[2022] EWFC 56

Case No: LV20C00210

SITTING IN THE FAMILY DIVISION
OF THE HIGH COURT

Liverpool Civil and Family Court

Vernon Street, Liverpool, L2 2BX

Date: 13/06/2022

**Before**:

**THE HONOURABLE MR JUSTICE HAYDEN:**

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**Between:**

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| **ST HELENS BOROUGH COUNCIL** | **Applicant** |
| **- and –** | |
| **M** | |
| **-and-** | **First Respondent** |
| **SS** | |
| **-and-** | **Second Respondent** |
| **JR** | |
| **-and-** | **Third Respondent** |
| **A, T and S (through their Children's Guardian, Elizabeth Perry, appointed as of 7th February 2022)** | **Fourth Respondent** |

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**Ms Elizabeth Isaacs QC and Ms Anna Fox** (instructed by **St Helens Borough Council**) for the **Applicant**
**Mr Louis Browne QC and Ms Elizabeth Brennan** (instructed by **Hogans Solicitors**) for the **First Respondent**

**Mr Damian Sanders** (instructed by Abel's Solicitors) for the **Second Respondent**
**Ms Rachael Banks and Ms Nicola Noon** (instructed by Haygarth Jones Solicitors) for the **Third Respondent**
**Mr Simon Povoas** (instructed by **Berkson Family Law Solicitors**) for the **Fourth Respondent**

Hearing dates: 19th – 27th May 2022

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# Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

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

## Mr Justice Hayden:

1. At the commencement of this hearing, I was invited to make care orders in respect of three children: A, a young person who is approaching 16 years of age; T, a young boy approaching 6 years of age and S, a boy who will very shortly be 2 years of age. Despite their differing ages, each of the children has an August birthday. A was made subject to Child Protection plans in January 2015, identified as being at risk of emotional harm. T was initially accommodated for a short period, by Cumbria Children's Services, in August 2016. A was removed from her mother's care under the aegis of Section 20 of the Children Act 1989 on the 4th December 2019.

2. At the commencement of the proceedings, both these children were subject to interim care orders made by the Liverpool Family Court. Both T and A are placed together in a foster placement in which it should be recorded they are thriving. All agree that their relationship is central to their mutual and individual emotional wellbeing. There is also agreement that separating them at this point would be inimical to their respective welfare needs.

3. It has been submitted that these proceedings have *"an exceptionally long and complicated history, involving multiple expert and other assessments".* I do not entirely agree with that characterisation of the case. Certainly, the litigation history is lamentable and undoubtedly, the delay in achieving a final hearing has been entirely irreconcilable with the obligation to promote the welfare of the children. That said, the issues in this case are paradigmatic of many cases that are heard regularly in the Family Court by both District and Circuit Judges. The expert evidence, as it has evolved, is really focused on two witnesses, Dr Weir, Consultant Psychiatrist and Dr Hansen, Consultant Psychologist. Their reports reflect their complementary disciplines. Their conclusions are mutually supportive. Their analysis is entirely uncontroversial, within the parameters of their respective professions. Their evidence is unchallenged by any other expert.

4. It is correct to say that there have been many assessments in this case. For reasons that I have struggled to understand, there have been 5 residential placements of Mother (M) and baby. That is not merely unusual but in the experience of every professional in the case, entirely unprecedented. Each of the assessments produced significantly negative information regarding M's capacity to care for S in the long term.

5. This is the fourth occasion on which the case has been listed for final hearing. Some of the adjournments can be explained, at least in part, by the exigencies of the pandemic. However, I am also left with the clear impression that a rather more robust approach to case management, by all concerned, would have avoided delay of this magnitude. Specifically, the plans for A and T ought to have been resolved at least 12 months ago. In the intervening period, there has been no coherently arguable alternative to the arrangements that I have endorsed today and which, I emphasise, proceeded by agreement at this hearing following discussions at a pre-hearing review, which I listed on short notice.

6. The significance of this delay is that both A and T have been anxious and unsettled by the lack of clear plans for their future. Rather than wait until the end of this hearing, I made final orders on the second day in respect of them both. I did so to signal that the Court recognised and was aware of the impact that the uncertainty had on them and to

make at least some small gesture of reparation. It is right that I record that A, who has been very clear from her reception into care and consistently thereafter, that she wishes to remain in foster care, was manifestly relieved. The key social worker has told me that A has blossomed in her foster home. The changes in her are not merely emotional, in the sense that she has developed her self-confidence, but also physical. I have been told that she stands in a way that is now relaxed and confident and no longer cowed and apologetic. All who have encountered her describe a young person effervescing with talent and aspiration. Her sensitively expressed wishes and feelings about her future should have been respected much earlier. It is also important to note that on their reception into foster care A was observed to have established a parenting or caring role in respect of her much younger half-sibling. Gradually, and to their mutual benefit, they have each let go of these respective roles to a significant degree. Nonetheless, they remain the primary focus of their respective worlds.

7. The catalyst for these proceedings was an injury to A's eye caused by M on 4th December 2019. On that day, Ms Melissa Swan, a social worker, arrived at the family's address to conduct an assessment. M was described as being in an *'erratic'* state. She was indicating that she could not 'put up' with A anymore and said that she *'wanted her gone'*, by which it was clear that she wanted her to be taken into care. The social worker took A to sit outside in her car to talk to her in private. A said that M had been *'goading her'* for days, *'winding her up'* and that when she retaliates her mother records her so that '*she can show people what she is like'*. When M was spoken to, she accepted that she had punched A in the face but contended that this was in response to A's aggression. M's position in the litigation is that she did not punch A but, as I understand it, slapped her on the face. She contends that the substantial ring that she was wearing at the time made contact with A's face and explains the extent of the injury. She brought the ring to Court to show me. M also referred to 'recordings' she had made, though she contended that they reflected the reality of A's behaviour rather than the contrivance asserted by her daughter. The 'threshold criteria', pursuant to Section 31(2) of Children Act 1989, having been agreed and having regard to the wider issues in the case, it was not thought necessary to resolve these differences in account. If I may say so, I entirely agree with the correctness of that approach.

