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

Case Number: WD20C00247

IN THE FAMILY COURT

11th September 2020

Before

His Honour Judge Middleton-Roy

Between:

A LOCAL AUTHORITY	Applicant
- and –	
A Mother	1st Respondent
Father A	2nd Respondent
Father B	3rd Respondent
D and S (The Children through their Children's Guardian)	4th and 5th Respondents

- -

Miss M Savage, Counsel, instructed by the Local Authority
Miss F Rowe, Counsel, instructed by Hepburn Delaney Ltd for the 1st Respondent
Mr D Lang, Counsel, instructed by Biscoes Solicitors for the 2nd Respondent
Miss A Hasan, Counsel, instructed by Arkrights Solicitors for the 3rd Respondent
Mr *H Rana*, Counsel, instructed by Collins Solicitors for the 4th and 5th Respondents

Hearing dates: 7th to 9th September 2020

JUDGMENT

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His Honour Judge Middleton-Roy

Anonymity

1. In line with the Practice Guidance of the President of the Family Division issued in December 2018, the names of the children, family members and the adult parties in this judgment have been anonymised having regard to the implications for the children of placing personal details and information in the public domain. The anonymity of the children and members of their family must be strictly preserved. All persons must ensure that this condition is strictly complied with. Failure to do so will be a contempt of Court and may result in a sentence of imprisonment.

The Application

2. This Court is concerned with two highly vulnerable young people with significant adverse childhood experiences.

3. D is a girl in her mid-teens. She is subject to the provisions of section 3, Mental Health Act 1983, having been admitted to an Adolescent Intensive Care Unit (AICU) which caters for young people with acute mental health difficulties. She experiences ‘voices in her head’ and presents with high levels of verbal and physical aggression, fulfilling the criteria for Socialised Conduct Disorder. Additionally, she presents with underlying symptoms of Attention Deficit Hyperactivity Disorder including impulsivity, disorganised behaviour, poor concentration and difficulty in settling to sleep. She has learning difficulties that are multifactorial in nature, including possible symptoms of dyslexia. She is not presently able to engage with mainstream education. She presents with symptoms of an Insecure Attachment Disorder. She is at significant risk of fulfilling the criteria for the diagnosis of emerging Emotionally Unstable Personality Disorder directly related to aetiological factors including the experience of insecure attachment to primary care givers, exposure to parental mental health difficulties, exposure to abuse and the impact of parental substance and alcohol misuse. She presents with symptoms of Post Traumatic Stress Disorder. She may also fulfil the criteria for a diagnosis of Antisocial Personality Disorder. She has repeatedly self-harmed since the age of 11, including by tying ligatures, punching herself in the nose to induce bleeding and by banging her head. She is prescribed antipsychotic, antidepressant and sedative medication. She describes being ‘triggered quite easily,’ being impulsive, having nightmares and ‘flashbacks’ to witnessing domestic abuse. She is reported to have physically attacked staff in the AICU resulting in her arrest by the police. She is reported to be at high risk of harm to others as well to as herself.

4. As a consequence of her complex mental health profile, D is considered by the experts to be at risk of future experimentation with harmful use of substances and alcohol as a form of self-medication, which will increase her risk of ongoing contact with police and forensic services. She is likely to struggle to make and maintain friendships, make and maintain future intimate adult relationships and build successful future working relationships because of an increased risk of conflict with employers and other staff. She is prone to becoming a young single parent and to struggle, in turn, to parent children appropriately and effectively because of the absence of positive parental role models. She will require intensive, individual long-term psychotherapeutic support to reduce the symptomatology of Emotionally Unstable Personality Disorder in particular and its attendant risks.

