Neutral Citations Number: [2021] EWFC 10

IN THE FAMILY COURT

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

AND IN THE MATTER OF THE CHILDREN

Date: 9 February 2021

Before :

Elizabeth Isaacs QC sitting as a deputy high court judge

- -

Between :

A LOCAL AUTHORITY

Applicant

- and -
(1) M
(2) F
-and-
(3) A and (4) B **Respondents**
(by their guardian)

Karl Rowley QC and Christopher Rank for the **Local Authority**
Samantha King QC and Emma Kendall for the **First Respondent**
Aidan McGivern for the **Second Respondent**
Daniel Dodd and Clare Bate for the **Children's Guardian**

Hearing dates:
4th-8th, 11th-13th, 18th-22nd, 25th-26th January, 5th and 9th February 2021

- -

JUDGMENT

INTRODUCTION

1. This is the final hearing about two very young children, A (dob: 10/9/18 – now aged 2 years 4 months) and B (dob: 12/1/20 – now aged 1 year) and where they should live in the long-term. Their parents are M (aged 41) and F (aged 48). Neither of the children has ever lived with their parents, and both parents accept that the children cannot live with them. A has lived with foster carers since he was three days old, and B was placed with him soon after she was born.

2. The issue for the court to decide is whether the children should live in long-term foster care and indefinitely and continue to have contact with M, or whether they should be placed for adoption, with only the hope, rather than the certainty, of having contact with M. Their current foster placement is short-term, and so whatever the court decides, the children will inevitably have to move to a new home.

3. The local authority plan is for the two children to be placed in an adoptive placement together and it seeks care and placement orders for both children. On 18 January 2021 the local authority changed the care plans and will now try to find an adoptive family for the children who would be willing to promote contact with M. If this is not possible, then a goodbye contact would be offered to the parents before the children are moved to an adoptive family.

4. M initially wanted the children to be returned to her care. However, on 8 January 2021 she filed a further statement confirming a change of position. She wants the best for the children, and although it is very hard for her to say, she has decided that she is not in a position to care for them at the moment. She does not accept she cannot look after them, and says that her needs have not been properly understood or supported by the local authority. Her case is that she has not had a fair opportunity to look after the children with support. She says if things were different she would like to care for them in the future when things get better for her, but for now she needs to move house and would like to get a part-time job so she can still see the children when she is not working. M absolutely does not agree with adoption because she does not think it is right

for the children to be away from her, and she thinks that long term foster care would be safer for the children than adoption because she would know what is happening in their lives. In terms of contact, M would like to see the children as much as possible, ideally once or twice a week but at the very least once per month, and she thinks the court should allow her to continue seeing the children. She hopes that when the children get older they will be able to go and stay with her, and maybe even live with her.

5. On 6 January 2021 F also changed his position and he also now accepts that he cannot offer the children a home. Although he does not actively support the children being adopted, he does not challenge the local authority's plans. F has not attended contact for some considerable time and says he would be too upset to have a final goodbye session with the children. He also accepts he may appear to be a stranger to them. He would like letterbox contact but accepts and asks for help from professionals in managing this.

6. The guardian supports the local authority's care plans for care and placement orders.

7. At the Ground Rules Hearing on 21 December 2020, in view of the worsening national health crisis situation, all parties agreed that the hearing should be heard entirely remotely, but that the matter of whether the parents could give live evidence should be kept under regular review. However, by the time the hearing commenced on 4 January 2021 the national position had changed and it was agreed that the hearing should take place completely remotely. I have heard all evidence and submissions remotely with the agreement of all parties.

8. In dealing with this case I have considered all the relevant evidence available to me at that time. Failure to mention any specific part of the evidence should not be taken as an indication that I have failed to consider it. I received and considered written submissions at the conclusion of the oral evidence, and also heard oral submissions on behalf of all parties.

BACKGROUND TO THESE PROCEEDINGS

9. As well as A and B, M has several older children. M is now separated from the father of those children. M accepts that she was violently abused in her

relationship with him and that their children had suffered significant harm, emotional and physical, as a result of being exposed to that abuse.

10. In 2008 the local authority issued care proceedings in respect of some of the older children since when they have been living together in a foster placement. In 2010 those children were made subject of final care orders. The local authority subsequently issued care proceedings in respect of some of M's other children, and in 2013 they were also made subject of final care orders. In 2015 they were made subject of placement orders, and in 2016 they were adopted in a joint placement. In both previous sets of care proceedings M was assessed as lacking capacity to conduct proceedings and she was represented by the Official Solicitor.

11. In September 2017 M and F began their relationship, having met online and on 23 November 2017 they became engaged. Soon afterwards, there followed a number of incidents involving the police being called to the family home by M. On each occasion M reported she had been physically assaulted by F, including on 26 December 2017 when said she had been punched and hurt badly by him. Both parents accept that their relationship was characterised by controlling and domestically abusive behaviour, including shouting and swearing and instances of physical violence. M also now accepts that she lied to the police in denying that there was domestic abuse in the relationship.

12. Even after M became pregnant with A in about January 2018, the violence continued. By 23 February 2018, when M was just a few weeks pregnant, the couple were reported as no longer being in a relationship. However, by 30 April 2018 they were reconciled and told the local authority that F had now moved into M's house and was making a claim for carer's allowance as her carer. But their relationship continued to be volatile and violent; by the time A was born on 10 September 2018 there had been at least eleven reports to the police of domestic abuse incidents.

13. On 12 September 2018 the local authority issued care proceedings in respect of A, and he was made subject of an interim care order on 13 September 2018. Once again the Official Solicitor was invited to act as litigation friend for M, and the court directed an assessment of M's capacity by a psychologist, Dr

Allen. An updated assessment of M's capacity and cognitive functioning was carried out by Dr Allen on 31 August 2018 (and set out in his report wrongly dated 5 October 2018 but which must, by logical inference, actually be dated 5 September 2018). Dr Allen concluded that M was learning disabled with extremely low cognitive ability. He also concluded that she was of insufficient mental capacity to conduct care proceedings and once again required representation by the Official Solicitor.

14. On 12 January 2020 B was born. The local authority issued care proceedings on 14 January 2020, and she was made subject of an interim care order on 17 January 2020. She has been placed with A in the same foster placement.

THE IMPLICATIONS OF DEAFNESS IN THIS CASE

15. M is profoundly deaf. No other member of M's family is reported as being deaf. The cause of her deafness is not clear, but M has been told she acquired deafness after being infected with measles and mumps by her brother. Dr Austen (one of the expert specialist psychologists instructed in this case) noted that many deaf people do not accurately know their cause of deafness because this relies on their parents being accurate historians. M describes herself as being bilaterally deaf, but having some useful residual hearing although Dr Austen was unclear about this. M reported that she was educated in a Special School for six years up to 1996 which had no specialist provision for deaf pupils.

What does the term 'deaf' mean?

16. The Advocate's Gateway Toolkit 11: Planning to question someone who is deaf (January 2018) ("the Toolkit") defines deafness in terms of audiology or cultural affiliation. The medical model of deafness defines the degree of deafness according to the extent of hearing loss (ranging from mild, through moderate and severe, to profound deafness) and emphasises the use of equipment to facilitate communication eg: hearing aids and hearing loop systems. It is generally the case that those people with severe or profound hearing loss are less likely to have any useful residual hearing and more likely to rely on sign language. However, there is considerable variability, with some severely deaf people making use of residual hearing. In addition, some severely or profoundly

deaf people communicate orally without sign language, either through choice or lack of opportunity to learn British Sign Language (BSL).

17. The Royal Association for Deaf ("the RAD") people uses the term 'deaf' as an umbrella term used to describe people with all degrees of deafness, whereas the term 'Deaf' refers to BSL users who consider themselves part of a community proud of its language, heritage and culture. As the RAD puts it, Deaf people consider themselves a linguistic minority and not disabled. The Deaf community espouses a cultural definition, less to do with decibels of hearing loss and more to do with cultural affiliation and the use of BSL. Many deaf people do not consider deafness a disability.

18. The Toolkit is clear that deafness is not a learning disability; there is the same range of intellectual ability in the deaf population as the hearing population. However, a substantial number of deaf people experience language and educational deprivation during development and may not have fulfilled their true intellectual potential. Such deaf people are often vulnerable, with limited language, poor social awareness and reduced understanding of complex topics. It is important to distinguish people with deprivation arising from developmental experiences from those with a learning disability. Some deaf people will have additional needs such as a learning disability, mental health problems, language impairment or neurodisability. Such disabilities co-existing with deafness often go unrecognised as problems may be attributed solely to deafness. The Toolkit also makes it clear that there is no simple correlation between degree of deafness and intelligibility of speech. Having good speech does not indicate that the person is just 'a bit' deaf. Nor does the presence of a hearing aid indicate full hearing. It is also important not to expect a deaf person to be able to read fluently. Due to a disadvantaged education, many deaf people of average intelligence have difficulty with written English. Research indicates that deaf people generally have lower literacy levels than hearing people, with some suggesting that the average reading age of a deaf school-leaver is around 7-9 years (Mayberry 2002; Powers and Gregory 1999).

19. In this case, M does not identify as culturally deaf and has never learnt or wanted to learn sign language. In accordance with the RAD convention, I therefore refer to her throughout this judgment as 'deaf' (rather than 'Deaf'). For the purposes

of characterising her needs insofar as they are relevant in this case, I have no doubt that, as a deaf person, she should be treated as a person with a disability.

How should a deaf person be treated in law?

20. s6 Equality Act 2010 prohibits discrimination in relation to disability which is a protected characteristic carrying a specific definition in the Act –

> *6(1) A person (P) has a disability if –*
> *(a) P has a physical or mental impairment, and*
> *(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.*

21. Physical or mental impairment includes sensory impairments such as sight and hearing – see **Millar v Inland Revenue Commissioners [2006] IRLR 112 IH; Hospice of St Mary of Furness v Howard EAT 2005**.

22. The Chronically Sick and Disabled Persons Act 1970 obliges a local authority to provide welfare services to a person with a disability.

23. Article 13(1) of the UN Convention on the Rights of People with Disabilities 2006 provides that –

> *'States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.'*

24. The Equality Act 2010 recognises that more than formal equality is required to enable disabled people to participate as fully as possible in society. It is discrimination to treat someone unfavourably because of something arising in consequence of their disability. s20 requires public authorities to take reasonable steps and to make reasonable adjustments to avoid putting disabled people at a substantial disadvantage by changing a provision, criterion, or

practice, by removing or modifying physical barriers, and by providing auxiliary aids and services. Specifically, s20(6) requires that where there is a requirement to provide information, the reasonable steps to be taken by the public authority include ensuring that the information is provided in an accessible format.

25. There are two ways in which the issue of reasonable adjustments arises in this case. Firstly, in terms of the way in which the local authority was required to approach practice with M as a deaf person. Secondly, in terms of steps the court has been required to take to ensure that M could participate in legal proceedings and the court hearing fairly and effectively.

Reasonable adjustments by the local authority

26. There is an unusually limited number of reported cases dealing with deaf parents in public law proceedings.

27. The significant case is **Re C (A Child) [2014] EWCA Civ 128** in which the Court of Appeal gave some guidance about the approach to be taken to cases involving parents with profound deafness, referring explicitly to the obligations on local authorities imposed by the provisions of the Equality Act 2010. At paragraphs 16-18 McFarlane LJ (as he then was) said –

> *16. …I will accede to the request made…to offer some guidance as to some lessons that might be learnt from this case. What I will say now is not at all intended to be comprehensive guidance, because my Lords and I have not engaged in the nitty-gritty of this case, and I would not profess to have extensive experience of these cases from other proceedings in other contexts but it does seem to me that some guidance is helpful.*
>
> *17. In preparing what I might offer by way of guidance I am assisted to a large extent by the judgment given by Baker J in Wiltshire Council v N and Ors [2013] EWHC 3502 (Fam)…That case concerned an individual with very significant learning disabilities, but what Baker J*

says from paragraph 74 onwards to the end of that judgment can be adapted to the circumstances of this case.

18. Before descending into detail, I would make this observation. It is crucial for professionals and those involved in the court system, in particular judges, to understand one profound difference between the ordinary need in cases where parties to the proceedings may speak a different language for there to be "translation", and the need for a different character of professional intervention in these cases. This need is not solely or even largely one of "translation" as would be the case in the straightforward translation of one verbal language to another; the exercise is one of "interpretation" rather than translation. Communication between a profoundly deaf individual and professionals for the purpose of assessment and court proceedings involves a sophisticated, and to a degree bespoke, understanding of both the process of such communication and the level and character of the deaf person's comprehension of the issues which those in the hearing population simply take as commonplace. For a profoundly deaf person, the "commonplace" may not be readily understood or accessible simply because of their inability to be exposed to ordinary communication in the course of their everyday life. What is required is expert and insightful analysis and support from a suitably qualified professional, and the advice this court has in the reports we have, a suitably qualified professional who is themselves deaf, at the very earliest stage.

28. At paragraph 23 McFarlane LJ went on to provide further guidance (adapted from the guidance of Baker J (as he then was) in **Wiltshire Council v N and Ors [2013] EWHC 3502 (Fam) at paragraph 74)**, the net effect of which can be summarised as follows –

    a. It is the duty of those who are acting for a parent who has a hearing disability to identify that as a feature of the case at the earliest opportunity.

    b. Both those acting for such a party and the local authority should make the issue known to the court at the time that the proceedings are issued.

c. It should be a matter of course for the provision of expert advice on the impact of the deaf person's disability in the particular circumstances of the case to be fully addressed at the case management hearing. An application for expert involvement for the purpose, if nothing else, to advise the court and the professionals how they should approach the individual, should be the subject of a properly constituted application for leave to instruct the expert under Part 25. The legal representatives should normally by the date of the case management hearing identify an agency to assist their client to give evidence through an intermediary or otherwise if the court concludes that such measures are required.

d. The issue of funding needs to be grappled with at the earliest stage before the case management hearing and during the case management hearing. The importance of addressing the funding issues at the earliest opportunity cannot be underestimated.

e. It is not simply a matter of good practice; the court as an organ of the state, the local authority and CAFCASS must all function now within the terms of the Equality Act 2010.

29. In conclusion, McFarlane LJ said in unequivocal terms –

'It is simply not an option to fail to afford the right level of regard to an individual who has these unfortunate disabilities.'

