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.

IN THE FAMILY COURT
(SITTING AT MILTON KEYNES.)

Before:
Her Honour Judge Brown.

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B E T W E E N :

AND IN THE MATTER OF THE CHILDREN ACT 1989
AND IN THE MATTER OF THE ADOPTION AND CHILDREN ACT 2002

MOTHER, MRS. R.
Applicant

-and-

MILTON KEYNES COUNCIL
1st Respondent

-and-

FATHER Mr. M.
2nd Respondent

-and-

THE CHILDREN
J, K AND Z.

(By their Children's Guardian Mrs. Sylvia Baker)
3rd – 5th Respondents

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Ms. Sayers Applicant/Respondent Mother.
Mr. Harris for the **Applicant/Respondent Local Authority.**
Ms. Meara for the **Child**

(By their Children's Guardian **Mrs. Sylvia Baker**)

Hearing dates: 19th. 20th. 21st. May 2014.
Draft judgment sent out on 28th. May 2014.
Judgment handed down on 3rd. June 2014

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Judgment

Her Honour Judge Brown.

I heard evidence in this matter over three days. At the end of the hearing I told Mother that I could not approve any of the children returning to her care but there were aspects of the case which I needed more time to consider and that I would hand down a written judgment. These are the reasons for my decisions.

The applications before the court.

J.

The local authority supported by the Children's Guardian seeks a Care Order in respect of J. Mother seeks the return of J to her care.

K.

Mother seeks discharge of the Care Order and revocation of the Placement Order in respect of K. Mother seeks return of K to her care. The local authority and Children's Guardian consent to revocation of the Placement Order but oppose the Care Order being discharged.

Z.

Mother seeks revocation of the Placement Order and discharge of the Care Order in respect of Z and seeks return of Z to her care. If the court does not consent to Mother's application for Z to return home, she seeks revocation of the Placement Order and for Z to remain in foster care with ongoing contact to her and the siblings, rather than being adopted. The local authority and Children's Guardian oppose both applications and the Children's Guardian supports the local authority placing Z with identified adopters.

The proceedings.

These proceedings are in respect of three children, J who is now 13 years old, K who is 8 years old and Z who is 5 years old. Their parents are Mr. M and Mrs. R who I shall refer to as Mother and Father. There are two older children in this sibling group, A who is now 18 years old and F who is now 16 years old. There is some dispute as to whether the father of two of the children is a Mr. I, but neither man has played a part in these proceedings.

There is a rather long and complicated history to this matter. This judgment should be read together with the judgment of Mr. Recorder Goodwin dated 15th. August 2012. I will not set out the history in any detail as it is clearly set out in that judgment. For the reasons given in that judgment, care proceedings were brought in respect of all five children and the four youngest were placed in foster care on 4th. October 2010. Suffice to say that the key concerns about the children were in respect of domestic violence between the parents and Mother's mental health. The children suffered from neglect but also from severe emotional abuse due to these difficulties. Mother accepts that at the time of the care proceedings she was extremely unwell.

At various stages, the Court determined that none of the children could return to their parents' care. The proceedings in respect of A, F and J were concluded on 24th April 2012 when Special Guardianship Orders were made to extended family members for three separate placements. The proceedings in respect of K and Z were adjourned to enable assessments in respect of alternative carers to be completed. This was not positive. Care Orders and Placement Orders were made in August 2012.

A has now left his placement and is now living with his paternal grandfather who is also his maternal great uncle. This is in a house in the next street from Mother's home. He visits Mother. F remains in her placement. I am troubled that she has not had contact with her mother or siblings for a substantial period of time.

The position of J is very troubling. Having been removed from his mother's care in September 2010, he remained in foster care until 21st. May 2012 when he was placed with family members under a Special Guardianship Order. He remained there until November 2013 when J's carers asked for immediate removal of J from their care when he was placed in foster care. J has remained in his current foster placement to date and His Honour Judge Hughes made J the subject of an interim care order on 19th. February 2014. The local authority, supported by the Children's Guardian, seeks a final care order with a view to either J remaining with his current carers or identifying a long term foster carer in the Bletchley area, in order that J will be nearer to the school of his choice, be nearer his friends and his mother. J attends a school in Bletchley but in fact wishes to move to a different school in Bletchley for reasons I do not have to detail here.

J is not separately represented. However, he takes a different view from the Children's Guardian. His case is that he wishes to return home to his mother's care. I enquired as to why J was not separately represented. The Children's Guardian told me that although J had stated he wished to return home to his mother, she did not consider these views to be strongly held and is concerned that they do not represent his real wishes and feelings. Mrs. Baker is particularly concerned that J feels under pressure to state that he wishes to return home when in fact he does not. At J's request I saw J with the Children's Guardian and with his solicitor. There is a note of that meeting prepared by J's solicitor Ms. Meara which is in the bundle. J told me very clearly that he wished to return home to be with his mother, he felt it was time for him to grow up and take responsibility and he is embarrassed about being in foster care. On the face of it, his wishes could not have been more clearly expressed.

Mother wishes J to return to her care.

In respect of K, he was removed from his mother's care on 4th. October 2010 and has remained with the same foster carer throughout. Until 20th. May 2012, K and J were placed together. The local authority's plan is for K to move to a long term foster placement in Birmingham. Mother wishes K to return home to her care and K wishes to return to live with Mother. The Children's Guardian supports the local authority's care plan. On the basis that the local authority no longer seeks an adoptive placement for K, the local authority and Children's Guardian support the revocation of the Placement Order.

In respect of Z, she was removed from her Mother's care on 4th. October 2010 when only 16 months old. She moved to a second carer on 2nd. August 2012 and then moved to her current carer on 22nd. March 2013. Mother seeks return of Z to her care and in the alternative for her to remain with her current foster carer. The local authority has identified adopters who have been waiting for a decision in respect of Z since October 2013. If the Placement Order is not revoked, Z will be placed with these adopters in July/August 2014.