5. S is a boy, not yet ten years old. He is the half-brother of S. He presents with established diagnoses of Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder and is being treated with stimulant medication. He is likely to present with symptoms of an Insecure Attachment Disorder which places him at risk long term of a diagnosis of a personality disorder, such as Antisocial Personality Disorder. He presents with behavioural and emotional difficulties. He does not yet fulfil the criteria for a diagnosis of Socialised Conduct Disorder but he is likely to be at increasing risk of verbally and physically challenging behaviour as he moves into adolescence. He may present with more florid psychiatric symptoms, such as symptoms of Post Traumatic Stress Disorder as a result of his exposure to multiple adverse experiences throughout his childhood. He attends a primary school for children with special educational needs where he is reported to be struggling to make progress academically. He is in receipt of an Education, Health and Care Plan. He is at risk of presenting with socialised conduct disorder in adolescence and may well present with antisocial personality disorder in adult life. He is at high risk in the future of self-medicating his symptoms including low mood and anxiety with harmful use of substances and alcohol. He is at high risk of future involvement with police and forensic services. He too is likely to find it difficult to make and maintain future adult intimate relationships and be a positive parental role model, in turn, to any children he might have. Further, he will require long-term individual psychotherapy and exploration of his family history and life story to address his adverse childhood experiences.

6. It is not in dispute between the parties that both children have suffered significant harm in the form of neglect, physical harm and emotional harm, including exposure to domestic violence, the adverse impact of parental mental health difficulties and the adverse impact of parental use of alcohol and other harmful substances. The children have been exposed to chaotic and unpredictable home environments, including multiple moves of home. Neither child has experienced predictable, consistent contact with their fathers or members of their extended family. They have been exposed to the impact of new short-lived, adult intimate relationships. They have suffered from their involvement in arguments between the siblings, with both children reporting physical assaults or restraint by their older siblings.

7. The First Respondent is the mother of both children. The Second Respondent is D's father, who I shall refer to in this judgment as "Father A." I will refer to S's father as "Father B." who is the Third Respondent. The children are both parties to the proceedings through their Children's Guardian.

8. In exercising its duty in law to safeguard and promote the welfare of all children within its area who are in need, initially the Local Authority issued an application for an Emergency Protection Order in respect of the child D on 24th February 2020, before withdrawing that application on the mother giving her consent to the Local Authority accommodating the child. On 25th February 2020, the Local Authority then made a substantive application for Care Orders in respect of both children. On 27th February 2020, the Court made an Interim Care Order in respect of the child D but dismissed an application for an Interim Care Order in respect of the child S, putting him under the interim supervision of the Local Authority. Sadly, during the national public health emergency caused by the Covid-19 pandemic the situation for S further deteriorated whilst living at home with his mother. On the further application of the Local

Authority, the Court determined on 21st July 2020 that S should be removed from his mother's care and placed in interim foster care under an Interim Care Order.

9. At this Final Hearing, which commenced on 7th September 2020, combing the physical attendance of the mother and her Counsel with the other parties, advocates and witnesses attending remotely by video and telephone, the Local Authority applied for final Care Orders in respect of both children. The Local Authority presented care plans for D to move from her current Adolescent Intensive Care Unit into a specialist residential placement and for S to remain in long-term Local Authority foster care. In preparation for the Final Hearing, the Court directed Local Authority parenting assessments, drug and alcohol testing of the parents and a written independent expert report from Dr Oppenheim, Consultant Child and Adolescent Psychiatrist, whose oral evidence the Court heard at the Final Hearing. Additionally, the Court has considered a considerable amount of documentation, including voluminous crime reports, medical records and contact notes.

10. To their credit, the fathers both took the difficult decision to support the Local Authority applications for Care Orders. On day two of the Final Hearing, the Court was informed that the mother had also taken the difficult, courageous and child-focussed decision to support the Local Authority applications. A discreet but important issue relating to contact with the children remained contested, in respect of which the parties all agreed to proceed by way of submissions.

Threshold

11. Section 31(2) of the Children Act 1989 provides that a Court may only make a Care Order if it is satisfied that the child concerned is suffering, or is likely to suffer, significant harm and that the harm, or likelihood of harm, is attributable to the care 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 or the child's being beyond parental control. These provisions are commonly called the threshold criteria. The relevant date for determining threshold is 24th February 2020.