30. In **Re Y (Leave to Oppose Adoption) [2020] EWCA Civ 1287** the Court of Appeal was invited to give updated guidance for managing cases involving profoundly deaf litigants in the new legal landscape of remote and hybrid hearings in family proceedings, building on the guidance in **Re C (A Child) [2014] EWCA Civ 128** (based in part on **Wiltshire Council v N and others [2013] EWHC 3502 (Fam)**). The Court of Appeal declined to give fresh guidance, noting that the problems arising in that case had only resulted in a delay in the start of the hearing and the legal argument was confined to the issues arising on the appeal. Baker LJ noted (at paragraph 2) that –

> *'In those circumstances, I would prefer to deal with those wider issues by referring the matter to the President of the Family Division and to MacDonald J, who with the President's approval has published guidance on the conduct of remote and hybrid hearings in the family jurisdiction, to consider whether the guidance needs amendment to address the difficulties faced by disabled litigants in general and those with hearing loss in particular.'*

31. Baker LJ did, however, reiterate the core aspects of the earlier guidance in **Re C (A Child) [2014] EWCA Civ 128** as follows (at paragraph 3) –

> *'…it is the duty of lawyers acting for a parent who has a hearing disability to identify that as a feature of the case at the earliest opportunity, that those lawyers and the local authority should make the issue known to the court at the time that the proceedings are issued, and that the court must grapple with the issue, including the support required and the funding of that support, at the first case management hearing with the aim of giving clear and detailed directions…In the case of remote or hybrid hearings, where the party, interpreter and/or intermediary are not together in the same room, it will be necessary to consider how they can communicate with each other separately from and alongside the platform through which the hearing is being conducted. That may or may not be a matter for a court direction but it will certainly be something to be considered and arranged by the parties' solicitors.'*

32. In this judgment I have therefore considered it appropriate to reflect on the extent to which some of those obligations have been approached by the local authority in relation to M and I have identified some lessons that may be learned in relation to the social work practice and procedure with M as a deaf person. This does not constitute guidance, nor should it be taken as such, but is simply an attempt to reflect on how the specific lessons from this particular case might be of wider interest in future similar cases. As indicated by McFarlane LJ in **Re C (A Child) [2014] EWCA Civ 128**, there are clear obligations arising from the Equality Act 2010 in relation to the approach to be taken to a deaf parent. Although in **Re C (A Child) [2014] EWCA Civ 128** the court was primarily

dealing with the way in which reasonable adjustments should be made during court proceedings, the Court of Appeal also clearly located the obligations of the local authority arising from the Equality Act 2010 in relation to the wider issue of work in general with a deaf person.

33. However, no party has sought findings arising from any alleged breach of the local authority's duties, and it would be quite wrong for me to make findings in that context. In any event, even if such findings had been sought, the duty under s20 Equality Act 2010 to make reasonable adjustments does not create a cause of action in itself. What I have done, however, is to consider how the local authority approached the provision of assessment, services and information to M through the prism of the framework of its specific obligations to her as a deaf person.

Reasonable adjustments by the court

34. Courts are expected to make reasonable adjustments to remove barriers for people with disabilities (Equal Treatment Bench Book (ETTB), 2018). The Toolkit provides extremely useful guidance to support the identification of vulnerability in witnesses and parties to proceedings, and the making of reasonable adjustments so that the justice system is fair. Effective communication is essential in the legal process. The Toolkit draws on the expertise of a wide range of professionals and represents best practice guidance. As Hallett LJ said in **R v Lubemba; R v JP [2014] EWCA Crim 2064** at paragraph 45 –

'Advocates must adapt to the witness, not the other way round.'

35. The same approach surely applies to the court and to the judge hearing the case; it is for the court and the judge to adapt to the witness, not the other way round. That is the way in which I have endeavoured, with enormous assistance from all involved, to conduct this hearing. It is to the credit of all involved that it has operated smoothly at almost all stages.

36. The ETTB (as amended March 2020) provides further assistance about what this means in practice at paragraphs 8,9 and 29 –

> *8. Effective communication underlies the entire legal process: ensuring that everyone involved understands and is understood. Otherwise the legal process will be impeded or derailed.*
>
> *9. Understanding means understanding the evidence, the materials, the process, the meaning of questions and the answers to them.*
>
> *29. It is for judges to ensure that all…can participate fully in the proceedings.*

37. As the ETBB says, it is not a question of being 'kind and sympathetic' towards a disabled person; that is patronising. The important point is that disabled litigants and witnesses are able to participate fully in the process of justice. Making reasonable adjustments or accommodating the needs of disabled people is not a form of favouritism or bias towards them, but part of showing respect for people's differences and helping to provide a level playing field. Adjustments should be made, provided they do not impinge on the fairness of the hearing or trial for both sides, and all parties can be expected to cooperate.

38. The guidance in the ETBB regarding disability is *'important advice which every judge and every justice of the peace is under a duty to take into account when hearing a case involving people with one disability or another'* (see **R (on the application of King) v Isleworth Crown Court [2001] All ER (D) 48 (Jan)**).

39. The ETTB guidance permits reasonable adjustments to be made in relation to breaks and shorter hours. For example, it may be necessary to adjust the timing, length or number of breaks, or it may be necessary to adjust the length of the day. There are also reasonable adjustments that may be made in relation to communication. For example, it may be necessary for the judge, advocates and other court staff to adjust their communication style by proceeding at a slower pace, using interpreters, or using intermediaries.

40. Lip speakers have been used throughout this hearing to assist M. Lip-speakers are registered professionals who are trained to speak very clearly with lip patterns that are as easy to read for the deaf person as possible. Some may

enhance this with finger-spelling and occasional signs. Understanding a lip-speaker is preferable to having to attempt to lip-read several people in court. In this hearing there have been three types of lip-speakers used. There have been two in-court lip speakers used at any one time, working in alternative sessions. Their role has been two-fold; firstly, to relay to M what is being said in court (in that role they simplified the language when necessary) and secondly, during M's oral evidence, their role was to relay to M what was being asked of her (in that role they did not simplify the language). There were two separate lip speakers provided by the court. There was also a single out-of-court lip speaker in this case. Her role was to relay what was being said out of court to M; in that role she also simplified the language when necessary. During M's oral evidence she repeated to the court only what she heard M say to the best of her ability and she did not seek to modify or change what was being said in any way.

41. The Toolkit advises that timetabling in cases involving lip speakers needs to be tailored to concentration span and interpreter fatigue. Regular breaks need to be planned, otherwise interpreters and the deaf person can experience cognitive overload and fatigue. In this case additional strain was caused by the remote nature of the hearing which could be intense and tiring. 15 minute breaks were therefore provided every 45 minutes, and longer lunch breaks were provided to ensure all professionals and parties could take proper time to rest. During M's oral evidence, 10 minute breaks were provided every 20 minutes.

42. A registered Intermediary, Chris Bojas, has also been used throughout the hearing. Mr Bojas is profoundly Deaf and uses British Sign Language (BSL) as his first language. Throughout conferences and out-of-court discussions he has been assisted by a BSL/English interpreter who has interpreted between Mr Bojas, M's legal team and the lip-speakers; she has not participated in any of the court proceedings or this hearing. Mr Bojas provided a report dated 22 January 2020 in which he made recommendations about special measures to facilitate the best communication with M during the court proceedings, and also advised about whether the presence of an intermediary during the hearing would improve the communication and M's evidence.

43. Mr Bojas assessed M's language and communication skills and concluded that M does use some signs to support her communication but this would be

considered as Sign Supported English, rather than British Sign Language, is able to write English but struggles to understand complex written information, and has the communication ability to give evidence with the required support and adaptation.

44. Mr Bojas recommended that an intermediary be used prior to and during the court proceedings. His role has been to ensure that M, as a vulnerable person, understands the legal process, the role of the professionals involved and the court proceedings. He has also assisted in all out-of-court conferences between M and her legal team, advising them on their language use, M's comprehension difficulties and how they can modify their communication to enable her to fully contribute and participate in the proceedings. During the hearing itself, he has ensured that M understands everything that is happening during the proceedings. If necessary he has used additional ways to communicate with M, such as using drawings. He has also highlighted any other significant issues throughout the hearing to the court.

THE EXPERT EVIDENCE

Dr Austen

45. On 13 September 2018 the court granted permission to M to instruct Dr Sally Austen, a specialist consultant clinical psychologist for Deaf people, as an expert to assess M's capacity and cognitive function. She has worked almost exclusively since 1992 in the assessment and treatment of Deaf adults with mental health problems and/or learning disabilities. She has worked at the National Deaf Services (London), the Royal National Throat, Nose and Ear Hospital in London, and presently works in the National Deaf Service in Birmingham.

46. On 5 October 2018 Dr Austen provided her report and capacity assessment for the court, having assessed M on that date. She concluded that M was capable of conducting the proceedings and disagreed robustly with Dr Allen's assessment of the extent of M's disability. In particular, she –

a. Did not agree that M has extremely low intellectual ability around the 1st percentile or that she has a learning disability.
b. Did not agree that M did not have a clearly recognisable language system.
c. Did not agree that M has a severe memory impairment, a working memory at the 1st percentile, or that short term auditory memory is at the 1st percentile.
d. Did not agree that M's ability to understand spoken English is extremely poor.
e. Did not agree that M is of insufficient cognitive ability to reliably understand these proceedings.
f. Did not agree that M is unable to suitably describe in lay terms the significant difference between foster care and adoption.
g. Did not agree that M has a global learning disability or an impaired memory.

47. She went on to confirm that M does not have a learning disability and this would not have fluctuated in the intervening time since she was assessed by Dr Allen on 31 August 2018. Therefore she concluded that M did not lack capacity when previously assessed by Dr Allen in August 2018, and she disputed the accuracy of Dr Allen's August 2018 assessment.

48. Dr Austen's opinion was that M is bilaterally deaf but uses spoken language to communicate, although her speech is difficult for others to understand. She does not use British Sign Language (BSL). She maximises her communication when she uses a mixture of spoken English, lipreading and (right side only) aided residual hearing, supplemented by occasional drawing, writing, role play and gesture. Dr Austen concluded that M does not have a global learning disability or an impaired memory. However, she confirmed that M's deafness has impacted in a number of ways which can be summarised as follows –

a. She has difficulty hearing what people are saying, which may result in her missing information and instructions.
b. She appears to be an adequate lipreader, but lipreading generally only has a success rate of about 50% due to many letter and word shapes being identical.

c. She was not skilled or confident in telling Dr Austen when she had not understood or in asking her to repeat.
d. She has gaps in her knowledge (which is common for all deaf people who are not able to learn by 'over hearing' or have poor literacy) which are the result of both her deafness and her historic and current social situation.
e. Her deafness has impacted her speech which is difficult to understand but this is not because she has a serious language impairment.
f. She does not have a severe language impairment; however, she may have some mild language delay.
g. Her literacy is poor with a reading age of 8 years and 11 months. Literacy is hugely affected by early deafness, and research shows that deaf adults of normal intelligence have on average a reading age of 9 years (which is considered functionally illiterate). Therefore, M's results are not indicative of cognitive abnormality, but are indicative of the additional support she needs both in accessing the court proceedings and also in parenting.
h. Language and speech are very different skills, and it is entirely possible for a deaf person to have unclear speech but good language. Dr Austen did not observe M to have a significant language problem.

49. Dr Austen concluded that M's greatest communication problem is that she does not stop to ensure that people can follow her speech which could be for a number of reasons. For example, she may not have the Theory of Mind (ToM) to understand what the other person needs, she may be embarrassed to question the other person's comprehension, she may (as many deafened people do) be just talking to fill the communication space so that she doesn't have to lipread. Dr Austen's opinion was that M's language skills were sufficient for fact-based conversations and were adequate for her to be questioned in court with the support of an Intermediary.

50. At the next hearing on 26 October 2018 it was recorded that no party sought to challenge the findings of Dr Austen's assessment and the order inviting the Official Solicitor to act on M's behalf was discharged. By agreement with all parties, I have therefore placed no weight on any aspect of Dr Allen's assessments relating to M in this case.

The implications of the expert evidence for practice

51. Dr Austen concluded that there was no evidence that the professionals conducting the pre-birth assessment of M's parenting ability had the skills suitable to her needs as a deaf parent. She therefore recommended that M's parenting ability should be reassessed by an expert in deafness at the earliest opportunity, namely Dr Andrew Cornes. However, on 3 November 2018 Dr Austen clarified that her recommendation about using an Intermediary at all significant appointments did not necessarily mean during Dr Cornes' assessment because she (and he) felt that he has sufficient expertise to carry out the assessment without the use of an intermediary. She did confirm, however, that Dr Cornes would require a lip speaker.

52. Dr Austen recommended that with help from deaf-aware professionals she thought M would be able to show a greater degree of ability than previously observed, and had the ability to learn and to remember.

53. Dr Austen described how professionals need support to understand what M is saying, even after they have got used to her voice, there will always be some clarifications required. She described the particular phenomenon of 'Deaf Nodding' which is a tendency for unconfident deaf people to nod while a hearing person is talking. This nod does not mean that the deaf person has understood. It can mean 'yes I am attending, please continue' or 'I don't know what you are saying but I am too embarrassed to admit it' or 'if you keep talking I might get the gist of this in a minute'. Therefore in order for professionals to ensure that the deaf person has understood, it is best to ask them to repeat what has just been said by the professional.

54. Dr Austen concluded that it appeared that professionals have found M's speech and communication style extremely difficult to understand; given the severity of this, she recommended that all significant appointments should include an Intermediary. However, shortly afterwards, on 29 October 2018 Dr Austen confirmed that, having researched the matter further, it appeared it would be difficult to find an intermediary with the appropriate lip speaking skills as the

person she had had in mind was no longer working. She therefore recommended that a freelance lip speaker should be used, noting that on balance she thought a lip speaker with deaf experience would be better than an intermediary who did not have deaf experience. She explained she had contacted the Association of Lip speakers with Additional Sign (ALAS) who confirmed they would be able to provide lip speakers who could help M lip read (as well as voice over M's speech for the benefit of the court).

55. Dr Austen also confirmed that the additional factors of profound deafness with poor communication support makes it extremely difficult for M to take in the sort of discussions used in parenting assessments, as well as giving instructions and in participating in proceedings. Dr Austen described two common misconceptions that may be made about M as a deaf oral communicator (who does not use sign language); firstly, it may be wrongly assumed that she can understand <u>everything</u> because she is oral, and secondly, it may be wrongly assumed that her very poor speech is because she is learning disabled. However, Dr Austen was clear that while M's language is at the lower level of intelligence and ability, it is not the case that she has no language. She advised in evidence that in order for professionals to make any progress with M, they need to know what they don't know. In other words, if a professional doesn't understand that M does not pick up 50% of what she lipreads, she agreed it would compromise what M is able to learn from them. She agreed that M's literacy levels mean that simply asking her to carry out an internet search or to research something herself can be difficult.