8. One of the reasons which may illuminate at least some of the drift and delay in this case has been the failure fully to grasp the complexion of the identified harm and the character of future risk. Though there are many hundreds of pages filed in these proceedings, I have not found, in any of the statements, a clear analysis of either the nature of the contemplated harm or the likely risk of it. In a 'Summary and Preliminary Report' prepared following A's medical assessment at the Safeguarding Unit in Alder Hey Children's Hospital, the examining doctor identified the following concerns. This was really the first and clearest iteration of risk and ought to have provided a good starting point for assessment:

> *'based on the story/social history that can cause significant harm to the child and would need further attention by social care/police'*:
>
> "*Multiple concerns regarding emotional abuse;*
>
> *Historical physical abuse of elder child;*
>
> *Disclosure of sexual abuse (historic)*"

9. When S was born, in August 2020, there was a perception that the decision as to whether M and S should remain together should be determined solely on the basis of whether there was an immediate physical risk to the baby and/or if there was, whether sufficient protection could be put in place. Indeed, I note that when His Honour Judge Sharpe came to consider whether there should be (a second) residential assessment, he made the following observation:

> *"Nobody has sought to argue that, in this case, the emotional or psychological welfare of [S] will be impacted by being within or outwith the care of his mother. It is all therefore about physical safety and in that regard, I was then immediately addressed in evidence by three witnesses on behalf of the local authority…"*

10. Physical harm to a child, or risk of it, rarely, if ever, exists in a vacuum. There is inevitably an emotional component. As I have highlighted above, *'multiple concerns regarding emotional abuse'* had rightly been identified from the outset in this case, along with *'historical physical abuse'* of two elder children and *'allegations of sexual* abuse' made by both of them. When contemplating the separation of a mother and baby, at an interim stage in care proceedings, it is misconceived, in my judgement, to divide concepts of 'harm' into discrete silos or to evaluate risk only by reference to immediate physical safety. A child's best interests cannot be evaluated in suspended animation. Assessing welfare is an exercise in a continuum, not in a vacuum. An assessment of risk confined to immediate physical harm is likely to be artificial and, inevitably, incomplete. When a decision is made, against a background of identified welfare concerns, to place a mother and baby together, it is one which requires recognition of the broad canvas of available evidence which is likely to illuminate both immediate and longer-term risk to the child. The decision to place mother and baby together in a residential placement, reflects not only recognition of their respective rights and interests, pursuant to Article 8 and 6 ECHR, but also a disciplined forensic focus on the objectives of such a placement and, accordingly, the proportionality of intervention. It is to be remembered that the legal framework providing for such assessment is found in Section 38(6), Section 38(7A) and (7B) of the Children Act 1989.

"**38 Interim orders.**

> *"(6) Where the court makes an interim care order, or interim supervision order, it may give such directions (if any) as it considers appropriate with regard to the medical or psychiatric examination or other assessment of the child; but if the child is of sufficient understanding to make an informed decision he may refuse to submit to the examination or other assessment."*
>
> *7) …*
>
> *(7A) A direction under subsection (6) to the effect that there is to be a medical or psychiatric examination or other assessment of the child may be given only if the court is of the opinion that the examination or other assessment is necessary to assist the court to resolve the proceedings justly.*

> *(7B) When deciding whether to give a direction under subsection (6) to that effect the court is to have regard in particular to—*
>
> *(a) any impact which any examination or other assessment would be likely to have on the welfare of the child, and any other impact which giving the direction would be likely to have on the welfare of the child,*
>
> *(b) the issues with which the examination or other assessment would assist the court,*
>
> *(c) the questions which the examination or other assessment would enable the court to answer,*
>
> *(d) the evidence otherwise available,*
>
> *(e) the impact which the direction would be likely to have on the timetable, duration and conduct of the proceedings,*
>
> *(f) the cost of the examination or other assessment, and*
>
> *(g) any matters prescribed by Family Procedure Rules."*

11. Two decisions remain determinative of the interpretation of s. 38(6). The leading authority is *Re C (Interim Care Order: Residential Assessment) [1997] 1 FLR 1*, which emphasises that the proposed assessment should be an assessment of the child, *'the main focus must be on the child'* (per Lord Browne-Wilkinson). However, Lord Browne-Wilkinson considered the specific facts of that case also illuminated the clear parameters of Section 38(6):

> *"What was to be assessed was the mother's capacity for beneficial response to the psychotherapeutic treatment that she was to receive. Such an assessment, no matter how valuable the information might be for the purposes of the eventual final care order could not, in my opinion, be brought within Section 38(6)."*

12. The second decision is *Re G (Interim Care Order: Residential Assessment) [2006] 1 FLR 601*. There Lord Scott said at [14]:

> *"It seems to me clear that the main purpose of the proposed programme was therapy for the mother in order to give her the opportunity of change so as to become a safe and acceptable carer... This purpose in my opinion does not come within section 38(6), notwithstanding that the results of the programme would be valuable and influential in enabling the court to decide whether a care order ... should be made and that if the purpose were to be achieved, it would very greatly benefit the [child].*
>
> *Baroness Hale summarised matters at [64-71]. At paragraph 64 she said this:*