12. The parties agree that the threshold for the making of public law orders is met. The Court finds, on the basis of the agreed threshold statement, that the children D and S were both suffering and were likely to suffer, significant harm in the form of neglect, physical and emotional harm and that the harm, or likelihood of harm, is attributable to the care given to each child, or likely to be given if the order were not made, not being what it would be reasonable to expect a parent to give.

13. The Court makes the following findings on the basis of the agreed final threshold statement:
   a. The mother has failed to protect D and S from physical and emotional harm:
      i. On 22 February 2020, D was arrested following an assault on her mother and brother, S, and damaging the property;

   b. The children have suffered and are at risk of suffering neglect and significant emotional harm through witnessing their mother's mental health issues and numerous suicide attempts:

i. On 31 August 2019 police were called to the family home due to an argument between the mother and her elder son ["O"] and reported the home conditions to be very poor and that mother had been bed bound for 3 days due to her mental health;

ii. On 28 August 2019 the mother was suicidal and reportedly took an overdose. She was taken to hospital;

iii. On 30 July 2019 the mother reported feeling suicidal to the social worker;

iv. On 24 July 2019 the mother was feeling suicidal and an ambulance was called;

v. On 6 June 2019 the mother took an overdose and was taken to hospital by an ambulance for treatment.

c. The mother struggles to manage the children's behaviour and set boundaries which places them at risk of emotional and physical harm:

i. In January 2020, D was arrested for common assault on her mother and brother after threatening them with a knife;

ii. In January 2020, D ran away from home and spent a night at her friends' house;

iii. On 15 December 2019, D threatened her mother with a knife and subsequently threatened the attending police officers with a knife. D was arrested for assaulting her mother and for having a knife in her possession;

iv. In November 2019, D was arrested for attacking her mother and when the police were called a knife was found in D's bedroom;

v. On 20 August 2019 the mother had D arrested for breaking a new cooker during an argument. D remained in police custody for 6 hours;

vi. In August 2019, D ran away from home on a number of occasions and the police were called each time;

vii. During the school summer holidays in 2019, S was found playing with a lighter and set fires to a piece of paper in the house;

viii. Professionals have observed the mother to cry in front of the children and say she cannot cope with them and has asked them to be taken into respite on numerous occasions. The mother says that this happened as a result of lack of support from the local authority;

ix. S is on a reduced timetable at school due to his behaviour towards staff and his peers.

d. The children have suffered significant emotional harm as a result of the parenting they have received:

i. On 17 February 2020 the mother reported that D had taken an overdose and said D is attention seeking and that she had no sympathy for D. The attending ambulance crew observed the mother swearing at D throughout their visit;

ii. On 5 February 2020 the mother reported that D had taken an overdose;

iii. On 3 February 2020 the mother reported that D had taken an overdose the previous day of five Tramadol tablets following an argument and physical altercation between them;

iv. On 15 December 2019, D was taken to hospital due to a suspected overdose but refused to allow blood tests. The nurse observed cuts on D's arm which D stated she had made with a pencil at school;

v. On 22 November 2019, D attempted to self-harm and later the same day informed police she felt suicidal. She was observed to place a knife into her bag by the police who attended her home;

vi. On 30 July 2019, S tried to harm himself in his bedroom by tying something around his own neck and had to be admitted to hospital for a few days.

e. The children are exposed to domestic violence between mother and her partner Mr P, which caused and places them at risk of suffering emotional and physical harm:

i. On 26 July 2019 a domestic violence incident took place between the mother and her partner at his flat, whilst D and S were present. Police attended and took the mother and the children back to their home;

ii. In July 2019, D stood in between her mother and Mr P during a domestic abuse incident in order to prevent Mr P from hitting her mother;

iii. The mother is a regular user of cocaine which impacts on her ability to parent the children.