56. Dr Austen defined two key elements of being 'deaf aware'; firstly, having the ability to notice any communication breakdown and adapting to ensure that the communication with the deaf person works, and secondly, being aware that the deaf person may have knowledge gaps – not because they are necessarily learning disabled, but because they have missed communication. She confirmed, however, that a professional can <u>learn</u> those skills of deaf awareness, and that a hearing person should be able to learn to work with deaf people in a one day course - dependent on that person's role; for example, she thought that would be adequate for a care or support worker. However, she observed that if the worker was required to understand complexities of language and abstract concepts such as Theory of Mind (empathy), then they would require more than

a single day's course. She did not consider that helping people to understand how a deaf person thinks or the way in which language is crucial to understanding could be taught in a single day's course; nor did she think a single day's course could assist in understanding why a deaf person can have mixed skills. It is for that reason Dr Austen recommended it was important that M should be assessed by an expert in deafness. She recommended Dr Cornes because he has significant experience in assessments with deaf parents, and also additional expertise in attachment assessments.

Dr Cornes

57. At the next hearing on 8 November 2018 the local authority agreed to provide and fund a lip reader for all significant appointments, to include meetings between social workers and M, and also any assessment work undertaken between M and Dr Cornes. That commitment was reflected in Paragraph 17 of the order of 8 November 2018 which provided that *'the LA shall provide a lip reader for Dr Cornes assessment and all appointments to include LAC reviews and core group meetings.'* I shall return to this issue in due course.

58. It was on that explicit basis that the court granted permission for Dr Cornes to be instructed to carry out an assessment of M and to provide his report by 21 December 2018.

59. Dr Cornes is a consultant counselling psychologist with experience and expertise in the psychological assessment and treatment of hearing and deaf children and adults in clinical settings, schools and family contexts. He has worked with deaf and hearing-impaired children and adults for the past thirty years in the UK and Australia. He is appointed as an Expert (Health) with the World Federation of the Deaf. He is also trained in the Triple P (Positive Parenting) Programme and in Webster-Stratton parenting. He was the expert approved in **Re C (A Child) [2014] EWCA Civ 128** in which he was described by McFarlane LJ as an expert who, whilst not deaf himself, has had a lifetime of experience in matters of communication between deaf people.

60. On 12 November 2018 Dr Cornes was instructed to carry out a parenting assessment as recommended by Dr Austen and could have started work very

soon thereafter. In respect of the parents, he was asked to assess the following particular areas –

a. whether M or F are able to offer consistent and safe care to A;
b. what specialist assessments of M are required in light of her hearing impairment; and
c. what special measures are required within these proceedings to ensure M can participate properly and fairly.

61. Although Dr Cornes initially observed contact on 29 November 2018, the court was informed at the hearing on 14 December 2018 that his assessment had been delayed due to a lip reader not being made available for the appointments. It was noted by the court that it was the joint responsibility of the local authority and of M's legal representatives to ensure that a lip speaker was made available.

62. Dr Cornes eventually interviewed M on 18 December 2018 and on 31 January 2019, and set out his conclusions in his report dated 10 February 2019. Like Dr Austen, he also made recommendations about M that had direct implications for practice.

63. He confirmed that M has a profound hearing loss and identified the following characteristics of M's hearing, speech and language –

- She communicates via speech, some of which is incomprehensible.
- She can be 'off-topic' at times.
- When she is nervous, or when she was asked about domestic abuse, she talked rapidly and was much harder to understand.
- She can give the impression that she has understood the question when she clearly has not.
- She had a very limited understanding of emotions and had a poor affective vocabulary to describe emotional states.
- She exhibited major impairments in her expressive and receptive English abilities and her literacy is poor.

64. He described M as using speech as her main communication and relies on audition through her hearing aid and lipreading. She has considerable problems

with receptive and productive English speech and written English when concepts are involved.

65. Like Dr Austen, he reported that there is a common misconception that deaf people can access information through lipreading people's speech or by reading written English. He observed that with respect to lipreading, only 30-40% of English phonemes (speech sounds) have a particular facial and mouth position (viseme). Many phonemes share the same viseme and thus are impossible to distinguish from visual information alone. Lipreading skills are not necessarily concomitant with deafness and can rarely be taught with any great success. Ability to lipread also depends enormously on situational factors, which vary constantly; for example, lighting and background, speaker's facial hair, accent, speed of speech, use of unfamiliar language and so on.

66. Dr Cornes recommended that M required full access to information via a lip speaker and note takers, with constant checks to ensure that she has understood the communication. Dr Cornes made specific reference to the multitude of information available from organisations that can assist professionals to adapt their practice and ensure that deaf people are not discriminated against. He also made four specific recommendations about how any agencies, services or person providing information or support to help M improve her parenting skills should proceed –

    - Provide information in an accessible format, interpreted into simple English using a lip speaker.
    - Information should also be available written in simplified English, at a reading level that is accessible.
    - Undergo deaf awareness training.
    - Be aware of their obligations under the Equality Act 2010.

67. It is accepted by the local authority that its compliance with these recommendations was sub-optimal, and I shall deal with that in more detail in due course. However, there appears to have been no active social work with the family in the period from 5 October 2018 (receipt of Dr Austen's report) until 4 March 2019 (LAC review). The local authority's assurance to the court

(recorded in the order of 8 November 2019) that it would ensure lip speakers were used at all appointments with M therefore proved completely redundant in terms of any social work or family support worker appointments during that period.

68. By the time supervised contact began on 18 September 2018 (when A was 8 days old), the local authority was well aware of the challenge to Dr Allen's assessment of M as lacking capacity which had been dealt with at the first hearing on 13 September 2018.

69. Six supervised contact sessions took place before Dr Austen's report was completed on 5 October 2018. A lip speaker was never arranged or used at any of the supervised contacts in that period, or indeed at any contact at all in the entire period of over two years that has then followed.

70. The social worker allocated to work with the family at this time was Social Worker 2. She provided an initial statement dated 15 September 2018 in support of the local authority's application for an interim care order. She confirmed the local authority's understanding at that stage that M had been assessed to have learning difficulties and hearing impairment; she also stated that the local authority believed M to be vulnerable and set out the history of involvement with the family since the local authority was notified of M's pregnancy by the community midwife on 23 February 2018.

ANALYSIS OF THE LOCAL AUTHORITY'S ACTIONS

Local authority actions before A was born

71. On 12 March 2018 a pre-birth assessment was commenced with M by a social worker, Social Worker 1, due to M's vulnerability, the historical issues and removal of M's previous five children. Social Worker 1's report is dated 1 May 2018. Within the pre-birth assessment there is minimal consideration of M's needs as a deaf person and any analysis, such as there was, was predicated on the belief that M could adequately lip read –

> *'M has learning difficulties, she is also deaf, she can lip-read and has hearing aid but communication can be difficult…*
> *…there is a Certificate as to Capacity to conduct proceedings within the bundle – assessed 21st and 28th November 2014…She is deaf and does not have sign language, she attempts to communicate via lip reading. Her reading ability is basic and not functional.'*

72. The extent of the local authority's analysis about M's needs as a deaf person was limited simply to this –

> *'The Local Authority recognises that parents with intellectual disability can learn but that this also comes down to support. It should not be assumed that a person with a disability is unable, as with the right supports in place, parents with disabilities can afford their children an appropriate level of care. However, the most successful parents are believed to be the ones with a good support system, which M and F do not appear to have.*
> *Whilst history does not necessarily dictate the future, it may give an indication of how this child's needs will be provided for.'*

73. Most notably, the pre-birth assessment provides no meaningful analysis about the impact of M's deafness on her parenting. Dr Austen was instructed to evaluate whether the pre-birth assessment completed by the local authority was conducted in a way which was suitable given M's specific needs as a deaf parent. Dr Austen was forthright and unequivocal in her criticism of the assessment and concluded that there was no evidence to suggest that the professionals conducting that assessment had skills suitable to M's needs as a deaf parent. She said, in terms, that the Pre-Birth assessment was not suitable. I accept that analysis, and shall return to this issue in due course.

74. On 27 July 2018 a social work assessment was carried out by Social Worker 2, for the Initial Child Protection Conference. She carried out two visits to M and F as part of her assessment – on 18 July 2018 and 23 July 2018. There is no indication that a lip speaker was used at either of these visits, and the social work assessment largely just copied and pasted the results of Social Worker 1's pre-birth assessment. There is certainly no new or additional information

provided about the impact of M's deafness on her parenting, with the only real reference being that –

> *'Previous assessment of M's capacity have* [sic] *outlined difficulties in her processing and retaining verbal and written information.* ***That she is deaf, that she is unable to sign and attempts to lip read but that this is basic and non-functional.****'* [emphasis provided]

75. The recommendation of this assessment was that the local authority should issue care proceedings once the baby was born with a plan of immediate removal from the parents' care, and thereafter carry out an updated PAMS assessment of the parents' parenting capacity.

76. On 9 August 2018 Social Worker 2spoke to M alone after a core group meeting about the domestic abuse she was experiencing from F. On 16 August 2018 the local authority was notified by the police that M had reported further domestic abuse occurring over the previous few nights. In response to that referral Social Worker 2 visited M at home on 22 August 2018 and they discussed an abusive incident on 15 August 2018 that had led to M and F separating. It is clear that by this stage Social Worker 2 knew about M's deafness because she said as such in her statement dated 15 September 2018 –

> *'M is a vulnerable person in her own right due to her low IQ and cognitive functioning. During the last placement proceedings of her sons in 2014, her full scale IQ placed her at below 1st percentile and M was assessed as not having capacity regarding the care proceedings.* ***This assessment highlighted that M is deaf and does not have sign language; she attempts to communicate via lip reading. Her reading ability is basic and not functional and it was concluded that M is likely to have had this impaired level of cognitive capacity across her life and this will follow a predictable trajectory in the future.'*** [my emphasis]

77. However, notwithstanding that clear understanding of the limitations placed on M partly by virtue of her deafness, there is absolutely no reference at all in the record of that meeting to the method of communication used, or what knowledge, skill or experience Social Worker 2 had of working with deaf

people. I accept I have not heard evidence from Social Worker 2, but this meeting is of particular concern in light of her further description of the local authority's position about parents with disabilities –

> *'The local authority recognises that parents with intellectual disability can learn and provide good enough care to their children but that this also comes down to support.* ***It should not be assumed that a person with a disability is unable, as with the right supports in place, parents with disabilities can afford their children an appropriate level of care.'*** [my emphasis]

78. On 24 August 2018 Social Worker 2 made a referral to Adult Services for M on the basis that M was vulnerable due to her learning needs and also that there had been incidences of domestic abuse in her current relationship. The adult team was told that it was the local authority plan to initiate care proceedings in respect of the baby once born. However Social Worker 2 was told that M would not meet the criteria for involvement as she had been living independently and had no disabilities that indicate that she would need social worker involvement. The adult team response was simply to ask Social Worker 2 to discuss these concerns with M and to ask M whether she wanted concerns about her vulnerability and domestic abuse to be raised as a safeguarding issue. Social Worker 2 was also asked to establish whether M wanted these issues raised or not and if so how she would like them addressed. Social Worker 2 was told that once this information had been established, she should then contact the adult team again.

79. On 30 August Social Worker 2 made a referral for an advocate for M. An advocate, T, went to see M. There is no evidence about whether T was assisted by any form of lip speaker or indeed if she herself had experience of deaf people.

80. On 3 September 2018 a core group meeting was held, attended by the midwife, the health visitor, both parents and Social Worker 2. Unfortunately, T did not attend. Social Worker 2 reported that T had said she was not able to identify any areas of support M might require from adult services and had also mentioned that she was no longer in a relationship with F. T said that M reported having a lot of family support from her mother and sister, had talked about wanting to move to another town because she was having problems with neighbours

making noise and she did not want the baby to be brought up where she was currently living. T had also told Social Worker 2 as follows –

> *'T said she talked to M about meetings and M said that she was fine and she understood what people said during meetings. T said M said people talk slowly and she can lip read…T said she will be involved after the court when she is needed.* ***T said she can identify that M is a bit confused about what*** **[sic]** ***the local authority's intention to remove the baby soon after birth.****'* [emphasis provided]

81. There was no lip speaker intermediary or any form of suitable interpreter present at this meeting. There is no information before the court to suggest that Social Worker 2 had received any deaf awareness training or herself was experienced or able to support them as a deaf person. The risks identified at this core group meeting were that M had substantial learning needs and was considered to be vulnerable in her own right. It was proposed that an updated PAMS assessment of the parents' capacity to meet the baby's needs should be completed after the baby was born.

82. On 5 September 2018 Dr Allen provided his updated assessment of M's capacity and cognitive function (carried out on 31 August 2018).

83. On 15 September 2018 Social Worker 2 provided her statement ("the SWET"). The statement, and the local authority's proposals for a PAMS assessment to assess her capacity to safeguard the baby long term from domestic abuse are entirely devoid of any consideration of M's deafness, albeit in the context of the local authority's not unreasonable belief at that stage that M might also still lack capacity. However, a belief that a parent might lack capacity does <u>not</u> obviate or relieve the local authority of its duty to consult and engage with a parent appropriately. If anything, the obligation on the local authority in such a situation is arguably <u>greater</u> to ensure that there is sufficient and adequate communication. None of that happened in this case.