> *"The purpose of these provisions is, therefore, not only to enable the court to obtain the information it needs but also to enable the court to control the information gathering activities of others. But the emphasis is always on obtaining the information. This is clear from the use of the words "examination" and "other assessment." If the framers of the 1989 Act had meant the court to be in charge, not only of the examination and assessment of the child, but also of the medical or psychiatric treatment to be provided for her, let alone for her parents, it would have said so. Instead, it deliberately left that in the hands of the local authority."*
>
> *At paragraph 66:*
>
> *"I appreciate, of course, that it is not always possible to draw a hard and fast line between information-gathering and service-providing. Some information can only be gathered through the provision of services. It may be necessary to observe the parents looking after the child at close quarters for a short period in order to assess the quality of the child's attachment to the parents, the degree to which the parents have bonded with the child, the current parenting skills of the parents and their capacity to learn and develop..."*
>
> *At paragraph 69:*
>
> *"In short, what is directed under section 38(6) must clearly be an examination or assessment of the child, including where appropriate her relationship with her parents, the risk that her parents may present to her, and the ways in which those risks may be avoided or managed, all with a view to enabling the court to make the decisions which it has to make under the 1989 Act with the minimum of delay. Any services which are provided for the child and his family must be ancillary to that end. They must not be an end in themselves."*
>
> *And finally, at paragraph 71:*
>
> *"Further or other assessments should only be commissioned if they can bring something important to the case which neither the local authority nor the guardian is able to bring."*

13. In *Re Y (A Child): Section 38(6) Assessment [2018] EWCA Civ 992,* Peter Jackson LJ, having reviewed the above authorities, identified two questions for the Court when determining an application pursuant to Section 38(6), namely:

> *"18. In my view, a judge deciding an application under s.38(6) must address two questions:*
>
> *(1) Is this a proposal for an assessment that falls within the terms of section 38(6)?*

> *(2) If so, is the assessment necessary to assist the court to resolve the proceedings justly, as required by ss. 7A, having regard to the matters in ss. 7B?*
>
> *Both questions must be approached in a manner that upholds the right to a fair trial under Article 6 and the right to respect for family life under Article 8. Only if both are answered affirmatively can the court make the direction requested."*

14. Peter Jackson LJ also considered the wider principles engaged in any contemplated separation of mother and child in: *Re C (A Child) (Interim Separation) [2019] EWCA Civ 1998*. Jackson LJ's convenient summary of the applicable principles is frequently cited and was set out in the judgment of Judge Sharpe.

> *"(2) The removal of a child from a parent is an interference with their right to respect for family life under Art. 8. Removal at an interim stage is a particularly sharp interference, which is compounded in the case of a baby when removal will affect the formation and development of the parent-child bond.*
>
> *(3) Accordingly, in all cases an order for separation under an interim care order will only be justified where it is both necessary and proportionate. The lower ('reasonable grounds') threshold for an interim care order is not an invitation to make an order that does not satisfy these exacting criteria.*
>
> *(4) A plan for immediate separation is therefore only to be sanctioned by the court where the child's physical safety or psychological or emotional welfare demands it and where the length and likely consequences of the separation are a proportionate response to the risks that would arise if it did not occur.*
>
> *(5) The high standard of justification that must be shown by a local authority seeking an order for separation requires it to inform the court of all available resources that might remove the need for separation."*

15. Paragraph 2(4) above requires to be read in conjunction with para. 18 in Re Y (supra), see para. 13 above. There is no tension between the two. What is required is identification of the nature and extent of the risk, consideration as to whether a residential assessment is necessary, having regard to the factors set out in Section 38 (7B) Children Act 1989 and, ultimately, the proportionality and length of the intervention.

16. Thus, a decision to place mother and baby in a residential unit requires to be rooted in cogent and coherent consideration of all the available evidence, with particular regard to what it is thought the residential assessment can contribute to an accurate understanding of the matrix of risk. A plan for immediate separation is not to be conflated with or confused by a perception of immediate risk of harm.

17. All the parties agreed, at the commencement of these proceedings, that the facts of this case required M and S to be assessed in a residential unit. Following the negative conclusions of that first assessment neither the Local Authority nor the Guardian considered that a further assessment was either necessary or in S's interests. Judge Sharpe took a different view. He ordered a further residential assessment. No party appealed that decision. From that point on, as best as I can understand it, the residential placements which followed (interspersed by foster care placements), appear to have been driven by a view that M and S should be kept together until a final hearing in which the plans for S's future could be properly considered.

18. By this point, the case had been re-allocated to the District bench. These placements do not appear to have been directed towards any focused assessment on M's care. They have been described before me as 'holding placements'. That is not a concept that I am familiar with, nor am I attracted to it. It appears to me that the thinking behind it was effectively 'to hold the ring' in the litigation, predicated on the view that this might keep options open for the future. Whilst this might, in some circumstances and within tightly constrained parameters, be necessary and thus desirable, it also carries the risk of elevating process above substance, guarding procedural rights at the expense of a child's welfare. That, I regret to say, is what occurred here. The need for a residential placement will be indicated by consideration of the factors that I have set out above. Engagement in analysis of those factors will also illuminate the child's welfare in the interim. Here S, now I reiterate approaching two years of age, has lived almost the entirety of his life in an environment in which he and his mother live communally; are observed on a 24-hour basis by either staff or video surveillance or both. These mother and baby units were inevitably restrictive of S's potential to engage more widely with the world at a crucial stage in his development. I have asked Counsel on a number of occasions how this was permitted to endure for as long as it did. No party has sought to justify it.

19. As Ms Isaacs QC and Ms Fox, on behalf of the applicant Local Authority, have argued, the contemplated risk to S has logically to be evaluated by reference to the harm sustained by the other children. With respect to Mr Browne QC's arguments on behalf of M, I regard that proposition as self-evident. In this context, it is important to highlight the allegations made by A's elder sibling, Q in earlier proceedings.

20. Q was medically examined, following a complaint, and found to have a faint bruise to his chin, multiple faint bruises to both upper arms and a mark to his left chest. He said that his mum slapped and punched him and the mark on his chest was as a result of a kick. Q said that he was selfish and that because of his behaviour, his mother had not been eating or sleeping and that she hit him because *'he winds her up'*. He thought he could be a *'good person'* but *'flips'*. He reported to the examining doctor that his mum told him that he *'controls everything the family does'*, and this '*winds her up'*. He said that caused her to punch, slap, hold him down and bite him.