Issues.

J

1. Are the threshold criteria satisfied in respect of J.
2. Should he be made the subject of a final care order or should the court approve his return home to his mother.
3. What level of contact should J have with Mother and his siblings depending on his placement.

K.

1. Should the Care Order be discharged and K return home or should K be placed in long term foster care. There is agreement that the Placement Order be revoked.
2. What contact should there be between K and his mother and siblings.

Z

1. Should Z be returned to the care of her Mother.
2. If not should Z remain in long term foster care.
3. Should the court approve adoption for Z at this stage.
4. What contact should Z have with her mother and siblings.

I should note here that Mother was granted permission to apply to revoke the Placement Orders in respect of K and Z. The matter came before District Judge Perusko on 3rd. March 2014 who granted Mother permission to make these applications. District Judge Perusko was, I am told, presented with an agreed position between the parties. The pre-amble to the order states,
"And Upon the parties agreeing that there has been a change of circumstances and the children not having been placed for adoption and not yet having been matched with permanent carers and that the Respondent's mother's applications should be heard."

On that basis Mother was given permission to apply for revocation of the Placement Orders in respect of K and Z. There was therefore no judicial determination at the permission stage in respect of what (in my judgment) is the key issue in the case, namely mother's current mental health and her consequent ability to care for the children. The basis of the permission granted is in fact now incorrect in respect of Z as a placement has been found and the local authority wishes to place Z as soon as possible. I will address the way I approach the application to revoke the Placement Order in respect of Z in due course.

The Hearing.

I have read the bundle of core documents from the previous proceedings and the current bundle. I heard oral evidence from an expert witness Dr. Sarkar, from J's social worker Ms. Gill Howard, from K and Z's social worker Ms. Stott, from Mother and from the Children's Guardian. As mentioned, I also saw J at the end of the first court day.
I have read the documents from the earlier proceedings. Contained within that bundle is a report from a Chartered Clinical Psychologist Dr. Amita Sarkar who assessed the children and Mother.

I noted with interest that in 2011 A, J and K shared a close bond. F felt particularly close to K followed by J and Z but F, "expressed her dissatisfaction regarding her past role of caring for her younger siblings, particularly Z."

The first witness I heard from was Dr. Sarker who was instructed by the parties as an expert witness, with Mother as lead. He is an adult psychiatrist. He brings with him the enormous advantage of being able to conduct his assessment in Bengali and can therefore communicate directly with Mother. He also has a very good understanding of the cultural issues in this case. Having seen Dr. Sarkar's CV I am satisfied that he is suitably qualified and has extensive experience in the relevant field. Dr. Sarkar has prepared a number of reports both in the current and past proceedings. The first report I have from Dr. Sarkar is dated 15th. January 2011.

In that report Dr. Sarkar writes the following,
"After careful assessment it is my opinion that Ms. R suffers from Severe Depression (Major Depressive disorder). It is my opinion that the Severe Depressive Episode is presenting with Psychotic Symptoms. I have attached at Appendix the DSM 1V-TR criteria for Major depressive Disorder. The court will see that Ms. R fulfils many criteria such as depressed mood, suicidal ideas, sleep and appetite disturbance, hopelessness, helplessness, low self worth. Additionally she has persecutory beliefs, visual hallucinations and delusions of being controlled (passivity and thought interference.) I do not believe she meets the criteria for any Personality Disorder. It is likely that she has some form of Chronic Post Traumatic Stress Disorder arising from years of abuse but it is difficult to ascertain what part of her significant anxiety symptoms (hot flushes) are attributable to the severe depression and what is because of the Post Traumatic Stress Disorder. I believe the anxiety is part of the overall depressed picture and will be allayed by appropriate treatment of her depression."

Dr. Sarkar addressed Mother's belief that she had been forced to behave in certain ways (including fathering two of her children by a man who is not her husband) due to "Black magic." Dr. Sarkar comments on the issue of black magic as follows,
"The only thing that can be said with a degree of certainty is that had Ms. R not been depressed and psychotic, she would have probably been less likely to believe in the so called "Black Magic." Conversely, if she is treated and recovers from her depression and psychosis, she is less likely to rely on it as an explanation for all its ills. That she has suffered ill is not in dispute. Whether they are caused by so called "Black Magic" is clearly an issue in her mind. I remain hopeful that once her illness is effectively treated she will be able to separate the two issues and not focus on the causal link even if she continues to believe in the practise. Stress is well known to be a precipitator of mental illness in someone so predisposed. In Ms. R's case it would appear that she had a fair amount of stress to contend with. The family discord which

Ms. R alludes to …can easily be a major stressor perpetuating her illness in a circular way."

In terms of treatment Dr. Sarkar recommended in 2011 that Mother needs intensive treatment for depression and therapeutic work to deal with Mother's issues of trust, dealing with authorities and the sequelae of prolonged abuse. In an addendum report dated 28th. January 2011 Dr. Sarkar wrote,
"It is impossible to predict with any degree of certainty how long before the improvements begin to manifest. It depends on number of factors such as treatment given, social support, home situation, employment, personality structure of the patient and resilience. The improvements expected with effective treatment would be an increase in energy level, not feeling tired and run down, improvement in the level of paranoia, improvement in sleep, appetite and activities of daily life. Childcare is an essential part of Mrs. P's daily life but sadly this has proven too much in her current state. Despite what she says she should not be rushed or pressured into resuming care of the children, especially the little ones."

A third report from Dr. Sarkar in the bundle dated 7.3.2012. In that report Mother is noted as stating,
"Ms. R remains depressed and felt that her life is finished with nothing to look forward to. She said that not only does she not have happiness in her life, she does not have peace either. She said she did not have a moment's happiness in the last 12 years which have been marked by neglect from her husband, constant persecution by the neighbours and slowly the children being the way they were. She admitted that she was in the end unable to look after the children as it all became too much for her with virtually no support. She became tearful when talking about how the children's relationship with her are changing and how the little ones do not seem t o be as attached to her as they should be under normal circumstances."