84. The prescribed format of the SWET is recommended by the President, the Association of Directors of Children's Services, Cafcass, HMCTS, the Department for Education, the MoJ and the Chair of the Family Justice Board,

in compliance with the revised Public Law Outline (PLO) 2014. Notably, at the very end of the SWET, social workers are explicitly obliged to consider the issue of procedural fairness –

> *10: Statement of procedural fairness*
> *Have the contents of this statement been communicated to mother, father, significant others, and the child in a way which can be clearly understood? If not, what has been tried?*

85. Remarkably, the social worker's answer in relation to this case was limited as follows –

> *'Risks outlined in the chronology have previously been outlined to parents.*
> *M is aware of the ongoing concerns and the local authority's intention to issue proceedings and is aware of all the concerns that have been raised.*
> *F is aware of the ongoing concerns and the local authority's intention to issue proceedings and is aware of all the concerns that have* [sic]
> *This statement will be made available to parents via their own legal representation.'*

86. The duty for social workers and local authorities to consider and implement procedural fairness is not just a box to be ticked at the end of the SWET. The SWET represents sworn evidence of how the local authority has fulfilled its duty to guarantee a parent's Article 6 rights to a fair trial throughout its involvement; see Munby J (as he then was) in **Re L (Children) (Care: Assessment: Fair Trial) [2002] 2 FLR 730** –

> *'151. The state, in the form of the local authority, assumes a heavy burden when it seeks to take a child into care. Part of that burden is the need, in the interests not merely of the parent but also of the child, for a transparent and transparently fair procedure at all stages of the process – by which I mean the process both in and out of court…'*

87. In **Re L (Children) (Care: Assessment: Fair Trial) [2002] 2 FLR 730** Munby J also made clear the requirement on social workers to keep parents informed at all stages about the progress of the case and to advise them about how they might improve; of particular relevance to this case he said –

> *'154. …(i) Social workers should, as soon as ever practicable:*
> *(a) Notify parents of material criticisms of and deficits in their parenting or behaviour and of the expectations of them; and*
> *(b) Advise them how they may remedy or improve their parenting or behaviour.*

88. Inherent within that approach is the requirement to communicate adequately with parents in a way that they understand. It is right that in **Re V (Care: Pre-Birth Actions) [2005] 1 FLR 627** the Court of Appeal subsequently suggested that trial judges should be cautious about reading too much into paragraph 154 of **Re L (Children) (Care: Assessment: Fair Trial) [2002] 2 FLR 730** because the paragraph is preceded by a judicial disavowal to formulate any statement of good practice. However, the Court of Appeal did identify that what Munby J was rightly seeking to do was to draw attention to certain principles of practice that deserved emphasis.

89. It is the combination of the local authority's approach to those principles of good practice in the context of M's needs as a deaf person in this case that deserves some scrutiny.

Local authority actions after A was born

90. A was born on 10 September 2018 and the local authority issued care proceedings on 12 September 2018.

91. On the same date, M's solicitors issued a Part 25 application for permission to instruct a fresh assessment of M's capacity and cognitive functioning by Dr Sally Austen, on the basis that Dr Allen had no particular expertise in assessing the impact of her deafness on M's ability to communicate, interpret and understand information.

92. In knowledge of that challenge, the local authority went on (with the guardian's endorsement) to arrange contact at a frequency of twice per week (not agreed by M). Those contacts took place on 18 September, 20 September, 25 September, 27 September, 2 October and 4 October 2018.

93. There is a distinct lack of note in any of these contact records about any communication difficulties or issues, other than in a single note on 27 September 2018 where it was noted (in relation to M and MGM) –

> *'Issues: Some conversation was hard to hear as they both talk quietly and M's speech is often mumbled.'*

Local authority actions after receipt of Dr Austen's report

94. By this time Dr Austen had also been instructed to advise about the nature of any further assessments with M, and the way in which professionals should aim to work with her. In particular, she was asked to advise about any additional measures which professionals should take when discussing information and documents with M. Once again, she was forthright and unequivocal in her opinion. She recommended that M's parenting ability, including an assessment of attachment, should be reassessed by an expert in deafness at the earliest opportunity, namely Dr Andrew Cornes.

95. In relation to the approach to be taken by professionals, she said –

> *'It appears that professionals have found M's speech and communication style extremely difficult to understand. Given the severity of this, I think all significant appointments should include an Intermediary. M has limited literacy. Written material will need to be abbreviated and explained orally.'*

96. After receipt of Dr Austen's report there then followed a further eight supervised contact sessions – on 9 October, 16 October, 18 October, 25 October, 30 October, 1 November, 6 November and 8 November 2018. Apart from the first session which was supervised by Social Worker 2, all sessions were supervised by the contact supervisor. The guardian also observed the contact on

9 October 2018. At each contact session the notes begin by recording that a handover is given by the foster carer. The extent of the foster carer's training in deaf awareness is unclear, but in the absence of any positive assertion to the contrary, it is reasonable to infer that she was never assisted by a lip speaker, and was not trained in deaf awareness. the contact supervisor confirmed in evidence that he had never given the foster carer any advice. In any event, even if the foster carer was trained in deaf awareness, then there is certainly no indication of that training being applied to improve communication in the contact sessions, or to assist the contact supervisors in their communication with M.

97. the contact supervisor gave oral evidence. Although there were a handful of other supervisors, it is clear from the notes that he undertook by far most of the contact supervision in the period October 2018 until September 2020. He has an NVQ Level 3 in Health and Social Care and is a very experienced contact supervisor who has been doing such work for about thirteen years. He began working with the family on 16 October 2018, but had in fact met M many years ago when he supervised a couple of contact sessions with some of her other children. He confirmed that when he started his involvement in these proceedings he was certainly aware that M is deaf but said this is his first case involving a deaf parent.

98. He explained that he introduced himself to M and explained his role which is to note what he observes about a parent's presentation, the way in which they greet the child, their basic care, attention to safety, their general engagement, display of emotional warmth and the way in which they part from the child. He said he tried to be as clear as he could when speaking to M in order to convey what he needed to say. He said that at the start of contact the foster carer would give M a verbal handover, by crouching down and making eye contact with her explaining if A had been fed, and the time his next feed was due and so on. He said he would take a note of what was said by the foster carer and then talk to M to remind her during the session if a feed was due. He said he would talk clearly to M, trying not to make sentences too complicated and to keep them short, and to make sure M was looking at him. He said he often had to prompt M to support her and to help her meet the children's needs, including feeding and playing with the children.

99. The contact supervisor confirmed that in the period of his involvement he did not see any improvement in the need to prompt M. He said he had to prompt about feeds and play very often. At the end of contacts he would give M positive feedback, and if he felt M was missing the children's cues, he would try and highlight and pick up the issue with her at the next contact.

100. However, although he presented as an impressive, clear and sensitive witness who was undoubtedly doing his best to communicate effectively with M, he did not use a lip speaker in any contact. He also confirmed in evidence that he has not been offered nor has he received any relevant training in deaf awareness, nor have any of the other contact workers to his knowledge. He was never told that M would only be able to pick up about half of what he was saying via lipreading. He never had any discussion with his colleagues about how they should run or plan the contact sessions. It had never been suggested to him that it would be a good idea to show M how to do things, or to use visual aids such as clock faces, rather than tell her. The times he spoke to the social worker were few and far between, and certainly during the period of Social Worker 4's absence on personal leave (February to May 2020) he spoke to no-one from the local authority. He confirmed that there was never any suggestion that there should be any sort of meeting to review the progress of contact in this case, although he had been involved in other cases where such review meetings took place.

101. The two social workers who have been most recently involved with the children also gave evidence. Social Worker 3 was allocated to the case in February 2019 and ended her involvement a year later. She was therefore involved at the point of Dr Cornes' assessment. By that stage, of course, Dr Austen's assessment, dated 5 October 2018, was also known to the local authority. However, Social Worker 3 said in evidence that although she did complete a one day deaf awareness course (as recommended by Dr Cornes), it was not until 6 November 2019. That course provided teaching about understanding how to speak and communicate clearly with a deaf person. She explained in evidence what she had learned. She said she knows that when you speak to someone who is deaf or who has a hearing impairment you should not speak loudly because changes in the way your mouth moves can help with communication. She also learned

about how deaf people experience their lives including how they manage daily living. This training was delivered by a lip speaker. She said in evidence that before that training she was able to have some conversations with M and also wrote things down for her. She said at times she was able to communicate via the maternal grandmother or F who could speak to M and whom M understood. She said M liked text messages and understood them. She believed it was effective when she wrote things down for M in meetings.

102. Social Worker 3 had relied on Dr Cornes' assessment when she was considering where A should live in the future, in particular his concern that M would need such a high level of support and for such a long time that it would not be in A's time scales.

103. However, the extent and nature of the local authority's involvement with M following receipt of Dr Cornes' report on 10 February 2019 also bears some scrutiny.

Local authority actions after receipt of Dr Cornes' report

104. The next significant meeting after receipt of Dr Cornes' report was the LAC review on 4 March 2019. Both parents attended this review, as did Social Worker 3 and the guardian. At this review M was properly and adequately supported by a lip speaker (Dian Donovan who worked with M for several years) to enable her to communicate properly with professionals. At this meeting A's progress and development in placement was noted to be very positive. This was a critically important meeting because it considered the outcome of Dr Cornes' assessment. Social Worker 3 explained that Dr Cornes had concluded M would be unable to meet A's needs in the long term.

105. At the meeting the local authority, through Social Worker 3, confirmed that the best plan for A that would meet his needs was adoption. A section of the review form sets out the views of each of the parents. F stated that he was not putting himself forward to be assessed to care for A, but he did not agree with Dr Cornes' report in respect of M and felt that she could care for A. F said he wanted A to stay in foster care until he is 18 and have contact with A during that time which would allow them to work on themselves as a family. M said that she could care for A and was as clever and smart as anyone else when it

comes to his care. She said A needed his parents, but she agreed with F's plan. She also wanted A to stay in foster care until he is 18 and have monthly contact with him. Both parents confirmed that they had been living together since the end of October or the start of November 2018 and planned to move to another county in the future.

106. On the basis of the information provided at the review the Independent Reviewing Officer (IRO) concluded that the care plan for adoption for A was appropriate and met his needs at that time. She noted that while parents would want A to remain in foster care until he was 16 or 18 years old, this would not be in his best interests. She noted that the recent assessment of Dr Cornes indicated M was not in a position to meet A's needs, that A's age meant he required a permanent care arrangement. She recommended therefore that A's needs would be met via a care plan for adoption. It was agreed that Social Worker 3 would progress the relevant paperwork for a decision to be made by the Agency Decision Maker, and that A would remain in his current placement until a permanent placement could be identified.

107. There then followed a period of some flux in the case caused by M's solicitor withdrawing due to reasons of professional embarrassment at the hearing on 17 April 2019. There was some delay in the case while M identified new solicitors. By the time of the next hearing on 3 May 2019 M was acting in person.

108. It is in that context that on 13 May 2019 the guardian visited the parents at home. He said that attempts to book a lip speaker during this period were unsuccessful, and eventually he decided to go ahead with the meeting without a lip speaker because his primary purpose was to explain to F why adoption was recommended for young children who could not return home. Although plainly he should have used a lip speaker in accordance with Dr Cornes' recommendations, the purpose of this meeting was ultimately to reiterate what had already been discussed with and explained to the parents at the LAC review on 4 March 2019, when a lip speaker was present. The guardian considers that both parents participated fully in this meeting. He noted that neither parent would accept that there were any concerns about their parenting. This was a repetition of their position as expressed through the lip speaker at the meeting on 4 March. The guardian noted that F could not accept discussion of adoption

and eventually told him he did not want to speak to him and preferred to speak with his solicitor.

109. By the time of the next hearing on 20 May 2019 M was represented again, by new solicitors. Neither parent attended this hearing at which the issue of the impact of Dr Austen's assessment on the two sets of previous proceedings was raised. The court expressed the view once again that, regardless of whether it was M's intention to re-open previous proceedings and/or to seek to discharge care orders already in force, the timetable for A should not be adversely affected within the proceedings. Both parents were ordered to file and serve position statements by 3 June 2019 confirming the status of their relationship, their plans for looking after A, and M's views on special measures . They were also asked to provide explanations about their reasons for not attending the court hearing.

110. It is perhaps unsurprising that within that context no social work visit was made to M after the LAC review on 4 March 2019. Social Worker 3 next visited the parents at home on 3 June 2019. She did not have a lip speaker present. Her note of this meeting is set out in a statement made in February 2020. It reads as follows –

> *'On 3/6/19 M and F were visited at home by the social worker. The issues of accessing further parenting support were discussed with M and F. Neither parent was agreeable to undertaking any parenting as they both felt that they had enough knowledge of parenting. There was no lip speaker present at this visit. However the social worker was able to communicate with M and F was able to enable M to understand any words that she had not understood. M said that she felt that as she had already had other children she felt that she knew enough about parenting.'*

111. It is clear from Social Worker 3's evidence that the purpose of this meeting was not to carry out any form of assessment or direct work with the parents because the local authority had by this time received Dr Cornes' report and had made the decision, as endorsed by the IRO, that it was in A's best interests to have a plan of adoption. As with the guardian, it would have been preferable for Social Worker 3 to have used a lip speaker at this meeting. Although not a critical

meeting, it was an important meeting because the social worker was attempting to offer advice about parenting support for both parents.

112. Failure to have used lip speakers at these sorts of meetings is one of the key learning points for the local authority (and indeed the guardian); not only was this important appointment carried out against the expert advice of Dr Cornes, it was also in direct contravention of the order made on 8 November 2018 that the local authority should provide a lip speaker (referred to as a lip reader) at all appointments.

113. Social Worker 3 accepted in evidence that at this meeting she used F as the 'bridge for communication', despite confirming that she knew by then that F had been assessed as having a very low cognitive ability by Dr Allen on 22 March 2019. Dr Allen's assessment of F has not been challenged and I therefore accept his evidence about this issue.

114. It is relevant to set out in some detail the extent of F's cognitive ability. Dr Allen described F as a man of borderline/extremely low intellectual ability with an IQ in the range 66 -74 which means he is theoretically performing below 98% of age-matched peers. On the whole and across all areas of formally assessed cognition he performs at an extremely low/borderline level. He has very basic literacy, and it is debatable whether he could be considered to have functional literacy; his reading comprehension ability is commensurate with that of a child aged 9 ½ years. It is clear that he has learning difficulties, although not at all clear whether he fulfils the diagnostic criteria for a formal diagnosis of learning disability. Most importantly, Dr Allen concluded that it is necessary for those working with F to take into account his very limited intellectual ability.

115. F was also assessed by Dr Frank Furlong, a chartered psychologist, on 10 July 2019. His evidence, set out in a report dated 10 July 2019 is not challenged, and I therefore also accept it in full. Dr Furlong reviewed and confirmed Dr Allen's assessment of F. He described F as demonstrating an understanding of the role of the various professionals involved in the case, including the social worker. F was accurately able to describe and acknowledge (albeit disagreeing) professional concerns about his mental health, alcohol consumption and police history, and he was able to identify the expectations of professionals about his

parenting. F also acknowledged that if he could not do what was asked of him by the professionals, then he might be less likely to be able to provide full time care for his children who could then be placed with a family member, remain in foster care or be adopted. He was also able to state the changes he was expected to make by the professionals which were for him to attend contact sessions and meetings and to complete any assessments.