21. These allegations are, as in those made by A, accepted by M only in part. Again, M casts herself as a reactive victim. It must also be noted that M has three criminal cautions for assault. They are now over a decade old and there have been no further or recent allegations. It is, however, pertinent to identify as Ms Isaacs QC, invites me to do, that in explaining each of those three cautions, M describes herself essentially as the victim.

22. Finally, looking at the broader spectrum of risk, both Q and A have made allegations of sexual abuse. Both sets of allegations arise at a time when each child was living at home. Neither child felt able to communicate their allegations to M at the time.

23. In the care proceedings that followed Q's allegations, M was noted to be aggressive, challenging and intimidating. These features of her personality were immediately obvious to the social workers in these proceedings. They were also noted by the staff in each of the residential units, who found her to be manipulative, challenging, loud, and uncooperative. More broadly, they found her to be a disruptive influence on the day-to-day life of the unit, identifying her propensity to generate ill feeling amongst other residents.

24. Very early in the investigative process, it was identified as necessary to seek the opinion of both a Consultant Psychiatrist and an experienced Psychologist. Dr Michael Weir, a highly experienced Psychiatrist was instructed and Dr Hansen, a Clinical Psychologist. Dr Weir emphasised, in his oral evidence, that he found M to be one of the most hostile, aggressive, and obstructive clients that he had ever encountered. He has been involved in a number of high-profile cases and his experience is, forensically as well as clinically, extensive. He was particularly struck by the extent to which M was *'controlling interviews by not answering questions'* and providing only *'minimal information'* in order to *'assert herself to those around her'*. Dr Weir considered M's relationship with the elder children to be *'extremely worrying'*.

25. Dr Hansen spent 19 hours with M during the course of her assessment. She told me that this was significantly in excess of the time she would ordinarily spend in an assessment for the Court. Indeed, she could not recall any case that had involved so many sessions. Despite this, it is notable that she did not discover M's previous history of assaults and accordingly, did not have the opportunity to identify some aspects of the pattern in which M identified herself as a victim, even where she was investigated and subsequently cautioned. I note that this resonates with Dr Weir's observation regarding M's sophisticated capacity to withhold or conceal information. In her report, Dr Hansen observed:

> *"[M] reported that there is a repeated cycle of her child experiencing sexual abuse, presenting with difficulties as a result of this and her being a victim to their behaviour. She reported that Q presented as psychotic, yet she was sectioned"*

26. Collateral information within the papers filed reveals that at the time of his move to care, M was expressing views that Q was, in some way, *'possessed by demons'*. In her oral evidence, she denied the accuracy of these documented remarks. As Dr Hansen noted, the concerns of the professionals at the time were focused on M's mental health. There did not appear to be concern, in this respect, in relation to Q. It is important that I record for reasons of accuracy that, M was not in fact 'sectioned', but was admitted to hospital voluntarily. She continues to assert that Q has mental health problems.

27. Dr Hansen notes:

> *"She fully believes her own narrative; she holds a different perspective despite the collateral information. It could be hypothesised that this is either as a result of being disconnected*

> *from reality and having difficulties with delusional disorder, or, that she is aware but cannot admit to any misgivings or inappropriate actions on her part. Furthermore, her narrative is that the information is based on lies and she is being unfairly targeted. This area would be the first to address with [M] so that she is able to move forward positively with the Local Authority, to understand the children's perspectives and move on forward positively."*

28. Earlier, Dr Hansen noted that *'if the collateral information is accurate then [M] lacks insight'.* Mr Browne advances a case on behalf of M, to the effect that whilst there may be a lack of insight there are sufficient positives within the evidence to indicate that M may be able to *'move forward positively'* in the future. I shall return to the points Mr Browne identifies in the paragraphs below.

29. Very helpfully, Dr Hansen identified the following facets of M's behaviour which signalled, unambiguously to her, that the mother had a significant disorder of personality. The following disorders were appended to Dr Hansen's report and Ms Isaacs took her through them in cross examination:

> *"**Anankastic (Compulsive) Personality Disorder**: A personality disorder characterised by a preoccupation with orderliness, perfectionism, mental and interpersonal control at the expense of being flexible, openness and efficiency;*
>
> ***Anxious (Avoidant) Personality Disorder:** A personality disorder characterised by persistent and pervasive feelings of tension and apprehension, belief that one is socially inept, personally unappealing, or inferior to others, excessive preoccupation with being criticised or rejected in social situations, unwillingness to become involved with people unless certain of being liked, restrictions in lifestyle because of need for physical security and avoidance of social or occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval or rejection;*
>
> ***DAST**: Drug Abuse Screening Test. Structured interview instrument designed to detect drug abuse;*
>
> ***Histrionic Personality Disorder**: A personality disorder characterised by a pervasive pattern of attention seeking and excessive emotionality. It is characterised by a person who engages in attention seeking, theatrical and/or inappropriately seductive behaviour. Such individuals can be lively, dramatic and flirtatious. They can express strong emotions with an impressionistic style, can be easily influenced by others, exaggerate their behaviours and emotions and crave stimulation. Associated features can include egocentrism, self-indulgence, continuous longing for appreciation and persistent manipulative behaviours to achieve their own needs;*

