible. Even if evidence were unlawfully or improperly obtained, it would be admissible in proceedings relating to a child where the welfare of the child plainly requires that the truth of the manner in which he was abused should be ascertained. If the doctor takes the view that covert video surveillance is essential for the treatment of his patient, he is entitled to undertake it without parental consent, provided that he is satisfied there is no risk that his patient will come to any harm.

(9) The local authority's care plan should set out its plans for the child in as objective a manner as possible and in neutral unemotive language.