116. Based on the information obtained during a three hour assessment interview, Dr Furlong's opinion was that F did demonstrate an ability to retain, recall and weigh up information relevant to the case. F was also asked about what action he would take if he could not understand something said by the social worker; he said he would ask them to repeat it using words that he understands and he gave an example of when he was unsure about an allegation made against him whereby he asked the social worker for clarification. Dr Furlong concluded that F should be regarded as capable of instructing his solicitor as well as having the capacity to understand the care proceedings. However he also advised it would aid his understanding of information if professionals were able to communicate with him using plain language, and reiterating and rephrasing questions where necessary. He proposed that given F's specific cognitive profile, combined with his limited verbal reasoning and working memory skills (as identified by Dr Allen), it might prove beneficial to F and the professionals working with him if he was granted access to an advocate.

117. In all the circumstances, although Social Worker 3 should have carried out her meeting with the parents on 3 June with a lip speaker and ought not to have relied on F as the 'bridge for communication', I do consider that ultimately it is likely F would have been able to understand what Social Worker 3 was saying. Dr Furlong's assessment was carried out just a few weeks after this visit and he was confident that F fully understood, or was able to ask for clarification, the nature and purpose of the proceedings including the social workers' involvement. Social Worker 3 confirmed in evidence that F was helpful and there were times when he would explain things to M. She also said she knew she would have left that meeting confident that both parents would have understood what she was saying. This was because her experience of M was that she could tell her if she wasn't happy about something. I accept her evidence about this.

118. A further appointment using a lip speaker was then made by Social Worker 3 on 16 July 2019. I have not seen evidence of what was discussed at that meeting.

119. The next LAC review was held on 12 August 2019. I have not seen the minutes of that review but Social Worker 3 said both parents attended and confirmed that they did not want to pursue the parenting course previously offered by the local authority. It does not appear that a lip speaker was booked for that meeting. My earlier observations made in relation to the meeting on 3 June 2019 apply here, but I also note there has been no explanation provided by the local authority as to why no lip speaker appears to have been booked to attend as ordered by the court on 8 November 2018.

120. There is no evidence that any further social work meeting took place with the parents before Social Worker 3 then completed her deaf awareness training on 6 November 2019.

121. On 8 November 2019 Social Worker 3 met the parents again – this time with a lip speaker – to discuss Dr Cornes' report. This was an important meeting because Social Worker 3 was signposting the parents towards how they may improve their parenting. It was put to Social Worker 3 in evidence that she had told M that if she did not do the courses suggested, then the children would be adopted. Social Worker 3 denied having said anything of the sort to the parents and said that is not how she would speak to any parent. She explained how she discussed the parenting courses on offer with them. She said both parents had independently gone to seek parenting courses in the summer of 2019 having said they wanted to enhance their parenting skills. Social Worker 3 had become aware of a parenting course for deaf parents and therefore suggested to M that she might want to do it. She was quite clear in evidence that the courses were explained to the parents in the way that would help them to become better parents. However, the way in which she gave the information about the parenting course was simply to provide details of a website address. The guardian said in evidence that he thought this was inappropriate because M would inevitably require support to use the internet; he would have expected M to have been given that support by Social Worker 3. I accept that analysis. M ought to have received support and help to access resources in a way that was suitable for her particular needs, and as advised by Dr Cornes.

122. However, I accept Social Worker 3's evidence about how she spoke to the parents. She appeared genuinely horrified in evidence at the suggestion that she could have threatened the parents in this way and I found her to be a straightforward, credible witness.

123. It was also put to Social Worker 3 in cross-examination that her assessment of the effects of adoption on the children was unbalanced. It is right to say that in written form her report did not go into the sort of detail or depth of analysis required in considering whether adoption is in a child's best interests. However, in evidence it was quite clear that she had considered the detriments of adoption, as well as the benefits. In particular, she had plainly considered that adoption would serve to sever the children's relationships with their birth family and deprive them of the opportunity to live with their birth family. In evidence she was also able to articulate the positives and negatives of long term foster care and was clear about its advantage in enabling children to remain in contact with their families. She said that even for children of this young age, long term foster care could be beneficial if there was a plan of reunification; she identified that long term foster care in those circumstances could be used as a temporary placement. However, her evidence was clear: given that reunification was not considered to be in the children's best interests, she felt that the children would benefit from having permanent carers via adoption who are invested in them. Any deficits that were present in respect of Social Worker 3's written evidence were more than rectified in her oral evidence. It was put to her that she had simply carried out a tick box exercise and that she had just written down platitudes. She disagreed. I reject such analysis and I accept her evidence in its entirety.

124. Social Worker 4 also gave evidence. She became the allocated social worker in February 2020 and took over the case from Social Worker 3. She said at the point of handover she understood the plan was for the children not to return to the parents and that the parents wanted the children to stay in long term foster care. Social Worker 4 demonstrated clearly in evidence that she had read the contact notes and spoken to some of the contact supervisors. Her concern was that the quality of contact on the whole was less than positive in terms of the parents demonstrating emotional attunement to the children. She gave examples

such as the parents being unable to respond to the children when crying without being prompted. Her understanding was that concerns about the limited emotional attunement had been a theme throughout the supervised contacts.

125. She started work with the family on 6 February 2020. On 12 February 20 she attended the LAC review meeting. A lip speaker was booked for that review. By that stage Social Worker 4 had read the case history, received a handover from Social Worker 3 and discussed the case with her manager. Her understanding was that the recommendation was for adoption and she considered her role to be to support the children and to progress that plan. A's plan had already been confirmed as being for adoption. B was placed with him immediately after birth in foster care. The plan was for the children to stay together. Therefore she felt that adoption was heavily weighted as the proposed plan for B. Social Worker 4 has not carried out any assessment herself and has relied on the evidence that was already in place before her involvement, including the primary expert assessments from Dr Austen and Dr Cornes.

126. Helpfully, Social Worker 4 was part of the children's disabilities team. She undertook a one day deaf awareness training course but also said she has substantial personal and professional experience of work with deaf people and people with learning disabilities. In her practice she makes adjustments by using short simple sentences in texts and in her responses to M.

127. Regrettably Social Worker 4 had not met the parents by the time of the hearing on 28 February 2020 and thereafter was on personal leave throughout March and April. She was back at work by the time of the LAC review on 6 May 2020 which the parents did not attend. After Social Worker 4 returned to work she sent messages to the parents by WhatsApp. She also sought to confirm their views in a telephone call with F although she was not sure if M was present. By that stage the plan of adoption for A had already been approved (Social Worker 3 having completed his Child Permanence Report (CPR) on 2 September 2019). Social Worker 4 wrote the CPR for B on 11 May 2020. She said in evidence that she had spoken to M before completing the report but not via an intermediary or with the assistance of a lip speaker. She was also the author of the final care plans for the children dated 6 May 2020. She accepted in evidence that by the time she wrote the care plans she had not met the parents directly.

128. She said she had made an appointment to meet M after the Agency Decision Maker's decision about B on 11 May, but M cancelled the meeting due to ill health. Social Worker 4 accepted that she did not take steps to rearrange the meeting saying that she anticipated M would not attend. In her evidence she frankly accepted that she should have made attempts to meet M to discuss the outcome of the Agency Decision Maker's decision with her. Although she was aware of the need to involve a lip speaker in meetings with M, no meeting ever took place with the parents who missed the three meetings that were arranged (two LAC reviews and a care planning meeting).

129. In evidence Social Worker 4 was also questioned about an apparent lack of balance in her analysis of the welfare checklist criteria in her final evidence. She very frankly agreed that her written evidence lacked the depth and detail required. However she confirmed that she had looked at all the realistic options and pointed to evidence elsewhere in her final statement of a consideration of the various different options in the case. However this written evidence does not reflect either the benefits of long term fostering or the detriments of adoption. In that respect it is right to say that her written evidence was unbalanced. She conceded in evidence that she felt she needed to reflect on the quality of her evidence written evidence and felt she had let the children down.

130. However, in her oral evidence, like Social Worker 3, she was able to expand appropriately on her written evidence. When I take account of the entirety of the local authority evidence, including the revised balancing exercise carried out by the Agency Decision Maker, I do not find that the deficits in the written evidence support a proposition that the local authority has not considered or presented its evidence fully about what is in the children's long term best interests. There is a lesson to be learned here about the way in which social work evidence in adoption cases ought to be presented to the court; but that point is more than amply covered in guidance and case law elsewhere and there is no need to say more in this judgment.

131. Finally the guardian gave evidence. He has been the guardian in all of the care proceedings relating to M's children. He has also made concessions about the nature of his involvement and recognises that he had not spent enough time talking to the local authority about its practice. He accepted in evidence that he

had done nothing to push for M to have social workers with deaf awareness training, and accepted it had taken a long time for the social worker to receive deaf awareness training. He fairly accepted that on reflection there had been missed opportunities in this case.

132. However he also said that although he accepted that M had been disadvantaged, at the same time she had been made aware of the concerns and given opportunities to change. He said it was regrettable that it was not until the 8 November 2019 meeting with Social Worker 3 that the Dr Cornes assessment was really discussed with M. I do not entirely agree with that because it is clear that the outcome of the assessment was discussed and understood by both parents at the LAC review on 4 March 2019 at which a lip speaker attended.

133. The guardian welcomed the change of care plan by the local authority to seek open adoption but did not consider that it was necessary or proportionate to set time limits for searching for such a placement because of the long delay that has already occurred in this case. He did not seek any findings about the reasons or cause for any delay in this case and having considered the matter carefully I do not think it now proportionate to deal any further with that issue. The important point is that a decision for these children should be made without any further delay.

134. In evidence the guardian was very positive about M and said he had always found her to be friendly and co-operative. He described her as really trying to communicate and in the past had always felt they could have conversations which had led him to believe that she understood what he was saying. He said he spoke slowly to M and in short sentences and thought he had understood her a lot of the time. In his reports and in his oral evidence he analysed the benefits and detriments of long term foster care and adoption which are incorporated into my overall analysis of the children's welfare later in this judgment.

135. The guardian said he had been very impressed by the communication team supporting M in these proceedings, which now leads him to think he may have missed things she wanted to say to him in the past. He feels this case has presented an opportunity and a learning experience and he intends to disseminate lessons learned from the case within Cafcass, particularly because, as was said on his behalf, there is no Cafcass guidance or practice note relating

to practice with deaf parents. If that is right, then any attempts by the guardian to bring the relevant issues to the attention of wider Cafcass management ought to be welcomed. If required, I shall also direct that an anonymised copy of this judgment should be sent to the relevant Cafcass senior management in due course.

LESSONS TO BE LEARNED IN THIS CASE

136. In closing submissions Karl Rowley QC sensibly made a number of concessions on behalf of the local authority about deficiencies in practice. In particular, in relation to issues of general practice, it is conceded by the local authority that –

- An attempt should have been made to meet the parents prior to the completion of B's CPR.

- An attempt should have been made to meet the parents prior to the completion of the final social work evidence.

- The examination of the pros and cons of adoption versus long term foster care could have been better demonstrated in the social work statements.

- The records of the Agency Decision Maker's decisions in respect of both children could have more fully reflected the thought processes involved, although there was no defect in the reasoning itself.

137. I accept those concessions. I also accept the local authority's concessions about its approach to M as a deaf person which are incorporated into a list of lessons to be learned set out below.

138. However, what is not accepted, as was also proposed, is that deficiencies in the provision of good quality social work practice to these parents, to M as a deaf person with cognitive difficulties, and to F as a person with learning difficulties, can all be attributed to the COVID-19 crisis since March 2020. As I have already indicated, knowledge and belief by the local authority about the extent of the parents' difficulties does not exculpate the local authority from the requirement

to keep parents fully and properly involved at all stages about important decision-making for their children.

139. It is also not sufficient to find that no actual unfairness may have resulted to M. The local authority proposed in closing submissions that no amount of active social work could have removed the central obstacle to M's improvement of her parenting skills because she regards herself as a good parent and believes she can meet the children's needs unassisted. The local authority also argued that M would not wish to access formal support networks as she does not identify as a deaf person, which would have been the case no matter how the information was shared with her.

140. I do not accept those arguments. At the risk of stating the obvious, it is absolutely fundamental that any parent in care proceedings should have the reasonable expectation that they will be treated fairly, provided with appropriate information clearly and in a timely fashion, without any attempt by professionals to 'second guess' what they may or may not say or how they may or may not respond. Put simply, what appears to have occurred in this case is a fundamental lack of understanding for M's needs as a deaf parent from the earliest pre-proceedings point. Even after clear advice and guidance was received from two leading experts in working with deaf people, there was then only fluctuating adherence to that advice – by all concerned. It was as though, once raised and identified, the issue of M's deafness was then placed well and truly on the 'back burner'. Having raised the impact of M's deafness at the hearing on 26 October 2018 such that it was recorded within the recitals to the court order, the issue was thereafter never again recorded as a relevant matter on any court order in a meaningful or helpful way. M was only ever referred to in court orders as being 'hearing impaired'; even the proper nature of her disability was wrongly recorded.

141. M's deafness was of course not the only issue in the case. Ultimately, any deficiencies in the local authority's approach have been ameliorated by the assessment of Dr Cornes, an acknowledged expert in working with deaf people. I am satisfied (for reasons set out below) that M was adequately and properly assessed in an appropriate way. However, M's deafness and the local authority's

approach was certainly of critical importance and relevance to a number of matters affecting M and the children.

142. It is encouraging that the local authority has firmly stated and confirmed its intention to learn lessons from the review of its approach in this case in order to improve its service provision to deaf parents in the future. In due course I will order that a copy of this judgment in full is to be sent to the director of the local authority's Children's Services Department for full consideration in that regard. There are a number of lessons to be taken from this case, but the following points in relation to the approach to deaf parents are perhaps the most critical in importance.

- **Point 1**

  The local authority should have ensured that the social workers working with M as a deaf person were aware of their obligations under the Equality Act 2010.

- **Point 2**

  M was wrongly identified in most, if not all, of the court orders as being 'hearing impaired'. All parties should have ensured that M's disability as a deaf parent of the children was accurately recorded by the court.

- **Point 3**

  There should have been a 'joined-up' approach between Adult Services and Children's Services before A was born, to identify M's needs as a deaf parent, particularly in light of the clearly identified potential safeguarding issues and M's increased vulnerabilities as a deaf parent reporting domestic abuse, and to identify the extent of the local authority's duties to M as a parent with protected characteristics under the Equality Act 2010.