Fortunately Dr. Sarkar was available to complete a recent psychiatric assessment dated 17th. January 2014. His updated assessment reads as follows,
"As directed by the court I have conducted a psychiatric assessment that included a psychiatric interview, record review and interview with a third party informant. After my careful assessment it is my opinion that Ms. R suffers from Moderate depression (Major Depressive Disorder). It is my opinion now that the Depressive Episode is no longer presenting with Psychotic Symptoms. I do not believe that she meets the criteria for any Personality Disorder. It is likely that she still suffers from some form of Chronic Personality Disorder arising from years of abuse but it is difficult to ascertain at the moment the full extent of it. She does not show anxiety symptoms and it is likely with treatment (with anti depressants) much of the anxiety symptoms have remitted. Given that she has almost no psychological treatment for PTSD, it is likely that if hr depressive symptoms relapse, she might have a relapse of her anxiety symptoms.
It is my opinion after careful consideration of the longitudinal history that Mrs. R is in remission from the psychotic symptoms and in incomplete remission of her depressive illness. Although it is encouraging to see the tremendous progress she has made with treatment, certain bio-psycho-social factors are contributing to maintaining the depressive illness. Inter alia, these are relative social isolation, loss of children (akin to bereavement), lack of meaningful activity and the stress of continuing litigation. However, she is being treated and followed up by mental health professional and it is

likely that resolution of the court case will give her some sort of closure. The more she recovers, the more she will be able to fight off the stressors and maintain her recovery. Regarding sustainability of the recovery, it is prudent to take a cautious approach as the factors outlined above are essentially external factors (out of her control.) It is however reasonable to surmise that, in the absence of further major life events and adherence to treatment, the risk of sudden relapse can be mitigated to a large extent. If she remains under treatment and supervision, it is likely that the improvement will be sustained."

In respect of risk of relapse Dr Sarkar writes,
"I will say there is a risk of relapse which cannot be predicted with certainty. Following factors would point towards a heightened risk of relapse – a. stopping treatment, b. going off the radar of support and supervision of mental health professionals, c. major life events, d. lack of or withdrawal of social support from the family or the state and , e. return to an abusive relationship. These risks can be mitigated relatively easily through ensuring that she has the support and supervision from the mental health professionals, support of the family and some psychological work around loss and relationship. I am aware of the paucity of psychological therapy in the NHS and the practical difficulties in arranging these. However, I would be failing my duties as a psychiatrist if I did not spell out clearly what would be beneficial to the patient given her presentation."

Dr. Sarkar continues,
"I believe that Mrs. R has recovered to an extent whereby she has now good insight into her difficulties and how to tackle them. She is readily agreeable to treatment and supervision and seems to understand the risk of relapse and what to do in case of imminent relapse. I consider therefore that she is now ready to take the necessary steps to sustain her recovery and works towards further improvement. It would not be wise to prescribe a set timescale anyway, I would say at least a further year in treatment accompanied by therapy will place her in a better position to sustain recovery and make the necessary changes.
We have seen already the impact of this illness on her capacity to care for her children both physically and emotionally. It is true that mothers with depression (severe and untreated) leaves the children open to possibility of developing psychological problems in later years. However, treated depression and depression that is in remission does not ordinarily have any impact on a patient's ability to care for her children. In this stage of recovery, I do not consider her to be unable to satisfactorily perform her role as a parent. That she will be the sole carer may be cause for concern for her mental health as parenthood is not an easy matter but this risk could be managed by additional support which the human services will have in place for her. It needs to be ensured that the patient does not stop treatment without medical advice and is supervised and monitored closely when she is under treatment."

One particular issue raised by Dr. Sarkar was in respect of whether Mother would ever reconcile with her husband. Dr. Sarkar wrote in his addendum report,
"First of all Ms. R made it clear to me that she was "thinking" about giving her husband another chance. She has not decided on it. Should she decide to do exactly that, there is very little one can do about it."
Dr. Sarkar noted that mother has not had psychotherapy. As he stated,

"If she was under my care, I would have arranged for a Bengali speaking psychotherapist to work with her issues of loss, violence and abandonment. If I was co-ordinating her treatment, I would have ensured that such therapy took place once a week for at least a couple of years. I know the reality is very much different."
In evidence Dr. Sarkar was asked about Mother suggesting she may allow her husband back into her life. Dr. Sarkar told me that it is a possibility Mother would consider but she had not decided. This is only on the basis that Father actually turned up at her house and asked her to take him back. She told Dr. Sarkar,
"I do not know where he is but if he does come back I will think of giving him another chance." Dr. Sarkar asked her if she thinks her husband has changed and she told him she does not know and she would have to see. She would talk to a therapist and her brothers.

Dr. Sarkar was asked whether he had read the report of the Children's Guardian which had not been filed at the time that he had written his report. Dr. Sarkar wrote,
"My basic opinion has not changed but having seen the Guardian's report I'm beginning to see where the concern lies."

Dr. Sarkar pointed out that when he assessed mother, he thought that Mother only sought return of the two younger children and there was no question of three children being returned. Dr. Sarkar told me,
"Mother is medically in a better position than she was during the last proceedings – that is encouraging – she now accepts her illness and the need for treatment and support but I also have concerns about maintenance of her condition. I have set those out – I was and am very clear – the degree of stress which probably drove her to serious episodes of psychotic depression – there is more than an even chance that she will relapse if she is exposed to the same sort of stress."

The stress to which Dr. Sarkar is referring is the stress of her husband returning, the stress of looking after three children under 14 years old and lack of social support. Going through the support mother has, Dr. Sarkar clarified that Mother has the monthly depot injection which clearly assumes a form of administration of the drug which allows for clear monitoring that the patient is taking treatment. This is for the psychotic symptoms. Mother also takes anti depressants in tablet form and this cannot be monitored. One has to assume insight on the part of the patient for the need to take this medication. Dr. Sarkar repeated that tight supervision and ongoing treatment would, "go a long way to maintaining remission."