> ***IPDE**: International Personality Disorder Examination. Clinical assessment of personality disorder used specifically for diagnosis;*
>
> ***IPDE-SQ**: IPDE screening questionnaire, screening assessment of personality disorder;*
>
> ***MAST**: Michigan Alcoholism Screening Test. Structured interview instrument designed to detect alcoholism;*
>
> ***Paranoid Personality Disorder**: a personality disorder characterised by paranoia and a pervasive longstanding suspiciousness and generalised mistrust of others where the individual is hypersensitive, easily insulted and can bear grudges. They can interpret other's intentions as hostile and have a persistent tendency to self-reference or a tenacious sense of personal rights;*
>
> ***Personality Disorder**: maladaptive personality traits clustering to cause the individual concerned significant difficulty across domains of functioning;*
>
> ***Schizoid Personality Disorder**: This is characterised by an individual who lacks interest in social relationships, a tendency towards a solitary life or sheltered lifestyle, emotional coldness, detachment and apathy;*
>
> ***TSI-II**: Trauma Symptom Inventory version 2. A psychometric examining reported trauma symptoms."*

30. As I understood Dr Hansen's evidence, she deferred to Dr Weir as to the making of any formal diagnosis. Though M had blocked or disengaged with Dr Weir's assessment, he considered that analysis of the evidence made available to him enabled him confidently to conclude that M has a Paranoid Personality Disorder. He did not exclude features of the other personality disorders set out above but considered that the paranoia predominated. Mr Browne submitted that reliance on the filed evidence rather than information solicited from direct interview fell outside the relevant professional guidelines for establishing secure diagnosis and that, accordingly, Dr Weir's opinion could not stand, in what he contended was, the effective breakdown of his assessment of M.

31. I am not persuaded by this submission, given the strength of the broader evidence supporting the relevant diagnostic behaviours, in particular Dr Hansen's own identification of them. The respective professional skills from these two disciplines establish, to my mind, a confluence of information for Dr Weir's conclusion, and I consider he was, logically and in the circumstances, entitled to take such an approach. In her report, Dr Hansen specifically suggested that Dr Weir had sight of the extensive 'self-reported' information that she set out in order for him to consider any formal diagnosis. However, I doubt whether the distinction between the facets of behaviour pointing to a disorder of personality (as identified by Dr Hansen) and a formal diagnosis of Paranoid Personality Disorder (determined by Dr Weir) has any real forensic

significance, at least in illuminating the outcome in this case. To some degree, the actual label strikes me as largely irrelevant. What is pertinent is the prognosis for significant change and the likely timescales for it.

32. The evidence is replete with examples supporting Dr Hansen's observations. Most strikingly, is M's persistent and pervasive feelings of tension and her excessive preoccupation with being criticised. This has been observed not only in each of the residential placements she has occupied, but also by the social workers in the earlier proceedings concerning Q. M expresses emotions on a dramatic scale and her oral evidence, on my own assessment, reflected a strikingly egocentric perspective of the world.

33. One of the tensions in the breakdown of her relationship with both Q and A centred upon M's fastidious preoccupation with housework and tidiness (itself, I note, foreshadowed in Dr Hansen's identification of anankastic or compulsive behaviours). M told me that she was much more relaxed about it now but recent observations in the latest 247 assessment reveal it still to be troubling for her. This is certainly associated with times of stress for M. I also note that M had recognised within the Independent Social Work assessment, conducted by Ms Amanda Walsh, that she *'could be paranoid'*. She disavowed that, however, in her oral evidence. Certainly, she has a deep mistrust of the social workers and in particular, Ms C, the present social worker. Ms C told me that M is controlling of their relationship, obstructs day-to-day communications and behaves in a loud and intimidating manner. Though Ms C was at pains to emphasise that M had never been violent or threatened violence to her or indeed to any of the other professionals in the case, the height and level of verbal aggression seemed consistently to carry with it, a physical threat. There have been 5 social workers involved in M's case. Three, including Ms C, have experienced strikingly similar behaviours. I also note that social workers investigating Q's case record similar experiences of M.

34. In her meeting with Dr Weir, M described how social services were treating her disrespectfully, she spoke of a *'personal vendetta'*, engaging in what she considered to be *'dirty tricks'* and *'making the rules up as they went along'*. Dr Hansen, reviewing Dr Weir's report noted that he considered M's belief *'that she was lied to and treated disrespectfully'* was both *'intense and enduring'*. Dr Hansen enquired of M whether she considered that she had learned from the social work assessment. M said she had learned that *'she must not trust social services again'.* She went on to say *'this is her second run in with social services and … she is paranoid about things'* and *'she has never had good experience of authority, government, or social services'*. When asked what she considered the impact of the care proceedings on her children had been, she told Dr Hansen that *'it has been toxic when A has been at home'* and that although she would like A home, she feels A needs help first. This resonates very strikingly with her earlier views of Q. It is clear (see paragraph 19 above) that Q accepted M's narrative that all fault lay with him. The evidence before me is that A has been more resilient and was fortunate to find a placement with her brother that enabled her to move forward. I also note that in one of her interviews with Dr Hansen, M had spoken enthusiastically about applying for the foster carer's notes which she believed would reveal that A had acknowledged that she had been the attacker and that accordingly, M would be absolved of responsibility.

35. Dr Hansen's 19 hours of interview produced a very great deal of information. Overwhelmingly, however, it is 'report', rather than analysis. Her analysis is inserted into her report by subtle inference and her conclusions are oblique:

> *"There are a number of potential presenting difficulties for [M]. She could have a non-bizarre persecutory delusion of feeling judged, targeted and fearful of life. This could manifest itself in relation to ex-partners, her family, professionals and her children. A delusion is said to be a strongly held belief. This could have resulted in a life of living in fear. Alternatively, she has experienced trauma being raised in a community filled with criminal activity and drugs, she has connected with men who have been high profile criminals and are dangerous, and this is a reality. Her own brother who she was close to, attacked his girlfriend with a machete. It could be added that such experiences have predisposed her to being paranoid as a safety survival strategy. She has used avoidance as a key mechanism to avoid criticism, conflict and to provide a better life for her children; somehow she has been unable to escape it.*
>
> *6.11. Being involved in such a highly criminal community would exacerbate any underlying feelings of paranoia so she stays alive. Aged 16, she described hiding out in hotels, being involved by association in gang and drug dealing. She was pregnant and experiencing challenging and traumatic experiences from this age.*
>
> *It may be understandable therefore that she can misinterpret innocuous events in a negative and paranoid manner. What was once a crucial survival strategy, might now be a sensitive response. For example, she reported consistently that the social worker smirked at her. Whilst I cannot comment if this was true or not, it would give an example of where she perceives was not able to tolerate alternative explanations such as she might have been nervous. Instead, her perception is always that intent is malevolent. A further example is when she saw other mothers at the school laughing and she interpreted this to be connected to her. Such a cognitive bias and thinking error when predisposed to paranoid thinking would then lead to confrontational responses."*