- **Point 4**

  The local authority should have ensured that the pre-birth assessment incorporated expert advice about the extent of M's needs as a deaf person, and should have been carried out by professionals with the

skills suitable to understand and analyse the impact of M's deafness on her parenting.

- **Point 5**

  The deaf awareness training for Social Worker 3 was not accessed in a timely fashion. The local authority should have ensured that all social workers and contact supervisors working with M as a deaf person received adequate and timely deaf awareness training. Such training should have included information about how to provide information in a clear and appropriate way to a deaf person who also has communication difficulties.

- **Point 6**

  Using F to communicate with M was not appropriate for matters of substance.

- **Point 7**

  Using text messaging to communicate with M, whilst her preferred mode of communication and appropriate for regular contacts and discussion about everyday matters and arrangements, was not appropriate for matters of substance.

- **Point 8**

  The local authority should have ensured that a lip reader was made available to support M as a deaf person at ALL meetings as soon as the need was confirmed by Dr Austen in November 2018. Although there were attempts to engage M in face-to-face meetings for which lip speakers were booked, more efforts could have been made, particularly in respect of basic social work meetings and around the issues noted in contact.

- **Point 8**

  The local authority should have provided information to M as a deaf person in an accessible format, interpreted into simple English using a lip speaker.

Point 9

The local authority should have made information to M as a deaf person with associated cognitive difficulties written in simplified English, at a reading level that was accessible.

- **Point 10**

  The local authority should not have arranged supervised contacts without ever providing deaf awareness training for any of the contact supervisors, without ever using a lip speaker or an intermediary to assist M as a deaf person in contact, and without ever holding any review with the contact supervisors of the progress of contact.

- **Point 11**

  The local authority should have provided deaf awareness training to the children's foster carer who was involved in providing information to M at the start of contact sessions.

- **Point 12**

  The local authority should have ensured that, in considering the issue of procedural fairness in relation to M as a deaf parent, the SWET explicitly identified how they fulfilled the requirement to communicate adequately with a deaf parent. It was not enough simply to state that the SWET would be made available to M's legal representatives; that did not obviate the need for the local authority to fulfil its own responsibilities to M as a deaf person.

THE LAW

143. The law involved in this case is straightforward and uncontentious, and can be summarised as follows.

144. The local authority is seeking care orders for the children. s31(2) CA 1989 provides that -

> *"a court may only make a care order or supervision order if it is satisfied – (a) that the child concerned is suffering, or is likely to suffer, significant harm; and (b) that the harm, or likelihood of harm, is attributable to the care being given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him…".*

145. A care order can only be made if the threshold criteria in s31(2) CA 1989 are satisfied. In this case the threshold criteria have been agreed and are set out in a composite document dated 8 January 2021. For the avoidance of doubt, I find that the threshold criteria are satisfied as follows –

> *At the time when protective measures were put in place in respect of the children, they were both at risk of suffering significant harm, attributable to the care likely to be given to them by their parents, not being what it would be reasonable to expect a parent to give to them, if an order were not made.*
>
> *The nature of the likely harm was psychological, emotional and physical, and is based upon the following facts:*
>
> 1. *M was vulnerable to forming relationships with men who abused and exploited her.*
> 2. *M had experienced domestic abuse at the hands of the father of her older children. Those children had suffered significant harm, emotional and physical harm as a result of being exposed to that abuse.*
> 3. *M's relationship with F was characterised by controlling and domestically abusive behaviour. There would be shouting and swearing and there were instances of physical violence.*
> 4. *M lied to the police in denying that there was domestic abuse in the relationship.*

146. Once the court is satisfied that the threshold criteria are met, the court must then go onto consider whether it is in the children's best interests for them to be made subject of care orders. When the court is deciding whether to make a care order it is required to consider the permanence provisions of the care plan for the children, but is <u>not</u> required to consider the remainder of the plan. In considering

the care plan, the court must consider how it deals with the impact on the child of any harm that he has suffered or is likely to suffer, the child's current and future needs (including those needs arising out of that impact), and the way in which the long term plan would meet the child's current and future needs.

147. Where the court is considering an application for a care order which involves approval of a care plan of placement for adoption, the court should carry out its balancing exercise by reference to both welfare checklists in s1(3) CA 1989 and s1(4) ACA 2002 – see **Re C (Appeal from Care and Placement Orders) [2014] 2 FLR 131**. The court must also consider the no-order principle in s1(5) CA 1989 and the general principle in s1(2) CA 1989 that any delay in determining the question about a child's upbringing is likely to prejudice the welfare of the child.

148. When the court is considering the children's welfare it must carry out a welfare evaluation of which set of arrangements for the child's future care are in his or her best interests - **Re G (A Child) [2013] EWCA Civ 965**. In carrying out that welfare evaluation, the court must consider the Article 6 and Article 8 rights of each of the parties, but most especially those of the children. Where there is a conflict or tension between the Article 6 or 8 rights of a parent or carer on the one hand, and of a child on the other, it is the rights of the child which prevail **Yousef v The Netherlands [2003] 1 FLR 2010**.

149. The importance of a child either living with, or maintaining a relationship, with his parents and natural family cannot be underestimated. It is not enough for it to simply be better for a child to be adopted than not - **Re B (A Child) [2013] UKSC 33, paragraph 34**. The interests of the child must make the permanent removal of a child necessary as it must be a 'last resort', and the court can only separate a child from its parents if satisfied that it is necessary to do so and that nothing else will do. Before making an adoption order in such a case, the court must be satisfied that there is no practical way of the authorities (or others) providing the requisite assistance and support.

150. However, there is no presumption that a child will be brought up by his or her natural family. The arrangements for the child fall to be determined by affording paramount consideration to the child's welfare throughout his or her life in a

manner which is proportionate and compatible with the need to respect any Article 8 rights engaged – see **Re W (A Child) [2016] EWCA Civ 793**.

151. Where a care order is in force, s21(3) ACA 2002 provides that the court may only make a placement order if, in the case of each parent, the court is satisfied that the parent consents to the child being placed for adoption with any prospective adopters who may be chosen by the local authority and has not withdrawn the consent, or that the parent's consent should be dispensed with. s52 ACA 2002 provides that the court cannot dispense with the consent of any parent or guardian of a child to the child being placed for adoption or to the making of an adoption order in respect of the child, unless the court is satisfied that the parent or guardian cannot be found or is incapable of giving consent or the welfare of the child requires the consent to be dispensed with – see **CM v Blackburn with Darwen Borough Council [2015] 2 FLR 290 at paragraph 33**.

152. There are material differences between adoption and long-term fostering in terms of what they offer by way of security – see **Re V (Children) [2014] 1 FLR 1009 at paragraphs [95-96]**.

THE EVIDENCE

153. I have considered all the evidence in light of the relevant law.

154. A is a young boy who is now 2 years and 3 months old. He is of white British ethnicity and both his parents are white British. His first language is English although he still has limited speech due to his age. B is just over a year old. Whilst the children's wishes and feelings are not ascertainable on account of their age it is likely that they would both want to be part of a loving and stable home where they can be given the best opportunity to achieve their physical, emotional and educational potential and where they are not at risk of significant harm. It is reasonable to assume that they would want, if at all possible, to live with carers who will promote their identity, whether as children living within a foster placement or as adopted children. It is reasonable to assume that they would want to remain living together. It is also reasonable to assume that they would want, if possible, to live with their birth family. Both children, like all

children, need a relationship with a primary caregiver who can provide them with a secure attachment that creates a foundation for identify formation that includes a sense of competency self-worth and a balance between dependence and autonomy. They need such attachment figures throughout life.

155. A does not have any identified health concerns or specific behavioural needs, and he presents as a healthy, active little boy. He has regular vision and hearing tests but no abnormalities have been detected. He is meeting all his developmental milestones and it is anticipated that he will grow into a healthy young boy. Prior to the Covid-19 crisis he attended a local nursery one session a week and was also attending stay-and-play groups with B. He loves swimming which is his favourite activity, and he also likes playing games involving cars and balls. He is described as a generally happy child with lots of smiles and giggles. He needs stable, secure and loving carers who can provide him with stimulation, love and attention, and who can ensure that his physical, emotional and educational needs are met consistently and reliably.

156. B does not present with any emotional or behavioural difficulties, but will require emotional and nurturing support in order to develop a secure sense of self. Prior to the Covid-19 lockdown period she was gaining weight very slowly. It is thought she has experienced suspected milk intolerance, but since being prescribed specialist milk by the GP her tolerance and growth appear to have improved; however, this needs continued monitoring. In all other respects she is a healthy baby, is meeting all of her developmental milestones and it is anticipated she will grow into a healthy young girl. She is described as a very happy little girl with beautiful huge and infectious smiles, and she loves being cuddled. She also needs stable, secure and loving carers who can provide her with stimulation, love and attention and who can ensure that all her needs are met consistently.

157. Both children need to continue to live with each other. They also need to have their global health and education needs met by their carers, including the expectation that carers will be able to recognise and seek professional advice if and when necessary. Neither of the children follow a formal religion, and neither parent has indicated to the local authority that they want the children to follow a particular religion, although they do celebrate Christian festivals such

as Christmas and Easter and would like the children to do so as well. M is profoundly deaf but there is no evidence to suggest that this is due to a genetic or biological condition. She has been assessed as having some degree of cognitive impairment, but the cause for this is unclear. F is of borderline/extremely low intellectual ability and it is clear that he has some form of learning difficulties, although it is unclear whether there is any genetic or biological reason for this. It is therefore important that the children's educational development is monitored carefully throughout their childhoods.

158. Neither of the parents proposes that the children could return to their care, and it is therefore essential that – wherever the children are placed – they receive good quality life-story work to ensure that they have a full understanding of their identities, and their family history. In the event that they cannot maintain contact with their birth family, it is still essential that they grow up knowing their full family history and background. In the event that they do maintain contact with their birth family, it is essential that such contact takes place consistently and predictably to avoid unsettling the children.

159. At present both children have each lived for their whole lives with their current foster carers to whom they are very well attached. However, they are short-term carers and so the children cannot stay living with them. The reality is that, regardless of placement option, the children will need to move – either to a long-term foster placement or to a prospective adoptive placement. It is agreed by everyone that they should stay living with each other, and no-one is suggesting that they should be separated. But a change in placement will inevitably have an unsettling effect on them and will need to be managed carefully and sensitively, at a pace that each child can manage and which is in their best interests. They will both need help in transferring their attachments – whether they move to a long-term foster placement or to an adoptive placement. If the children are placed in long-term foster care they will definitely continue contact with their birth family, certainly M, and it may also be possible in an adoptive placement; this is a factor that could ameliorate the risks posed by a transition to a new placement.

160. If the children are adopted, there would be an inevitable impact on their sense of identity in having ceased to be a member of their original family and

becoming adopted people. A move to an adoptive placement would have a significant and possibly detrimental impact upon each child's sense of identity. The local authority intends to search for an open adoptive placement that could promote contact with their birth family; however, this is by no means a certain prospect and is only an aspiration. If contact could continue, it could ameliorate the risks posed to the children's identities of being adopted; however, it could also cause the children some confusion. However, both the children are developing well and have already developed good attachments to their current carers. There is no evidence to suggest that they would not be able to transfer attachments to new carers – whether foster carers or prospective adoptive carers. It is likely that this process will be assisted by them remaining together as they have always lived together and it is agreed by everyone involved in the case that they should continue to do so. Although the children have several maternal half-siblings, they have never had any contact with them.

161. Neither child has ever lived with the parents, so has not suffered any actual harm in their care. The primary risks of harm in this case arise either from moving to a long-term foster placement, or moving to a prospective adoptive placement. Nor is it actively proposed that the children should move to live with either parent at this stage; however, M's case is that at some stage, in a few years' time, she will want the children to live with her. There are two risks of harm arising from that proposal.

Domestic abuse

162. Firstly, there is a risk of exposure to domestic abuse. Both parents have accepted that their relationship has been characterised by domestic abuse. In particular, M also recognises that this is not her first violent relationship; her relationship with the father of her other children was also violent. The parents' relationship has also been characterised by instability and volatility; they have regularly separated then reconciled. There is no evidence that this pattern has changed for the better. Although the parents separated most recently as last October 2020, there was a recent incident between them when M had to call out the police. It is likely that if the children were placed in the parents' joint care, then they would be exposed at best to that continuing volatility and chaos and at worst to the very real risk of being caught up in violence. If the children were placed in

M's sole care, then her history of violent and abusive relationships makes her vulnerable to that continuing in the future, and thereby placing the children at real risk of emotional and/or physical harm. Dr Cornes identified that M has a number of predisposing vulnerabilities which include a learning disability, profound deafness, an unfortunate childhood history of exposure to domestic abuse and violence, she has herself been in local authority care, she has a history of previous violent relationships, she has had several of her other children removed, and has, in his opinion, poor mental health and untreated mental health problems. As well as being an expert in deafness, Dr Cornes is also an expert in trauma within his clinical practice. He described M as having experienced multiple trauma events over a long time. He considered that M is at greater risk of being drawn into a future similar abusive relationship as a result of her predisposing vulnerabilities.

163. In her evidence, M was asked about her relationship with F. In particular she was asked if he hurt her sometimes. She needed prompting to remain focused on this part of her evidence, but eventually said that he had pushed her too much and she had not pushed him back. She described asking him not to hurt her any more, and said she told him he had to 'do something about it'. By contrast, she was much more able to describe the violence she had experienced from the father of the older children with whom she was in a relationship for 13 years. She described how he tried to kill one of the older children by putting a pillow on her face, and hit two of the older children. She called him a 'serial killer'. She was quite clear that he was worse than F. She said she had told F all about the father of the older children. She was asked why she had stayed with F when she found out he was the same as the father of the older children. She said she told him about everything that had happened and he said he felt sorry for her and that the father of the older children shouldn't have behaved like that towards her. She was unable to answer the question about the extent or scope of F's violence, despite significant and repeated prompting or rephrasing of the question. M presented as a straightforward witness who did not appear to be deliberately evasive. However, I was left with the impression that, for whatever reason, she simply could not or would not answer questions directly about the extent or effect of F's violence. It is not for me to speculate about why this might be. It matters not. What does matter is that both parents have accepted there was

regular and repeated violence. She said she would try and work things out with F by asking him to calm down and tell her 'all about it'.