14. There are three elements to the threshold conditions in s.31(2) of the Children Act 1989: The harm must be actual or likely; it must be significant; and it must be due to parenting that is not reasonable. The concessions made by the parents together with the totality of the evidence in the case leads to the inescapable conclusion that all three of these elements are satisfied in respect of both children and that the threshold for protective intervention is crossed.

Welfare

15. The evidence sets out a history of Children's Services' involvement with the family for eight years, dating back to 2012, relating then to reports of an alcohol related domestic violence incident between the mother and S's father. In November 2015, S's school was reported to have concerns about his violent behaviour, when S is reported to have kicked a teacher, repeatedly hit her and threatened to kill her numerous times. There were concerns regarding the mother's ability to manage S's behaviour. The behaviour of D and S escalated. There were reported concerns that S and his older half-siblings were violent towards each other. There were reports that D stabbed her mother's bed with a knife and punched her mother in the face. S is reported to have been copying his sister's behaviour and expressed a wish to take his own life. In 2018, the mother and S's father were reported not to have engaged with a Local Authority 'Family First' assessment and there were ongoing reported concerns about cannabis misuse whilst S was in his father's sole care. The school is reported to have been concerned that the mother was not able to consistently act protectively. The mother has an adult social care worker due to her own physical and mental health needs. There are concerns about the mother's ability to keep herself and the children safe. A further referral was made to Local Authority Children's Services by The Child and Adolescent Mental Health Services (CAMHS) in 2018, reporting that S had placed himself at risk on several occasions, running off barefoot, damaging property in the home and being hit regularly by D.

16. A community-based parenting assessment of the mother was completed by the Local Authority. That report, dated 29th May 2020, concluded negatively. The mother engaged well with the assessment and was reported by the Social Worker to be open and honest when discussing her parenting. However, the assessment highlighted several concerns including a chaotic home environment, an absence of boundaries or appropriate guidance, the relationship dynamic between the mother and the children, difficulty in managing the behaviour of either child, using inappropriate techniques for managing the negative behaviour of both children, the mother's sanctioning of restraint of S by his older brother as means of controlling S's volatile behaviour and being unable to actively reflect on and understand the impact of those actions. The assessment also concluded that the mother struggles to empathise with the children as a result of her own adverse childhood experiences and managing her own health needs. The assessment concluded that the mother has been able to reflect to an extent on her parenting, she is keen to take action to address the Local Authority concerns and she has attempted to make changes. However, she has been unable to make or sustain the necessary changes, notwithstanding an overwhelming amount of support from the Local Authority, including the Local Authority Family Safeguarding Team, a Children's

Practitioner, a domestic abuse practitioner, and outreach worker, support from MIND mental health services, CAMHS and from the children's respective schools.

17. Toxicology evidence relating to the mother in the form of hair strand testing covering the approximate period from November 2019 to May 2020 detected cocaine and cannabinoids. The toxicology report concluded that cannabis has been consumed by the mother occasionally, at low levels. Blood testing results concluded that alcohol had not been consumed excessively. The report concluded, however, that the mother had consumed cocaine repeatedly at medium levels over the whole 6-month period tested.

18. A community-based parenting assessment of D's father completed by the Local Authority also concluded negatively. The report records that the father was committed to the assessment. The report records that the father wants the best for D and notes positively that, despite not being available for D while she was growing up, he has now made the effort to speak to D by telephone. The report identified concerns relating to evidence of the father's excessive alcohol consumption and concerns that he does not have the insight to understand D's complex needs or meet those needs now or in the long term. Toxicology evidence in the form of hair strand testing and blood testing for D's father indicated the likelihood of excess alcohol consumption over the six-month period of testing from November 2019 to May 2020, including excessive alcohol consumption in the four weeks immediately prior to the sample collection.

19. S's father was not the subject of a parenting assessment, given his position that he was unable to put himself forward to care for S. Toxicology evidence in the form of hair strand testing and blood testing relating to S's father dated June 2020, suggests chronic excessive alcohol consumption in the approximate six month period prior to testing, including recent excessive alcohol intake. There was no evidence of use of amphetamines, cannabis, cocaine, methamphetamine or any of the drugs within the ecstasy or opiate drug groups.