36. These insights into M's predisposition to interpret innocuous events in *'a negative and paranoid manner'* provoke interesting alternative analyses of her behaviour. It may be that they can be harnessed in the therapeutic process. Some of Dr Hansen's observations are elliptical. This has led occasionally to confusion amongst the professionals e.g.,

> *"As a way of coping, [M] has developed an attitude where she can appear over-confident, boasting and cold and detached from others. Her confidence, passion and demeanour is also connected with her cultural identity**. She recognises that often***

> ***her being a lioness protecting her children can come across as aggressive (my emphasis)**."*

I have no doubt that M may perceive herself as a '*lioness protecting her children'* but her perception cannot be reconciled with the evidence. She has not been able to protect her children. Indeed, she has caused them significant harm. Reading Dr Hansen's report as a whole causes me to think that she would agree with this, but passages such as the above confound rather than illuminate understanding. Later in her report, Dr Hansen notes:

> ***"[M] is a sensitive and intuitive person; this has served her well to navigate difficult life experiences and to survive them**. She is left however coping with distress, hyperarousal, feelings of anxiety, depression, isolation, somatisation and relationship problems. Her sensitivity means she also likes food, sex, and the senses, so when channelled into more positive or acceptable experiences she experiences a release."*

I find it difficult to penetrate the logic of this paragraph. I sense that Dr Hansen is endeavouring to filter into her report some of the more positive aspects of M's personality. It is important that these positives are identified and acknowledged.

37. I formed the impression that Dr Hansen had found M to be a complex personality. She has given M the opportunity to talk with her at great length and garnered information which is important in enabling the professionals better to understand her. It may also, as has been suggested, be a useful foundation for therapy in the future. Ultimately, Dr Hansen identified that M would require extensive therapeutic input. As I have recorded above (see para. 19), the need for M to engage in challenging *'her own narrative'* must, in Dr Hansen's view, be the *'first to be addressed'*. There has been some debate as to the extent of the therapy that M has received. It would appear, that it is now agreed that she has attended 12 sessions. The number of sessions, however, is entirely irrelevant. What is significant, is that M has not even begun to confront the dissonance between her perception of the world and the perceptions of others, most importantly, her own children.

38. Dr Hansen considered that M might benefit from Cognitive Analytic Therapy (CAT): Assessment and information of early life and presenting difficulties. The objective of this would be to create a collaborative formulation which might enable her to *'contain her narrative of life'* and to reconsider repeating patterns and her own feelings. Dr Hansen told me that the length of therapy for such intervention varies but she was clear that M would need the maximum available. This may be in the region of 32 sessions. Additionally, Dr Hansen identified significant trauma in M's own childhood. In her evidence to me, M was asked about her childhood and her own experience of parenting. She effectively closed down that line of questioning immediately but, in the few sentences she did speak, the pain generated by the issue was almost palpable and the intensity of her reaction notably greater than to any other subject that was raised with her. Dr Hansen had foreshadowed this in her oral evidence and in her report. She considered that these experiences indicated significant trauma which in and of itself, required additional specialist support and treatment. In particular, Dr Hansen considered Eye Movement Desensitisation Reprocessing (EMDR): Management of

trauma, with a development of effective resilience. She made this observation in her report, which requires to be emphasised:

> *"The trauma intervention, such as EMDR needs to account fully for the potential for dissociative symptoms. Failure to do so could lead to trauma therapy, such as EMDR, failing to be effective if dissociative symptoms are not prepared for at the outset or mismanaged during treatment. Consequently, the identified EMDR therapist should assess the dissociative symptoms present with so that this can be managed effectively if required. Essentially the therapist needs to prepare for and accommodate such difficulties. Preparation for the management of any dissociative symptoms should include the treatment of these by the EMDR therapist before moving onto the other aspects of EMDR therapy. [M] may be able to access this via CMHT through a referral from her GP. In terms of length of treatment, this would be determined based upon how she engaged, the number of sessions available to her and her capacity to use the sessions productively."*

39. Though Dr Hansen considered this trauma therapy to be a separate piece of work, she was prepared to contemplate a degree of overlap, if a therapist could be found (and funded) who possessed the expertise and experience with both therapeutic models. I found Dr Hansen to be gentle and kindly disposed towards M. I felt that she was doing her best to help her and encourage her commitment to the therapeutic process. Dr Hansen concluded that the programme of work she outlined would *'at best'* take a period of 12 months from its start. Whilst I accept that timeframe, I feel bound to comment that as Dr Hansen outlined what was contemplated and the therapeutic distance M still has to travel, I felt that there was a degree of optimism underpinning her time estimates. Perhaps, more importantly, I could find no real indicator from Dr Hansen's evidence suggesting that M would engage constructively in the therapy. Intrinsic to this therapy is unambiguous confrontation with M's false or delusional view of the world. To date, she has recoiled entirely from such confrontation.

40. Dr Weir's prognosis was uncompromisingly bleak. I had some sympathy for Mr Browne's questions of him which intimated that Dr Weir's view was a counsel of despair. Dr Weir told me that most people with personality disorders of the type that he identified in M, *'die with those disorders intact'*. Change or therapeutic progress, he described as occurring at glacial pace *(my expression, not his*). Certainly, he was contemplating many years of therapeutic intervention. Insofar as there is a conflict of view in respect of prognosis and treatment between Dr Weir and Dr Hansen, I cannot resolve it, nor for reasons that I will explain below do I consider it necessary to do so.