164. She was also asked in evidence about the likelihood of reuniting with F. Although she said she felt she had moved on and accepted they had got back together in the past and tried for the children, she could not explain why this time was different. She said she didn't know and that her head was 'all over the place'. Then she said that she was trying to get things right but that sometimes she doesn't know what's in his head; notably, she said 'every relationship is like that'. She thought she might find someone else in the future but knows it takes time. She didn't think she needed any help to make sure she didn't find someone else who was violent, and said she would find someone herself online and they would talk to each other, and that she would tell them about her previous relationships. She was asked if she would go on a course, as recommended by Dr Cornes, to meet people who could help people who had been hit (the Freedom Programme), but said she did not get involved with 'those people' and said she doesn't like talking about it as it 'makes her feel sick'. The prospects of her accepting help to reduce the risk of domestic risk are therefore minimal.

165. She said she last saw F before the Christmas holidays on 7 October 2020 when they separated. But she also described their meeting on 29 December 2020 when she said he arrived at her home without her expecting him, and she said she told him he hadn't texted her. She described him arriving at about 5am and then having a bath, and then he stayed in her house for a couple of days. The last time she saw him was on that day. She said she has now blocked him on Facebook.

166. Social Worker 3 said in evidence that one of the reasons for the maternal grandmother stopping contact with the children was because she was worried that M kept reuniting with F after abusive incidents. Social Worker 3 spoke to the grandmother on numerous occasions who confirmed that she did not want to continue her own contact with A partly because she was so worried about M. Social Worker 3 spoke to M and the maternal grandmother on 8 November 2019 with the lip speaker present. They discussed M recently having reported a domestic abuse incident to the police. Both Social Worker 3 and the maternal grandmother were very worried and concerned about M's safety at that point.

167. In summary, Dr Cornes was of the opinion that M is highly vulnerable to being targeted, exploited and hurt by abusive partners. Dr Cornes also raised concern about both parents' difficulties in managing and regulating their emotions which have resulted in M being injured and the police being called. Dr Cornes' opinion was that it was M's pattern of being controlled as a child that has led her into abusive adult relationships. He said –

> *'M showed a very poor understanding of the effects of domestic violence on children and she was unable to move beyond her own trauma. This indicates that she has not adaptively processed her experience of being in verbally, emotionally and physically abusive relationships and therefore cannot cognize what it must be like for her children to witness arguments and unresolved conflicts between their parents. It is apparent that M believes arguments between couples are unavoidable, but she has a limited understanding of the impact of children's exposure to frequent, aggressive and unresolved parental conflict. Furthermore, she has an impoverished understanding of the effects of verbal and physical aggression, and together with her difficulties in tolerating frustration and regulating her behavioural responses, presents as a clear risk to A…'*

168. I did not hear oral evidence from F. However, he submitted a position statement dated 6 January 2021 which I have considered carefully and in which he deals with the issue of the allegations of domestic abuse. He accepts that he and M would argue, that these arguments would include shouting and swearing at each other, and that on occasions there was physical conflict between them which he now regrets; F also accepts there had been inappropriate physical altercations between him and M. F accepts that if those arguments had occurred in front of A, then he would have been at risk of harm.

169. However, some aspects of his position remain qualified and far from demonstrating that he accepts any or any adequate degree of responsibility for the state of his relationship with M. For example, although he accepts M has contacted the police on numerous occasions to make complaints and allegations against him, he maintains many of these were untrue and says that on many

occasions M then withdrew them or failed to pursue them. Although he accepts that he has been abusive to M, he says that on occasion he would act to physically restrain M so as to protect himself. This sometimes got out of hand and although he does not accept he was a perpetrator, he now acknowledges that it was an unhealthy relationship at times and that he and M acted inappropriately in resolving issues between them. He accepts this would have placed A at risk of physical and emotional harm. F's qualified and partial position is a further aggravating feature in considering future risk to the children.

Parents' capacity to meet the children's needs

170. Secondly, there is a risk of the parents not being able to meet the children's emotional and psychological needs. Although Dr Austen was quite clear in her opinion that M does not have a learning disability and said in evidence that there is nothing wrong with M's ability to understand things, she did confirm that M has an IQ in the low average – borderline range with some variation. This means she will have some difficulties in understanding on a cognitive level. She said that M has the ability to remember facts, but not things she doesn't understand. There is no suggestion that M does not understand at the very basic level, that a baby needs feeding or changing – regularly and consistently. There is no suggestion that M does not understand at a very basic level that a young child needs stimulation and play. Indeed, there is clear evidence that at times, when prompted, M was able to do such things. The issue is not whether she could do those things, but as to whether she could do them unprompted, of her own volition, consistently and, most importantly, borne out of empathy and emotional attunement with the children's needs. The evidence suggests that she could not.

171. Dr Austen did not explore M's capacity for emotional literacy and abstract reasoning, by which she meant she did not ask questions with 'ifs' in them, or quite complex questions. By abstract reasoning she meant whether someone can think through something and come up with the right idea about it. There is no criticism to be attached to that because she was not asked to do so. Neither did Dr Austen assess Theory of Mind (ToM) in M. Dr Austen was clear that she was not assessing parenting, but was only assessing language and cognition. She was also clear that she could not assess attachment and deferred to Dr

Cornes about that. Although she had not assessed theory of mind, she considered that it is possible bridge the gap with sufficiently attuned professionals. She said she felt that M was teachable and ought to have had the opportunity to have been taught, but could not say she would learn. She was clear she could not do more than assess M as she presents now.

172. However, Dr Cornes went one step further. His opinion was that M has considerable and significant gaps within her parenting knowledge. He said –

> *'She struggles with the most basic concepts of parenting which she should know as she has prior experience of parenting her other children. It is my professional opinion that M's gaps in knowledge, together with her difficulties with ToM and mentalisation…cannot be bridged with professional input within A's timescales.'*

173. Unlike Dr Austen, Dr Cornes did assess M's capacity for abstract reasoning and emotional thinking, and ToM in M. He explained that ToM is implicated in learning ability and the ability to understand the mental and emotional states in others. ToM abilities are considered important in social behaviours and parenting skills, where an understand of another's mental and emotional state is key. ToM is essential in order for parents to be able to attune to the emotional needs of their child. Dr Cornes gave a clear explanation about ToM and its importance in parenting during his oral evidence. The key points can be distilled as follows –

a. ToM is not just about having a different perspective, it is about being able to empathise.
b. It means being able to understand that someone else has a mind different to your own, may think differently, may have different dreams, desires, wishes and aspirations.
c. The problem is that if a parent has gaps in their ToM, when a child develops their mind, it means the parent cannot understand why the child thinks and behaves in a different way.
d. Children don't have the vocabulary to describe all their feelings which come out through their behaviour.
e. There is also a likely significant issue during adolescence when the child tries to separate emotionally and psychologically from the parent.

f. In child development there are two crucial things – attachment and separation. In adolescent (which is difficult for any parent), deficiencies in a parent's ToM make it even more challenging, and make it difficult to negotiate and compromise.

174. He is not aware of any research that indicates or confirms that ToM can be 'taught' later in life.

175. Dr Cornes' evidence was that throughout his assessment, there was considerable evidence to suggest that M has poor ToM. She has poor alternative hypotheses to situations and demonstrated very poor insight into children's needs and how to meet them. When he assessed M in February 2019, using a lip speaker as recommended and with all his own experience and expertise, he found her to have only a very rudimentary understanding of A's developmental, emotional and social needs. At that stage A was aged one – the same age as B is now. His opinion is that there is no evidence to suggest that M would be capable of changing that approach in the future to meet either child's developing and changing needs because, in his opinion, M has only a very literal and concrete view of what underpins children's behaviour. She has a very limited understanding of emotional states and finds it difficult to tune into what others are feeling. She finds it hard to take perspectives and to imagine what it would be like to experience something as another person. In summary, he considers that M lacks self-reflection or mentalisation, which is the ability to see ourselves as others see us, and others as they see themselves.

176. This is a critical deficit in M's parenting capacity because, as Dr Cornes identified, the gaps in M's ToM will interfere in the attachment relationship as the children develop and become more independent. During his assessment, he noted that M regarded defiance in children as an illness to be dealt with by GPs or by giving them Calpol. His opinion was that M will have significant difficulties supporting the children's emotional and social learning, which is premised on her as the parent encouraging the children to understand other people's feelings and holding perspectives different from her own. He said this (in relation to A) –

> *'It is my view that M has considerable difficulties in theorising alternative scenarios. My concern is that if A does cry, then she will deny his feelings as she will experience his sadness or frustration as naughtiness. This pattern will lead to him developing a poor understanding of emotions and will damage him psychologically…It is her belief that children should be controlled, and this stems from her experience of being controlled as a child…',*

and he went on to say –

> *'Her understanding of parenting seems to relate to parental control and children being compliant with their parent's wishes.'*

177. There is no reason or evidence to suggest that M would behave any differently towards B.

178. Dr Cornes relied partly on his observations of M with A in contact on 31 January 2019. He noted that the delay in feeding at this contact was clear evidence of M's inability to recognise the physical and emotional needs of her child, and she did not recognise the impact of hunger or tiredness on A. He made some allowance for the inherent difficulty for any parent in being observed, but commented that in those situations this usually results in the parent trying <u>too</u> hard. He felt that on this occasion it was a concern that with two professionals watching the contact, this still occurred.

179. Dr Cornes' analysis is in line with the evidence of the contact supervisor.

180. It is right to say that the contact sessions themselves do not constitute formal assessment or teaching sessions, and the local authority do not present them as such. However, the content of the sessions does provide evidence about the extent of M's capacity to meet the children's basic needs, and in particular provides evidence about whether M has been able to adapt her responses as the children have developed and grown. At the most fundamental level the contact supervisor was aiming to observe whether M could remember to feed the children on time, whether she could comfort them appropriately, and whether she could stimulate them by playing with them. In those three fundamental

regards, he found she could not provide a good enough standard of basic care. Although he confirmed in evidence that M did pick up on some instructions that he gave her when prompting, there was a lack of consistency in her ability to provide a consistent, positive support for the children's basic care and emotional needs. He confirmed that there were times when M spoke appropriately to the children, and that once prompted she was able to feed and stimulate the children. He certainly was not painting a wholly negative picture. However, he could not agree that he only needed to prompt M rarely, and described having to prompt her very regularly. He said that it was his honest belief that if contact was unsupervised, then he felt M would miss cues from the children that would fully meet their basic needs.

181. It remains the case that on a fundamental level M could not have recognised the need, over time, of the children to be fed regularly and consistently. The fact that M still needed prompting after two years is evidence of the concerns about the deficits in M's ToM identified by Dr Cornes, and it is relevant evidence about M's difficulties in adapting her parenting to meet the children's changing needs.

182. As I have already identified, Dr Cornes assessed issues of ToM and attachment that were not addressed by Dr Austen. I accept the evidence of both experts, but where Dr Cornes deals specifically with the issues raised by M's deficits in ToM, mentalisation and ability to change within the children's timescales, I prefer his evidence to Dr Austen's because it is founded not just in his direct expert experience in assessing M, but also in his clinical expertise in attachment. The assessments of the two experts may have overlapped in some areas, but they ultimately covered different things: Dr Austen was instructed to provide an opinion about M's capacity and cognitive functioning, while Dr Cornes was instructed to carry out an assessment of M's parenting capacity. Dr Austen did not see A, observe contact or assess any aspect of M's parenting, while Dr Cornes did all those things and also read the contact records in detail. Dr Cornes was clear that M was unable to state or demonstrate that routines for the children were important. His analysis of the contact notes in total demonstrated a lack of consistent interaction and ability to meet A's needs.

183. Dr Cornes presented as a fair, balanced and measured witness: he accepted there had been positives during the contacts when M had shown positive interactions, had played with A and had encouraged him. But it was his concerns about the lack of overall consistency that concerned him. Those concerns mirrored the contact supervisor's evidence that at the end of two years of supervising contact, he felt no nearer to recommending that M could be left safely unsupervised with either or both of the children. Dr Cornes agreed that M was able to demonstrate she had understood the concept of stimulation of the children in theory. But he confirmed that his assessment was not just based on his clinical observations, it was also based on his reading and analysis of the entirety of the relevant other evidence in the case. He remained clear that there was considerable evidence that M could not stimulate the children consistently to make them feel sufficiently secure that she could meet their needs without being prompted. Ultimately, the thing that concerned him the most was her limited ability to show sustained stimulation of the children; that was what was missing. I do not accept that Dr Cornes demonstrated an overly critical approach to M. On the contrary, he presented as measured and fair. Similarly while I accept that M said she felt Dr Cornes had spoken to her brusquely, he did not match that presentation in any way during his oral evidence. He was considered in his answers, measured in his concessions about M's positives, and gentle in his tone. In evidence he fairly recognised and appreciated that M felt he had been abrupt and made her feel uncomfortable, but that had not been his intention. He confirmed he had never heard such criticism of his approach before in practice. I accept his evidence.

184. I have considered whether it is possible to teach M about ToM in order to improve her attachment. Dr Cornes accepted that while it is theoretically possible for M to be able to identify the appropriate support, she needs to make up for her own lack of knowledge. However, he observed that the problem first is that M must first identify that she even has a lack of knowledge. The difficulty is that M does not accept there is anything problematic about her parenting style, nor that she could benefit from teaching.

185. I accept the opinion of Dr Cornes. Although he was able to identify some pieces of work that might assist M's parenting, he was also clear that the questions raised in his assessment about M's ability to provide the children with a stable

and stimulating environment and to meet their needs throughout their maturity required completion of those pieces of work before there could be any consideration of permitting her to care safely for the children.

186. Notably, Dr Austen also described important and relevant differences in M's presentation between her two assessments. In the first assessment in 2018 she described M as appearing very willing to listen and was quite calm. She was not with F on that occasion. Dr Austen described her as then having an air of humility, was really listening and demonstrating a willingness to learn. By contrast, at the second occasion, on 3 March 2020, she did not perceive the same sense of humility or a sense that M was really listening. Instead she appeared to be saying that she had her own strategies because those were what her partner had told her. She described M as having a new confidence unlike before when she had been listening and taking advice. Such evidence also serves as an important indicator of the effect of the parents' relationship on M's functioning over time.

187. In her oral evidence M said she thinks she is a good parent and says she always has been throughout her life. She said she loves being a mum and loves having contact with the children because they make her smile and feel happy. She said she knows she has to wash her hands and watch the children all the time, and said she doesn't want to hurt the children. She described how she wakes up the children in time for feeds and knows that she has to make sure their bottles are cool enough. She said she blames the local authority for removing the children and said they blame her for everything including things she has never done. She was very negative about the contact workers even though she tried to do her best and tried to concentrate on the children she said they had a go at her in particular there were two workers she felt she couldn't trust.