Dr. Sarkar told me that he thought three children would be too many for mother to care for but, "she could probably manage two with all the support around her."

Dr. Sarkar was asked about the position of J. He told me that it is normal in Asian culture for older children to assist in caring for younger children but he expressed concern that J would become more involved in looking after the children if he were to return home with his younger siblings.

Under cross examination from the local authority, Dr. Sarkar told me that Mother's basic diagnosis has not changed from when he first assessed her in 2011. However, two years down the line the psychotic symptoms have gone and the major depressive disorder is no longer severe. He now describes mother as having major depressive

disorder without psychotic features alongside PTSD, the latter still not having been treated.

Asked about Mother's PTSD, Dr. Sarkar told me this does not "directly compromise the children" but that it, "complicates the depressive picture." The presence of PTSD may contribute to and maintain the depression which can make the PTSD more difficult to treat. Dr. Sarkar thought CBT would assist Mother. I asked Dr. Sarkar about a patient accessing a talking therapy when an interpreter would be involved. Dr. Sarkar told me that there have been studies in respect of this. CBT has been shown to be successful even when accessed through an interpreter but other forms of therapies such as psychoanalysis are far more difficult when the patient and therapist cannot communicate directly. Dr. Sarkar thought that Mother would benefit from two years of therapy to treat the PTSD and the underlying causes of depression. In respect of Mother reconciling with Father Dr. Sarkar is concerned about the pressure mother may experience from her family to reconcile with her husband should he return.

Under cross examination on behalf of the children, Dr. Sarkar told me that Mother can suffer side effects due to the medication she is currently taking such as sleep disturbance, tiredness, restlessness, weight gain and a sense of feeling detached.

Dr. Sarkar told me that in his opinion the depot injections should be decreased and a trial take place to see whether mother could come off them completely. Given that Mother no longer has psychotic symptoms he was optimistic that she could stop receiving the depot injections and yet remain free of psychotic symptoms. He would also advise mother to take Temazapan rather than Amiltriptaline as an anti depressant. Dr. Sarkar accepted that it would be too risky to place any of the children back with mother whilst her medication is being "recalibrated." It would take at least three months for the "depot injection" to leave her system and monitoring take place to see what effect if any this would have on mother. Dr. Sarkar accepted that he had not discussed any of this with Mother's treating psychiatrist and did not know what his view of Mother's treatment would be.

I next heard from Ms. Howard. She is J's social worker. I have read her two statements. J has told Mrs. Howard that he wishes to return to live with his mother or to his grandfather's home with his brother A. He is however clear that he does not wish to move from placement to placement and he would like the next move to be until he is 18 years old.

Mrs. Howard told me that J is compliant and co-operative and has done well at school. J is very loyal to his family and has expressed a desire to help his mother. He sees his role as assisting his mother in caring for the siblings. Mrs. Howard told me that the SGO placement broke down because J had been "mixing with the wrong people, " and the carers could not cope with what they considered to be J's "difficult behaviour." Mrs. Howard has met mother on two occasions at her home. She was concerned that on both visits mother was just getting up and appeared lethargic. Mrs. Howard told me that mother was able to talk about the mechanical parenting that the children would require but in her opinion Mother showed little insight into the children's emotional needs. Mrs. Howard is extremely concerned about Mother having the energy levels to care for any child but in particular for three children.

Mrs. Howard told me that J has monthly contact with his mother and K and Z. He has erratic contact (if any) with F. He telephones his mother daily. Mrs. Howard had a practical approach to the issues of contact. She would like it to be consistent with long term foster care but accepted that J will contact his mother by telephone on a regular basis and did not consider it to be in J's best interests to be too prescriptive about this. Mrs. Howard told me that J and K have a very close relationship but J does not know Z very well.

J's current carers are considering whether they wish to be his long term carers. J wishes to move to Bletchley although J only lives about a 15 minute drive from Bletchley.

Mrs. Howard told me that J is extremely worried about his mother and feels a constant anxiety for her. Mrs. Howard is concerned that J states that he wishes to return to live with his mother out of concern for her and because he knows that is what his mother wants. However, there have been no behavioural concerns about J in his current foster placement, he has a good relationship with his current carer and he expresses his concerns and worries.

J had very little contact with his siblings and mother when placed with his Special Guardians.

I then heard from Ms. Stott, social worker for K and Z.

Ms. Stott told me that K is an incredibly gifted child and is academically extremely able. He has settled well into his placement. I am told that his current foster carer is not putting herself forward as a long term carer. Ms. Stott sets out in her statement her discussions with K about his wishes and feelings. I have taken particular note of paragraph 17 at C11. In a "perfect fantasy world," he would like to live with his current carer and see his mother. The local authority accepts that an adoptive placement will not be found for K and there has been ADM approval to accede to Mother's application to revoke the Placement Order, on the basis of a change of care plan. A long term foster placement has been identified for K. Although approved as foster parents, this particular family need to be taken to panel as a match for K but the social worker does not anticipate there being any difficulty at the matching stage. The foster family describe themselves as "liberal Muslims" and live in Birmingham. The social worker considers them to be a very good match with both the male and female foster parents likely to be excellent role models for K. Ms. Stott considers K to be extremely anxious about his mother. Ms Stott does not support K returning to his mother's care as she is concerned that his physical and emotional needs would not be met." Interestingly K has expressed concern to Ms. Stott that his needs might not be met if he returned home telling her,
"I might not be cared for, I might not go to school – it might be better if I see my mum but go somewhere else." K speaks English and some Bengali but not a great deal although he can understand more than he can speak.
Ms. Stott's assessment of Mother was similar to that of Mrs. Howard. She felt Mother's thinking about parenting was very concrete, focussing on the practical aspects of care rather than the more complicated aspects of emotional care, particularly for these children who have not been in her care now for four years. Despite his abilities, Ms. Stott considers K to be an emotionally fragile child.