41. It may seem inconsistent with much of what I have set out above to say that I have no doubt at all, that M loves her children very much. Even though, she has repeatedly blamed A's complaint for the situation the family now finds itself in, she nonetheless describes A as *'her princess'*. She has told me expressly, that she loves her greatly. I do not regard this as manipulative, on the contrary, I see it as entirely genuine. To understand the apparent contradiction requires a careful understanding of what Dr Weir and Dr Hansen have analysed. M's psychological functioning causes her to have a distorted perspective on the world in which her genuine and instinctive emotions

coexist in parallel with her own carefully constructed and ultimately false narrative. For M, that which is real and that which coexists in consequence of her paranoia, can be accommodated at the same time. The two run separately and entirely disjointedly. The tension that creates causes M distress.

42. In cross examination, M was repeatedly confronted with occasions on which she has been an aggressor. Whilst she expresses some platitudinous acknowledgment of blame, these wilt under the heat of her unsparing and occasionally, vituperative criticisms of others. In truth she struggles to see any perspective on the world other than her own. It is inevitable and healthy for children to challenge their parents, but challenge causes unsupportable stress for M and, in my judgement, having listened carefully to her, this triggers the construction of a narrative which she finds it easier to live with. When confronted by A's assertion of her own teenage autonomy, M perceives this negatively as opposition in which she is obliged to *'pull rank'*, to use her phrase. At similar times in their respective development and for similar reasons, this has caused M to resort to violence against both Q and A. I sensed that this is driven by fear and a need to control and is not simply malicious in the way that it may sometimes have been perceived to be. Thus, M has convinced herself that Q and A both have mental health problems. This is an easier option than confronting her own mental health issues which, on some level, I sense she recognises will expose her to considerable pain and, as Dr Hansen has identified, the reawakening of past trauma.

43. Since the birth of S, M has argued for and submitted herself to repeated residential assessments, in which every aspect of her own and her baby's life, has been monitored. This has not merely involved 24-hour scrutiny by assessors but has, for over 18 months, included video surveillance. Assessment of this nature and intensity over such a period of time, is, at least to my mind, dehumanising. It is corrosive of personal privacy. All this has occurred in a time of pandemic which carries further restrictions of its own. The fact that M has been prepared to put herself through such a process, reflects both her courage and resolve to reunite her family. She has readily sacrificed her own liberty and freedom. This requires to be acknowledged unambiguously.

44. Whilst M may have created turmoil and distress to many within the unit by what I find to have been her verbally aggressive, intimidating behaviour, it must also be emphasised, that for the vast majority of the time, she has provided warm, nurturing care to her son. She is an intelligent woman. On a conceptual level, she has an educated understanding of the principles of good childcare. Her son has always been clean, appropriately dressed, properly fed, and bathed with love and affection. She has provided him with good, nurturing care and as I have been told, *'lots of eye contact and cuddles'*. At contact sessions (family time), her relationship with T has also been similarly warm and affectionate. There is no doubt amongst any of the professionals, that T loves his mother, although he has become increasingly unsettled by the artificial constraints of their relationship. A has also attended those contact sessions. I have been told that her motivation reflects her protective instinct towards T, rather than a genuine desire to meet with her mother.

45. I listened carefully to M's evidence, but in it, I could not find any meaningful or sincere acknowledgment of her own responsibility for what has happened to her family. Her response remains to hit out, verbally, at others. Despite all this, she has cooperated with Dr Hansen's marathon 19 hours of interviews and attended 12 therapy sessions. This leaves me with a clear impression that, at least on an intellectual level, she is highly

motivated to care for her children. My assessment of her resonated with Dr Weir's view that she is *'reluctant to take ownership of her problems'* and *'has a tendency to blame others for her difficulties'*. As Dr Weir makes clear, this reluctance to *'take ownership of her problems and tendency to blame others for her difficulties'*, renders her prospects of making *'meaningful change in the medium term… extremely limited'*.

46. I have highlighted the privations of this protracted assessment process from M's perspective. Residential assessments most commonly involve parents and very young babies and for relatively short periods. It is important to emphasise, with even greater force, the impact on S. S has been continuously observed by professionals for the whole of his life, barring short periods in foster care. Latterly, and for the past few months, he has been in M's care at her home on a supervised basis and then returned at the end of the day to his foster carer. Happily, the foster carer has been the same person throughout.

47. The present arrangements are monitored by a company named '247 Supervision'. Extensive logs of their daily observations have been filed. The logs are impressively detailed. On the 23rd April 2022, M was plainly recognising that S was becoming unsettled. M said that it was *'not fair'*, she described S' routine as *'up the wall'*. M said it is *'just messing with his head'*. All this strikes me as both accurate and sadly inevitable, having regard to what has been referred to by Mr Browne as 'the hot house' of the environment in which he has spent most of his first two years of life. What is surprising, at least to my mind, is that it has not been articulated as unequivocally and more volubly by the professionals. Again, I confess that I am utterly perplexed as to how it was thought acceptable to continue these arrangements for as long as has occurred. I simply cannot reconcile them with S's welfare interests.

48. M, notwithstanding her own complex and distorted view of the world, is right to identify the harm that these protracted residential arrangements have caused to her son. It is entirely illustrative of what Dr Weir and Dr Hansen have said, that alongside this insight into S's needs, exists M's own powerful and ultimately overwhelming personal distress. In a pattern which has been observed over many years, M manifests this distress by lashing out at others. She criticises the foster carer who she contends gives S *'what he wants'*. This was in response to an occasion on which S was plainly fractious and crying. M observed to the supervisor *'all of my kids have mental problems, so do I' … 'the social worker and everyone set me up'… 'on 3 occasions, they have taken him with no reason or with no Judge saying it'*.