188. She was asked about whether she thought or believed she could now meet all the needs of the children and look after them properly. She appeared to find it difficult to stay focused on this question or give specific details about her abilities but was clear that she could look after the children. She was asked whether she thought she needed parenting courses or would attend. She said she did 'a bit of a course' before but doesn't have to do anything now because she said she knows what to do and knows how to look after her children. She said

she's clever and has got more sense and knows how to do things and knows everything about it. She thought she could go to contact regularly if the children stay in long term foster care.

189. In closing submissions the local authority seek specific findings about M's parenting based on Dr Cornes' analysis of the whole of the evidence (as identified above). Having accepted his evidence, having read and listened very carefully to all of M's evidence and having considered the opinions of the other professionals in the case, I do make the following findings in relation to this issue –

- M has an inadequate knowledge of food, feeding and hygiene and a poor understanding of the potentially harmful impact of her lack of knowledge and understanding.
- M has inadequate knowledge and understanding of a child's development and is therefore unable adequately to meet the children's changing developmental needs.
- M has inadequate knowledge and understanding of the need to provide adequate and consistent stimulation for the children.
- M has inadequate knowledge and understanding of the importance of consistent routines and the need to set boundaries for the children.
- M has inadequate knowledge and understanding of the need to provide a physically safe environment for the children.
- M has inadequate knowledge of and lack of insight into a child's basic health needs.
- M has an inadequate degree of empathy or insight into a child's emotional needs.
- M presents a risk to the children's welfare and safety in the context of unsupervised contact.

190. M does not actively oppose the making of care orders but does not support the children being placed for adoption. She was asked in evidence about what she wants to happen for the children. She said she feels it would be a good thing for the children to stay in long term foster care. She thinks adoption is not a good idea because it will upset the children. She said she thought the local authority keep going on about the same things as in the past which isn't fair on her. She

said the children need their mum, and in contact they both smile at her. She said that if the children live in long term foster care she would like to see them once a month or twice a week, depending on what the local authority thinks. She had no strong views about whether the children should see their half-siblings.

191. She was quite clear she does not want the children to stay living with their current foster carer, because she doesn't get on with her. She thought the children had been bruised in the foster carer's care and was also critical of the foster carer for not giving her a hug like the older children's foster carer does. She thought it wouldn't be safe for the children to stay living with the foster carer because she has too many children already and a big dog.

192. She was asked about what she wanted to happen to the children in the long term. She said that she was happy at present for the children to stay in foster care because she can go to contact and carry on with her normal contact arrangements. She thinks the children should stay in foster care until she moves to a different area. She said she would like to move to another town. She said she has to wait to sort that out however because she has to pay rent arrears first and see how much her balance reduces. She described about her current accommodation which is a two bedroom flat which she has spent a great deal of time and effort decorating and has bought everything that's in the flat. She was pleased that Social Worker 3 came to visit and said the flat was very nice and very good. However she couldn't understand why having said those things in the next minute the social worker took the children away from her and she didn't understand why. She said when she gets her new house is the time when A and B can come and live with her . She didn't know when that would be but thought it could be this year or next year or at another time. She said she has to get a house and settle down and decorate it. That could take her about two to five years. Ultimately she thought it would be in about three years' time when A is five and has started school. She said she definitely thought it would be safe for him to come and live with her at that stage. She would be more settled and could keep an eye on the children 24 hours a day.

193. In evidence it became clear that M's position is that she is not really supporting permanency for the children because she sees that position effectively as a

'holding position' whereby when her own circumstances become more settle the children should be returned to her care.

194. F does not actively support the children being placed for adoption, but does not challenge the care plans for care orders and placement orders. He did not give evidence and indeed after the first day of the hearing did not attend court remotely or at all. His counsel confirmed at the conclusion of M's evidence that he stood by his acceptance of threshold criteria but did not wish to come to travel to court from where he is living. He was well aware that questions had been put to M about his alleged behaviours although nonetheless gave no instructions that M's evidence in that regard should be challenged.

195. As already set out above, neither of the children have ever lived with the parents, although they have had contact relatively regularly. There is no indication that they do not enjoy contact, and Dr Cornes did not consider there to be a poor attachment between M and A (he did not observe M with B). The fact that the children appear to have been able to form secure and settled attachments to their foster carer will serve them well in the future change of placement they will have to make – whether to long-term foster care or to a prospective adoptive placement. Understanding for the children of their relationships with M and their birth family is critically important to their future sense of identity. However, the children cannot remain living with their current foster carer and will have to move.

THE REALISTIC OPTIONS FOR THE CHILDREN'S CARE

196. The issues for both parents are whether the children should be placed for adoption preferably with some contact ongoing, or in long-term foster care with the certainty of some contact continuing. There is no family member or any other person who is able to offer the children a placement.

197. Although I have considered the children's needs separately as I am required to do, it is from the starting point that they should remain placed together. No party advocates for the children to be separated. They have lived together for the whole of their lives since B was born. I do not regard any option for placement

based on the children being separated as being in any way realistic. It is also the case that they cannot remain living with their current foster carer. Staying with their current carer is also therefore not a realistic option for the children.

198. The two realistic options before the court are therefore long-term placement for the children together in foster care with the certainty of ongoing contact with M (Option 1) and placement together in a prospective adoptive placement with the hope of ongoing contact with M (Option 2). Whichever of the two options is in their best interests will necessarily require a placement move. For the reasons stated above I am satisfied the children's positive attachments to the current foster carer, with whom they have lived for each of almost all their lives, stands them in good stead for transferring their attachments - either to new foster carers or to unknown prospective adopters.

199. I have considered and balanced the benefits and detriments in relation to each of these two options when considering what is in the children's best interests.

200. Option 1 (long-term foster care) is supported by M. F, as I have already indicated, does not actively oppose this option. It is opposed by the local authority and by the guardian on the basis that it is not in the children's best interests, as very young children, to be subject to remaining in long term foster care with all the attendant uncertainty, intrusiveness and stigma subject to corporate parenting that such option would bring.

201. The benefits of Option 1 are that the children will have the certainty of being offered continuing contact with M as long as it is reasonable and still considered to be in the children's best interests. The advantage of long term foster care is that it offers a route back to their birth family for the children. The local authority will be obliged to continue to monitor and review the children's needs, including contact, every few months. The local authority will also be obliged to continue to consult M and obtain her views and wishes about various plans and arrangements for the children. This is likely to help the children in understanding the background history, their identity, and would of course maintain their relationship with their mother. As the children grow older that will continue to be of importance to their psychological and emotional wellbeing. If the children are identified as needing particular help with

education or health in the future, the local authority would be obliged to provide such help as is necessary to them as looked after children. Another benefit of Option 1 is that it would allow the children the possibility of moving to live with M in a few years' time when if and when her living arrangements change for the better. That would enable them to live with a member of their birth family which is to be encouraged and promoted if at all possible.

202. The detriments of Option 1 are the children would have less certainty because there is always the possibility, hanging over their heads, that M could apply to discharge the care order or could inform the local authority that she would like them to move to live with her. On her own evidence, by the time M might be able to do this, A is likely to be at school and B not far behind in starting school. Any such change in their circumstances, or even the prospect of threat of such a change in their circumstances, is likely to have an unsettling effect on them at an important stage of their respective developments. It is important that the children have a permanent home well into adulthood. Any placement would need to last much longer than a child's 18th birthday. A further detriment of Option 1 is that a fostering placement can never be said to be permanent because of the changes in circumstances and commitments that inevitably face many if not all foster carers. There is a potential for disruption in a long term foster placement to a greater extent than in an adoptive placement.

203. However committed a long term foster carer may be at the beginning of a placement, it cannot be an inevitable predictability that they will still feel the same or be in the same position throughout the children's lives until the ages of when they leave care. In addition, it cannot be predicted with any certainty that a long term foster carer would be able or willing to continue providing care, whether practical or emotional, after the children reach the age of 18 and the care orders expire. This would inevitably be a detriment to the children throughout the rest of their lives because the family with whom they may have lived and settled could not predictably be available to them after the age of 18. It is recognised of course that many long term foster placements can and do continue for the duration of a care order, and indeed many foster carers remain involved with the children in their care after the care order expires. That is M's experience with the foster carers for the older children. But this cannot be predicted nor is it in any way a certainty. Another detriment of Option 1 would

be the continued involvement of the local authority in the children's lives. It was put to various witnesses during the hearing that such involvement can be characterised as a stigma. I do not necessarily accept that characterisation. However, it is right to say that as looked after children A and B by virtue of Option 1 would continue to be reviewed every few months, would require permission of the local authority in respect of important medical or educational decisions, and would be regularly scrutinised during visits from a social worker. Again it is recognised that some children experience that intervention as helpful, but nonetheless it does represent an intrusion throughout a child's life for the duration of a care order.

204. In evidence it became clear that M's position is not really supporting permanency for the children because she sees that position effectively as a 'holding position' whereby when her own circumstances become more settled, the children should be returned to her care. She thought this would be in about three years' time. However, the nature of M's difficulties means that she will need to demonstrate change over time. So one of the main problems with Option 1 is that it is contingent on an unspecified timescale based on when M might consider she is ready for the children to be returned to her care and when professionals consider it is safe. This could provoke a sense of uncertainty in the children and have a detrimental effect on their ability to settle and feel secure in their foster placement.

205. In my consideration the detriments of Option 1 far outweigh the benefits for A and B because there are too many unknowns and uncertainties that would not be in the children's best interests throughout their lives. The children need stability and deserve certainty. The detriments that I have outlined and identified do not promote stability or certainty, rather they are likely to add to the children's sense of a lack of permanency. That cannot be in their best interests throughout their lives.

206. Option 2 is to make a final care order followed by a placement order with a plan of adoption outside his birth family. Option 2 is supported by the local authority and by the guardian, not actively opposed by F and opposed by M.

207. The benefits of Option 2 are that the children would be adopted which will make them a permanent part of the adoptive family to which they would each fully belong. It is right to say that adoptive placements do break down, but the commitment of an adoptive family is inherently and obviously different to that of a local authority foster carer. However committed a foster carer may be, the fact remains that they are always free to change or vary the fostering arrangement. In that sense adoption would be experienced as very different by the children. An adoptive placement is made to last throughout a child's life. As such, it provides certainty, predictability, security and stability. The children are still at a very early stage in life. Their existing history of positive attachments means it is likely that they will be able to attach to attach to prospective adopters and settle into a permanent, secure and stable family life. A further benefit of Option 2 is that they will have a settled routine life because, once adopted, the local authority would play no further formal role in their lives. That will mean the children will be free from intrusion and oversight into their health and education needs and it would be the adoptive family who makes the important as well as the day-to-day decisions about the children's needs. That would inevitably give the children a much greater sense of stability and security.

208. The detriments of Option 2 are that the children would be deprived of the opportunity to live throughout their childhood with their parents and their wider birth family. The children would grow up knowing that they are adopted children, rather than children who could live with their natural family. Adoption is an inherently draconian step that prevents a child from living with their family of origin. In particular, there is no certainty that they would be able to continue having contact with M because although the local authority intends to search for an adoptive placement with prospective adopters who would promote contact between the children and M, there is no guarantee that such a placement can or will be found. No party invites me to require a minimum search period for such a placement in light of the extensive delay that has already occurred in this case. It is therefore very much a hope and an aspiration, rather than a certainty. There is also an inherent risk of placement breakdown in any adoptive placement.

209. Having considered the benefits and detriments of Option 2 very carefully, I find that the benefits far outweigh the detriments because the children need and require a permanent stable family life throughout their whole lives.

DECISION

210. The threshold criteria in this case are satisfied. I have considered the no order principle and take the view that it does not apply in this case. An order is necessary and proportionate to promote the children's welfare. I have considered the welfare checklist and consider it necessary and proportionate to make a care order for each of the children and I approve the care plan for adoption. I do not consider that any other type of order would be realistic or appropriate in order to manage the risks that identified above. I make it clear that I do have in mind that there can be no guarantee that the children will be placed with prospective adopters who will be able or willing to promote contact with the parents, but I accept the local authority evidence, supported by the guardian, that finding such a placement in the first instance will be very much the aim and the aspiration.

211. Option 2 is the only realistic option that would meet the children's needs for stability and security within timescales that suit each of their developmental stages. Both children are still very young – A is not yet two and a half, and B has only just turned one - and each needs to feel settled and secure within a permanent home as quickly as possible. There are too many unknowns and uncertainties associated with the holding position proposed by M as part of Option 1 which would place the children at increased risk of becoming unsettled and insecure. While it is to be hoped that they could continue to have contact with M, it is not in their long term interests that this should be at the expense of them being able to settle permanently into a secure family with each other. Option 2 includes the possibility of contact continuing with M and the local authority has committed itself to searching for a prospective adoptive placement that would promote contact. In that regard, adoption or the proposed adoption plan for these children is unusual and different from many plans for adoption that come before the courts. No party invites me to make an order for contact and I do not make such an order. However I do endorse the change in plan of the local authority and I very much hope that such a placement may be obtained.

212. I have considered the welfare checklist in s1(4) ACA 2002 and I am satisfied that the children's welfare requires their parents' consent to be dispensed with.

In the circumstances I am therefore satisfied that it is in each of the children's interests to be made subject of a placement order. I have considered whether this is a proportionate interference in children's family life in light of their Article 8 rights. However, having balanced the benefits and detriments of the two realistic options, I do not consider it is in their best interests throughout their lives to be placed in long term foster care. I have carried out a global, holistic evaluation of the evidence and considered whether the local authority plan is the right one for each of the children, having balanced the advantages and disadvantages to them of living in long-term foster care with the certainty of contact with their birth family, against those of their being placed for adoption with the possibility, but no more, of continued contact with their birth family. I have borne in mind throughout my considerations that although the children's interests are paramount, the court must never lose sight of the fact that those interests include being brought up within the natural family, ideally by the natural parents, or at least by one of them, unless the overwhelming requirements of the child's welfare make it impossible. A placement order is in my judgment both a proportionate interference with the children's Article 8 rights and those of their parents, and therefore it is my judgment that a care order and a placement order should be made in respect of each of the children in this case.

213. That is my judgment.

Postscript

214. I promised M that I would explain my judgment to her in plain and straightforward language. I therefore prepared a simplified version of this judgment that was read aloud to M in court, with the assistance of the lip speakers and the deaf Intermediary, to maximise her understanding of the reasons for my decision.