In respect of Z, she has not lived with her mother now since she was 16 months old. She does not speak Bengali. Ms. Stott does not consider her to have a close relationship with her mother and does not ask to see her. Adopters have been identified for her. They are a dual heritage couple, but practise the Muslim faith. They were identified last October but due to the proceedings the matching process has faltered. Ms. Stott considers them to be a very good match and wishes to take Z to panel on 5.7.2014 with introductions to commence shortly thereafter. The local authority plan is for Z to be placed by the end of the summer holiday.

The documents set out why there has been an inordinate delay in placing K and Z. It serves no purpose to rehearse the difficulties here. Suffice to say that efforts have been made to find a placement for K and Z and ultimately the local authority decided to look for separate placements. The delay in finding permanent placements is extremely unfortunate.

Asked about contact Ms. Stott accepted that there were no particular problems with contact or areas of risk identified. However she felt that on the two occasions she observed contact there was a lack of response from Mother to the children's attempts to engage her.

Ms. Stott told me that Z, "mechanically attends contact, " with her mother and it seems simply part of her routine. She does not ask about her mother.

I was concerned about whether it would be in Z's best interests to remain with her current foster carer, if she cannot return to mother, rather than be placed for adoption. The local authority therefore sought permission to call Ms. Noble, the adoption team manager. She had met with the foster carer on 26.7.2013. This foster carer has just adopted a young baby and is therefore only seeking to foster another child for the foreseeable future although Ms. Noble thought that this was more for financial reasons. At the moment the foster carer is stating that she is prepared to be the long term foster carer for Z but she is not willing to put herself forward as an adopter.

Ms. Noble met with the prospective adopters a couple of months ago. They are a dual heritage couple and are Muslim. She described them as very experienced parents. She confirmed they have been prospective adopters since October 2013.

I then heard from Mother's brother Mr. R who has filed a statement. He lives in London with his wife and he has four children all of whom have highly achieved academically and are professionally employed, as are Mr. R and his wife. Mr. R explained that he had enjoyed a much higher level of education in Bangladesh than his sister. Mr. R told me that he and his wife had not been aware of the level of difficulties between his sister and her husband or that she had such dramatically declining mental health. He told me now that he would offer his sister physical, practical and financial support, "whatever she needs." His wife had usually spoken to mother on the telephone. He now tried to visit his sister once or twice a month and has telephone contact with her two to three times a week. He sometimes takes mother to Birmingham to see extended family. Mr. R takes the view that Mother has no mental health problems now and she is separated from her husband. He therefore takes the view that the children should be returned to her care. Mr. R has contact with

A and F but he has had no contact with the three youngest children since they were removed four years ago.

At the end of the first day I was told in terms by Counsel on behalf of the local authority that the prospective adopters for Z would facilitate at least annual direct contact between Z and her siblings and there may be a possibility of greater contact. However, this issue was clarified overnight and in fact at the present time the perspective adopters are not willing to facilitate direct contact with any members of the birth family.

I heard from Mother. She has filed two statements. In her first statement mother states that she does not know whether she will ever reconcile with her husband and that she has heard through a cousin that Father does not wish to reconcile with her. However she writes at C52, paragraph 11, "I have to admit that if he did want to reconcile I would agree to this."
Mother concedes in her statement that she has suffered from mental health difficulties in the past but she does not believe she will relapse now.

Mother also states that she has started English language lessons at the beginning of May 2014. She sets out that she believes that her circumstances are much better than before, with improved mental health and support from her extended family.

In evidence through an interpreter, Mother repeatedly emphasised that she intends to care for the children and she will not delegate care of K and Z to J and A. She told me that the state of the house (which had been poor) has also greatly improved.

Mother is strongly opposed to Z being adopted and extremely distressed at the thought of the siblings not having contact.

Mother told me that she intends to comply with her medication. She accepted that Dr. Sarkar had not spoken to her treating psychiatrist and therefore she does not know what his view of changing the drug regime would be. Mother accepted that she does suffer from sleep disturbance and can feel drowsy as a result of the medication. Mother told me she has not undergone therapy. She did not seem to realise this has ever been recommended.

Mother told me she has no contact with her husband and does not know where he is (although he is her first cousin.) She told me (despite what it says in her statement) that she has not thought about giving her husband another chance.

Lastly I heard from Mrs. Baker, the Children's Guardian. Mrs. Baker is an extremely experienced Guardian and had been the Guardian for these children in the previous proceedings. She was absolutely clear in her recommendation that the risks to these children are far too high to return any of them to their mother's care. She urges the court to make a Care Order in respect of J, to revoke the Placement Order in respect of K and approve long term foster care for him and not to revoke the placement order in respect of Z but to approve Z being placed for adoption.

In respect of J Mrs. Baker told me that having spent time talking to J she did not believe his views were that strong. She told me, "he recognises that he is likely to be

staying in foster care." Mrs. Baker believes J is almost paying lip service to his mother and believes he has to say he will return to the care of his mother. Mrs. Baker had actively considered whether J should be separately represented but took the view that his real views did not depart sufficiently from her own for separate representation to be justified. He has told Mrs. Baker he would like to move to the Bletchley area and be able to spend time with friends. In fact his current foster cares already facilitate that to a degree. Mrs. Baker supports contact between J and K at six times a year with the flexibility to increase this contact in the future.