49. Later that day (23rd April 2022), M said:

> "*Sometimes I think it's easier if he goes, he is going here there and everywhere and as a mum you don't want them put through it. I think, take him. Not nice, but I want what's best for him. This is messing him up.*"

50. In the early evening on the same day, M was plainly becoming stressed. She told the assessor: *'I have not got in a routine with baby, but I need to clean this house. This is getting on top of me, they are trying to put more pressure on me'.* A little later she is recorded saying *'I am putting him back on baby milk, it's got all of his vitamins in. I am just winging it and no one best clean my house and no one needs to open my curtains; it's nobody's business'.* After feeding S, M went upstairs with him to bathe

him and staff are recorded as sitting on the stairs when M returned downstairs. S is recorded to have closed the living room door. M told me, in her evidence, that he is always closing the doors. The logs record the following:

> "*[M] said, look at him closing the door again… I worry, serial killers do stuff like that. I'm not saying he is a serial killer, but I do worry".*
>
> *"[M] then told a long-winded story about her friend, whose dad was a Judge, he was stabbed by someone who had mental issues and had an obsession with closing doors"*

In the context in the history of this case, I find these remarks disturbing. They resonate with her views that Q and A have mental health problems. I note that M was stressed, and that S had been challenging at the time she made these remarks. Again, that resonates with the accounts of Q and A that I have analysed above.

51. All this requires to be factored into an accurate understanding of the nature of the risk to S. It is important that I highlight that notwithstanding the advice and guidance M has been given about the dangers of co-sleeping and the fact that there was a serious incident earlier in the assessment process which put S in danger, M again, recently had to be reminded not to fall asleep with her baby. On the 23rd April 2022, M had to be prompted three times before putting S in his cot. Reading the logs, I am sympathetic to M's distress. M had been trying to get S to sleep and she was plainly tired herself. She did not want to risk waking her son to put him in the cot, but her judgement was compromised. I accept, as Mr Browne points out, that at approaching two years of age, S is no longer at quite the same level of risk were he to fall. That is, of course, not the same as being risk free in a situation which was avoidable.

52. Finally, it is important that I address M's physical health. M suffers from a condition known as extra-cranial arteriovenous malformations (AVM). She was assessed by Dr Stephen Mullin, Consultant Clinical Neuropsychologist. He reported that there was no intracranial component and therefore no risk of any central neurological problem. He considered that M had been *'remarkably stoic'* about her condition. He found M to be highly articulate, friendly and entirely appropriate throughout the interview. She answered all questions put to her *'eloquently and well and provided accurate information about the nature of her medical condition… good recall of information and demonstrated no impairment to reasoning'.* This meeting was the polar opposite to the combative encounter with Dr Weir. Mr Browne leans on it to advance the proposition that those who deal with the mother sensitively and creatively may secure her open cooperation, rather than the responses that have been charted above. Whilst I respect the point made, I am left with the clear view, on the preponderant evidence, that M is entirely capable of being charming when she wishes to be so and especially, when her own 'false narrative' is not being challenged. Dr Mullin considered that there was no organic means by which AVM could affect M's personality or psychological functioning. But, he did emphasise that it is a *'serious physical health condition'* and the *'knowledge of having such a condition'* as well as *'the accompanying pain and discomfort'*, may well be highly stressful.

53. The Local Authority's care plan for S contemplates placement with a view to adoption. Counsel have not addressed me on the applicable law. It was not necessary for them to

do so. The law in this area is settled, though always challenging to apply, given the collision of such fundamental rights and responsibilities. What is contemplated is the deracination of a child from his mother and family. Wherever it is possible, and consistent with their identified welfare needs, children are entitled to be brought up within their birth families *(Re KD [1988] AC 806; Re W [1993] 2FLR 625)*. Care plans for adoption have been described variously as "very extreme" and only to be made when "necessary" for the protection of the child… when all other options have been discounted and "when all else fails" and when "nothing else will do". A plan contemplating adoption is properly characterised as 'a last resort': *(Re B [2013] UKSC 33; Re P (a child) [2013] EWCA Civ 963; Re G (a child) [2013] EWCA Civ 965).*

54. Despite her intelligence, eloquence and resilience, M's own experience of life has left her with significant psychological difficulties. On an intellectual level, she articulates a willingness to participate in what is, on any view, a gruelling therapeutic regime. The first objective of such therapy is to challenge M's distorted or delusional perspectives on the world. There is no evidence that process has begun. It is sadly all too clear that the timescales for M's therapeutic journey simply cannot be reconciled with S's pressing need for and entitlement to secure, loving, and settled family life. At two years of age, and in his circumstances, this can only be achieved within the framework of an adoption. In the not-too-distant future, A will most likely move on to college or university. T has a real prospect of being cared for by his father. Long-term foster care for S would therefore not involve a placement with his half-siblings. It would also not provide him with the security that adoption so frequently achieves for children placed at this age.

55. There are many aspects of M's care which have, properly, been commented upon in very positive terms. She has good practical caring skills and has been able to provide her son with a feast of good eye contact and cuddles. It will be painful for her to read but nonetheless important for her to know, that this serves to equip S well for the future and to enhance the prospects of a successful adoptive placement. Accordingly, I endorse the Local Authority's care plan, recording that it is also supported by the Guardian.

56. The Guardian has suggested that the Local Authority might consider an open adoption in this case. However, she recognises this is to be subjugated to the need to avoid delay. Ultimately, she considered that the objective should simply be to find a placement that is most suited to S's needs. I agree.

57. By way of postscript, I should add that it has not been possible to track down why it is that this case has drifted in the way that it has for as long as it has. No advocate or any other professional has sought to defend the lamentable delay, nor, in my view, could they. I have asked for a report from Children's Legal Services and from Cafcass setting out how they consider this has occurred and how it might best be prevented in the future.