20. Each parent has commendably reached the difficult decision to support the Local Authority application for Care Orders for both children as being necessary and in their best interests. The mother tells the Court, and I accept, that she is fully committed to the children. She acknowledges that the children have their own vulnerabilities. She accepts also that she needs help and support on account of her own vulnerabilities, including her physical complaints and her own unmet mental health needs. Plainly, the mother cares dearly for both children and wants what is best for them. I accept that the mother feels she has tried her very best for the children. Whilst the parenting assessment raises concerns in respect of the mother's insight, in reaching the difficult, child-focused decision to support the Local Authority application, I accept that the mother has demonstrated a level of insight in respect of both children's needs. There has been no suggestion that the mother would undermine the respective placements of either child. I accept entirely that the mother loves both children equally and would wish desperately for both children to return home, were that possible.

21. D's father tells the Court he is not in a position to care for D, given the complexity of her needs. He too has made the difficult, child-focussed decision to support the

Local Authority's application for a Care Order. He tells the Court, and I accept, that he loves his daughter dearly and wants what is best for her. He supports the Local Authority care plan, including the Local Authority proposals for direct and indirect contact between D and him.

22. S's father too tells the Court that, unfortunately, he not in a position to offer long term care to his son due to his own personal circumstances, including at present, an absence of any fixed abode. He too supports the Local Authority application for a Care Order and the plan for S to remain in long term foster care. He does not accept the Local Authority proposals to reduce the amount of time S spends with him.

23. The Local Authority application for a Care Order for each child is supported by the Children's Guardian. Further, the Children's Guardian supports the Local Authority care plan, save for the issue of contact.

24. The making of Care Orders for both children is not opposed and indeed is consented to by each of the parents. Nonetheless, I have reached my own decision in respect of the welfare of both children individually based on all the evidence and having regard to the factors set out under section 1(3) Children Act 1989. D expressed a wish very clearly to the Children's Guardian that she does not wish to return home but wishes to have good contact by video with her mother, her father and with her older brother, 'O.' S expressed his wish to the Children's Guardian, to remain with his current foster carer and not to return home. Pleasingly, both children have made progress in their current placements. Notwithstanding their love for the children, the evidence leads to an inexorable conclusion that, regrettably, none of the parents is in a position to meet the welfare needs of the children. Safe reunification of either child to the care of any of their parents is not an outcome supported by the evidence. There are no other family members who have been assessed as capable of meeting the needs of the children. Adoption is not an option for either child, having regard to their respective ages. In my judgement, the welfare of both children overwhelmingly demands the making of Care Orders. I am satisfied that a Care Order is necessary for both children, is in their best interests individually and is the proportionate response having regard to the risks.

25. I turn to consider the contested issue of contact. The Local Authority plan is for D and her mother to spend time together six times per year by way of direct contact, together with daily indirect contact by telephone or video. The Local Authority has the same plan in respect of contact between D and her father, namely six times per year direct contact, together with daily indirect contact by telephone or video. Direct contact between S and his mother is planned to take place twelve times per year, together with fortnightly indirect contact by telephone or video. The Local Authority plans direct contact between S and his father at a rate of six times per year together with fortnightly indirect contact by telephone.

26. The mother does not accept the Local Authority plan for direct contact with D six times per year. She seeks contact with D on a fortnightly basis, as soon as D is considered to be well enough, following her planned discharge from hospital. The mother submits that her direct contact with S should be at that same fortnightly

frequency as her contact with D, together with weekly indirect contact. Further, she seeks contact with S to move out of a contact centre into the community.