In respect of Z, Mrs. B strongly supports Z being placed for adoption. She takes the view that Z needs permanence. On behalf of Z she does not accept that long term foster care, with the possibility of further moves, when there is an appropriate adoptive placement available, is a viable option given Z who is only 5 years old and has not lived within her birth family for four years. Mrs. Baker did not know that the prospective adopters at the moment are not prepared to facilitate direct inter-sibling contact until the third day of the hearing, but having considered this information, she remained strongly of the view that Z's permanent adoptive placement must be secured. In her view, no other placement will meet this child's pressing need for permanence and stability particularly given her age and the history of placement moves.

Mrs. Baker accepted that mother has made changes but in her view the changes are not sufficient for her to have confidence to place the children back with mother. Mrs. Baker pointed out that mother has appeared tired within the court room setting and she is very concerned about mother's energy levels and her ability to meet the children's physical needs let alone their emotional needs. Mrs. Baker does not consider that it is reasonable to expect the 18 year old A to supplement Mother's care to a degree which would be acceptable. Mrs. Baker told me,
"These children have been through a dreadful experience before they were received into care – now they have appropriate care. Returning them to mother would make them feel insecure because they would fear Mother relapsing, in particular J who will remember his mother telling him that he is possessed. I am not sure that Mother has the insight and understanding to deal with that."

Mrs. Baker is also concerned about father returning and found it surprising that mother does not know his whereabouts given the close family connection.

Mrs. Baker is very concerned that J will feel so responsible for his mother if he returns to her care that his educational work, which is so important to him, will suffer. In respect of contact Mrs. Baker considers that fortnightly contact between J and his mother may be appropriate. However, the position of K and Z are very different. Z was 16 months old when she went into care and she described Z's memories of being parented by her mother as, "non existent." Mrs. Baker hoped that F would join in contact 6 times per year with J and K.

Analysis and findings.

I have considered the evidence in respect of Mother's mental health at some length. There is no doubt that Mother has been taking her medication and appears to be compliant not only with accepting the depot injections but also taking her anti

depressants. She has not accessed CBT and appeared not to be aware that that had been recommended. I can foresee difficulties with that because an interpreter would need to be found but Dr. Sarkar told me this is possible. There are clearly side effects from Mother's current drug regime and I am very concerned about mother's disturbed sleep patterns and low energy levels. I am also concerned about mother having the sufficient emotional attunement to her children's needs, particularly if heavily medicated. Dr. Sarkar recommended that a "re-calibration" of mother's medication be tried. That is of course a matter for the treating psychiatrist. However, even on Dr. Sarkar's evidence, he would not recommend any of the children being returned whilst Mother's medication is being altered. She would have to be closely monitored to see the effect on her, particularly if she is to stop receiving depot injections. That would take at least 3 months before the depot injection medication was out of her system. Clearly there would have to be consultation between Dr. Sarkar and Mother's treating psychiatrist and I have no evidence before me as to whether this "re-calibration" would be agreed upon or what effect such a change in the medication regime would have on mother other than Dr. Sarkar's opinion. Therefore, there would have to be an adjournment for Dr. Sarkar and the treating psychiatrist to discuss treatment plans and I would have to consider their joint opinions and timescales before I could consider placing any of the children back. That would cause further delay for these children.

Even on Dr. Sarkar's original opinion of Mother remaining on her current medication, there is a risk of relapse particularly with certain stressors namely, father returning, the care of three children under 14 and social isolation/lack of support.

Whilst I liked Mother's brother and consider him to be a genuine and decent man, he lives in London, works full time and has a full and busy family life. His wife also works full time as a lecturer. I have no doubt that he is very concerned for his sister and does all he can for her but his practical assistance is limited by his own responsibilities and by living in London. He is not putting himself forward as a carer for the children but as a support to mother. I accept he offers Mother companionship and emotional support to an extent but I do not accept that he can offer the daily practical support and monitoring that in my judgment this mother would require, at least in the short and medium term.

Mother remains quite an isolated individual. She has only just started at a college, some three weeks ago, learning English and therefore there are real communication barriers for her with the outside world. I am concerned about the pressure that would be brought to bear upon her by her extended family should her husband return and I am not confident that mother would turn her husband away if he wished to reconcile with her. Given the history of domestic violence I find this extremely concerning.

Mother has not had care of any of these children for four years. Each of these children has very specific needs. I am very concerned that J would take far too much responsibility for his mother and his emotional needs would not be met. He needs to be cared for and encouraged to fulfil his academic potential rather than become his mother's emotional carer. He is burdened with a heavy sense of responsibility for his mother's mental health and as an adolescent boy he is ill equipped to cope with trying to care for his mother. He should not be put in that position.

K is an extremely able child but has been described to me as "emotionally fragile." His views about returning home appear to me ambivalent and I accept the evidence of Mrs. Baker that he may fear Mother relapsing. That is certainly suggested by what he said to Ms. Stott.

Mother may find Z a very difficult child to parent if she was placed with Mother. Z does not have a strong relationship with her mother and cannot speak Bengali. She is very young and Ms. Stott thought Z will find it difficult when she first moves from her current carers. The next placement will be her fourth placement. A breakdown of placement and removal further down the line would be very damaging for Z.

In my judgment, the risk of relapse, which Dr. Sarkar tells me clearly remains, is too high to consider placing any of these children back with mother. It would be catastrophic for these children if they were to leave their current foster placements and be placed back with mother, only to suffer a further placement breakdown because mother suffered a further mental health relapse. I commend mother for her medication compliance and I consider her utterly genuine in her love for and commitment to her children, but in my judgment, the risks of relapse to her mental health in caring for any of these children are simply too high. With a very heavy heart I cannot approve return of these children to her care.

In respect of J I have to consider whether the section 31 threshold criteria are satisfied. The local authority has set out the threshold criteria which are supported on behalf of J through Mrs. Baker (although I doubt that J would articulate support of them.) Mother does not accept that the threshold criteria are satisfied on the basis that her mental health has significantly improved. I am satisfied that the threshold criteria are satisfied pursuant to section 31 as set out at A1 of the bundle. There is a clear risk to J's emotional wellbeing if returned to his mother's care. Rather than his emotional, psychological and educational needs being met, in my judgment there is an unacceptable risk that J would feel responsible for his mother and he would suffer emotional and physical neglect. He has received consistent care since November 2013 and is doing well in foster care. Given the difficulties of the past J needs stability and to have his needs met in until he reaches his minority.

I have considered the section 1(3) welfare checklist. I have in particular considered J's wishes and feelings. There is no doubt that he clearly expressed his views that he should return home to his mother. He feels responsible for her and he is embarrassed about being in foster care. However, he is achieving well academically and he is not running from his placement. In fact he is compliant and co-operative. Mrs. Baker is concerned that his expressed wishes are those expressed out of loyalty for his mother.

J's physical, emotional and educational needs. J needs to have his needs met, not be responsible for caring for his siblings or for mother. He has suffered neglect and emotional abuse. His mother did not deliberately emotionally harm him but she became extremely unwell and considered him to be possessed. This must have been extremely frightening for J. He may well have felt responsible for his mother's ill health. He is an able child with ambitions to attend university. In my judgment his needs will not be met if he returns to his mother's care and he is at risk of suffering emotional harm and neglect. Given his history this would be devastating. The likely effect of a change in his circumstances. J is already in foster care having suffered

placement breakdown. He seeks a foster placement in Bletchley although his carers have put themselves forward as long term carers. It may be that J will be prepared to remain there and I hope that option is fully explored. In any event, a foster placement will only be considered in the area local to Bletchley and which facilitates ongoing direct contact with the birth family.
I have set out the harm J has suffered and is at risk of suffering and it is for all of these reasons that mother is not able to care for J at this stage. His father is not putting himself forward and a family placement under a Special Guardianship Order has already been tried. For all of these reasons, in my judgment, the only order which will safeguard J's welfare is a Care Order. I therefore make a care order in respect of J approving the local authority's care plan to place him in long term foster care. In respect of contact I am not going to make any defined contact orders. Mrs. Howard presented as an experienced and sensible social worker with J's interests very much at heart. I have confidence in Mrs. Howard that she will promote as much contact between J and his mother as possible consistent with a foster placement. Mrs. Howard was realistic that J would have to be permitted quite a high level of contact with his mother given his age and determination to have contact with mother. It may be that weekly direct contact is appropriate. In respect of inter-sibling contact I hope J and K can have monthly contact but I accept that until they are both settled in their new placements, bi-monthly contact may be more realistic. J will see A as can be arranged and I expect this will increase as J gets older. I very much hope that F will take part in at least the monthly contacts that will be arranged between K and his mother.

In respect of K many of the same considerations apply to K as they do to J. K has expressed a desire to return home but he clearly has anxieties about whether his mother will be able to meet his needs if he does return. I accept the evidence of Ms. Stott that he is emotionally fragile but extremely academically gifted. He needs permanence and security and I sincerely hope that the identified foster carers will offer him long term care until he is 18 years old. He has a pressing need for his physical, emotional and educational needs to be met. However, given the evidence in respect of Mother's mental health and the risk of relapse, I do not consider it to be in his best interests to return home to Mother. I therefore refuse the application to discharge the care order. However, given that the local authority care plan has changed from one of adoption to long term foster care, it is in K's best interests that the Placement Order is revoked and I revoke the Placement Order in respect of K. I approve the local authority plan for long term foster care. In respect of contact I make no defined contact orders but approve the local authority proposal of bi monthly contact between mother and K. I hope there can be monthly contact between J and K but I approve a minimum of bi monthly contact. I hope F and A will attend these contacts.

I say at once that I have found the applications in respect of Z the most difficult aspect of this case. Whilst I am satisfied for all the reasons set out above that Z cannot return to the care of her mother and therefore I will not discharge the Care Order, the application to revoke the Placement order is a separate, distinct and important application. Although I do not consider it to be in Z's best interests to discharge the Care Order, it does not necessarily follow that I should therefore refuse to revoke the Placement Order. Different considerations apply. I was not provided with skeleton

arguments or referred to case law by any of the advocates. I have therefore considered the relevant law myself.

. Mother has permission to apply to revoke the order, decided on the limited basis that (at that time, the children not having been matched with permanent carers) although I am now told that the prospective carers for Z had been identified as far back as October 2013.

In considering the application to revoke the Placement Order, I have considered the entirety of **Re B-S (Children) [2013] Civ 1146.** Whilst I am considering an application to revoke a Placement Order, I remind myself of what that order means for this child. If it is not revoked Z will be placed for adoption with the identified adopters which is the most draconian of orders. In particular I remind myself of paragraph 22 of **Re BS** namely,
"The language in **Re B** is striking. Different words and phrases are used but the message is clear. Orders contemplating non consensual adoption – care orders with a plan for adoption, placement orders and adoption orders – are a "very extreme thing, a last resort", only to be made where "nothing else will do." Where no other course [is] possible in [the child's] interest", they are "the most extreme option", a last resort when all else fails" to be made "only in exceptional circumstances and where motivated by *overriding requirements* pertaining to the child's welfare, in short where nothing else will do."

I have also specifically considered paragraphs 32 – 34 of **LRP (A child) (Care Proceedings: Placement Order.)** per Pauffley J.

"The legal principles of application when the court is confronted with applications of this kind are well known, Where possible, consistent with their welfare needs, children deserve an upbringing within their natural families **(Re KD [1988] AC 806; Re W [1993] 2 FLR 625).** Care plans for adoption are "very extreme" only to be made when "necessary" for the protection of the children's interests, which means "nothing else will do," "when all else fails". Adoption "should only be contemplated as a last resort" (**Re B [2013] UKSC 33; Re P (a child) EWCA Civ 963; Re g (a child) EWCA Civ 965.)**
Before I could consider placing LRP elsewhere than with her parents, or one of them, I must be sure there is no practical way of the authorities or other agencies providing the requisite assistance and support which would allow her to be cared for by at least one of their parents **(Re B-S (Children) [2013] Civ 1146.)**
I must analyse and consider all of the realistically available competing options and I must weigh in the associated positive and negative factors. I have to be satisfied there is a sufficiency of evidence in relation to each proposal so as to undertake a global, holistic and multi-faceted evaluation of LRP's welfare."

For the reasons given, even with close medical supervision and with the assistance of friends and family, I am not satisfied that it is in Z's interests for me to discharge the Care Order, in order that she can be placed back with her mother. However, I must consider at this stage whether Z remaining in long term foster care is a realistic option for Z and whether I should no longer approve placement of Z for adoption at this stage. The benefits of revoking the Placement Order are that Z will remain at this stage with the carer she has been placed with now for over a year. She is settled and

happy there. Her foster carer is willing at the moment to keep Z as a long term foster child. Contact could continue between Z and her siblings and her mother. Z is the youngest of a sibling group of 5 and I am extremely concerned about the position of Z in terms of being the only child of this family to be adopted out of the family. There are clear positives to this course of action. This is the preferred plan by mother and J, if Z cannot return to her care.

However, the local authority and the Children's Guardian strongly urge me to reject that plan. They argue that although the foster carer has said that Z can remain with her in the long term, for her own reasons, (which I accept and respect) she is unwilling to commit to Z through adoption. Mrs. Baker in particular emphasises that the foster carer may genuinely believe that she can commit to this child in the long term but her circumstances may change. Mrs. Baker strongly argues that the only placement which will provide Z with a permanent and secure family life is one of adoption. She is extremely concerned that this will be Z's 4th. move and she has been in care for four years, for two years under final orders. Mrs. Baker cannot support Z remaining in foster care for the rest of her minority with all the uncertainties that brings when she is only five years old. Not only will Z be at risk of further placement changes but she will also be at risk of being the subject of future litigation. Mother cannot and does not accept the need for her children to be in care and it is submitted on behalf of Z that this risk, which is very real, will further disrupt and destabilise Z's upbringing.
In terms of contact, whilst the Children's Guardian is disappointed that the prospective adopters have taken the stance that they have in respect of sibling contact, Mrs. Baker has considered this evidence and remains firmly of the view that adoption is in the best interests of Z, even though there will be no direct contact with the birth family as matters currently stand. In respect of Mother, the local authority evidence is that Z does not have a strong attachment to her mother. Unfortunately Z has difficulty in communicating with her mother who does not speak English (although is learning.) Z has not lived with her mother for four years. Mrs. Baker does not consider that retaining direct contact with mother outweighs all the advantages of an adoptive placement. Mrs. Baker would have preferred Z to have had direct contact with her siblings even under an order for adoption but again, her opinion is that the advantages of an adoptive placement far outweigh a foster placement even with direct contact. Clearly there is a strong bond between J and K and contact is extremely important. At the time of reception into care Z had a close relationship with F, although this seemed to be based on F parenting Z rather than a sibling relationship. That relationship has faltered due to the lack of contact between the sisters once F was placed in her family placement under an SGO. The local authority and Children's Guardian do not point to a particularly strong bond between Z and any of her birth family at the present time.

The local authority and the Children's Guardian consider the proposed adoptive placement to be a good cultural match, given Z's Islamic and Asian heritage as well as her experiences in foster care. They argue that this child has been waiting for a permanent placement for a long time. They point to the commitment of the prospective adopters who have waited for a resolution and a decision since October 2013.

I have considered section 1 of the Adoption and Children Act 2002. Clearly Mr. Recorder Goodwin took the view that adoption was in the best interests of Z for the

rest of her life when he made the order in 2012. In determining Mother's application to revoke the Placement Order I must once again consider that section.

I have had to consider whether there is sufficient analysis of the merits of the options for Z by the local authority and the Children's Guardian. I made clear my concern about the way in which the local authority made known to the court and the other parties the up to date position of the prospective adopters in respect of inter sibling contact. However, I have had the benefit of hearing from the children's Guardian who has considered this information. I am also extremely concerned about any further delay for Z.

I have considered the welfare checklist under section 1(4) of the Adoption and Children Act 2002. I am concerned that Z will be the only member of her family to be adopted out of her family. I have considered section 1 (4) (C) of the Adoption and Children Act 2002. The reality is that Z has been separated from her family since the age of 1 year old although had time in placement with F and K. She has never experienced a settled permanent family life. This is a devastating history for a child who is still only five years old. I accept the concerns of Mrs. Baker who impresses upon me that Z cannot be left to the uncertainties of long term foster care at this age and with such a pressing need for permanence. If placed with the prospective adopters, she will be placed in a culturally appropriate placement. I have considered section 1 (4) (f) of the adoption and Children Act 2002. I have set out that Z has knowledge of and has had ongoing contact with her birth family but as set out above, the child care professionals do not consider that there is a particularly strong bond between Z with her siblings at this stage compared to other sibling relationships within the group. There will be indirect contact between Z with her mother and siblings and therefore she will grow up with a knowledge and understanding of her birth family. Having considered all of the factors under section 1 (4) in my judgment Z's overriding need is for a permanent and stable family life which can only be provided through adoption. It therefore follows that in my judgment adoption is in Z's best interests throughout her life.

I would like to note (if it is correct) that I am grateful to Z's prospective adopters for patiently waiting for a resolution in this matter since October 2013. I would ask them to reconsider with the local authority their views in respect of direct inter sibling contact and what if any are the real risks to the placement of such contact taking place.

I therefore make the following orders;

1. I place J under the care of Milton Keynes Council.
2. I revoke the Placement Order in respect of K.
3. I refuse to discharge the Care Order in respect of K.
4. I refuse the applications to revoke the Placement Order and to discharge the Care Order in respect of Z.
5. I approve the local authority arrangements for contact in respect of each of the three children subject to the comments I have made above.