27. D’s father agrees with the Local Authority contact plan for direct and indirect contact so far as it relates to him.

28. S’s father does not agree with the Local Authority contact plan. He seeks monthly direct contact with S.

29. The Children's Guardian’s recommendations for contact have fluctuated. His recommendation set out in his final written analysis, filed during the Final Hearing, later changed after hearing the oral evidence of Dr Oppenheim and further changed at the point of his final submissions to the Court through Counsel. I accept that the various changes in the Guardian’s recommendations to the Court reflect both the complexities of the case and the changing situation as it developed during the Final Hearing. Ultimately, the Children's Guardian recommended direct contact between D and her mother six times per year and direct contact between D and her father six times per year with regular indirect contact, therein supporting the Local Authority plan. The Children's Guardian’s final recommendation in respect of S was for fortnightly direct contact between S and his mother, together with fortnightly indirect contact. The Children's Guardian recommended monthly direct contact between S and his father. In this regard, the Children's Guardian did not agree with the Local Authority contact plan for S, being a marked reduction from the current weekly frequency of contact.

30. D’s wish, expressed to the Children's Guardian, to have ‘good’ contact by video with her mother and father is broadly in line with the Local Authority plan. However, the Local Authority plan for S is not consistent with his wish to see his mother weekly and to see his father twice each month. I very much respect those wishes and feelings expressed by both children. Both children are at an age where their wishes carry weight. It is a well-established principle that the wishes and feelings of a mature child do not carry any presumption of precedence over any of the other factors in the welfare checklist. The child's preference is only one factor in the case and the court is not bound to follow it. The weight to be attached to the child's wishes and feelings will depend on the circumstances of each case. In particular, it is important in every case that the question of the weight to be given to the child's wishes and feelings is evaluated by reference to the child's age and understanding. Within this context, and on the face of it, the older the child the more influential will be their views in the decision-making process. However, ultimately, the decision is that of the Court and not of the child. It is important to recall in this context that children's best interests are the Court's paramount consideration. In respect of S, he is noted by the Children's Guardian to be intelligent for his age and very aware of his circumstances. In my judgement, on the specific facts of this case, the weight of concerns means that the child’s wishes are not capable of being fully realised.

31. Dr Oppenheim was invited in her oral evidence to express a professional view in respect of contact. Dr Oppenheim told the Court that from a psychiatric point of view, it is important for children to maintain contact with their parents where that is possible, and further, there is benefit in maintaining sibling contact in the long

term, which can be a protective factor for siblings moving into adulthood. Dr Oppenheim considered that it was important for both children to understand that they would not be returning to their parents' care. Dr Oppenheim made plain in her evidence that whilst the principle or 'philosophy' of contact is within her expertise as a Consultant Child and Adolescent Psychiatrist, the specifics of the frequency of contact are not. In that context, Dr Oppenheim observed that the Local Authority's original plan for S of six times per year contact with his parents, 'might seem low,' whilst his mother's proposal for weekly contact and the father's proposal for fortnightly contact were, 'a little high.' Dr Oppenheim expressed the concern that high levels of contact might create an expectation on the part of S that he was working towards rehabilitation to his mother's care. Dr Oppenheim told the Court that settling into this foster care placement and fundamentally recognising his future does not belong at home are different but connected issues. If the frequency of contact is too high, he will be unsettled. Further, Dr Oppenheim told the Court that in her professional opinion, it was reasonable to argue that S should have more contact with his mother than with his father, given that his mother was his primary care giver. Dr Oppenheim's suggestions of monthly contact between S and his mother and contact with his father at six times per year, were ultimately accepted by the Local Authority in its revised contact plan.

32. Dr Oppenheim considered the possibility that D may be negatively impacted by knowing that S is spending more time with his parents than she is. However, Dr Oppenheim was of the opinion, first, that D and S do not share the same father and there is no direct equivalence. Further, D had limited contact with her father for many years. Furthermore, the children are in separate placements with very different health needs and there is no plan to bring them together. Dr Oppenheim was of the professional opinion that for S to maintain some regular contact with his parents may reassure him, as he is aware in particular of his mother's mental health difficulties, and a higher frequency of contact with her may help him be more settled. Furthermore, in Dr Oppenheim's opinion, the frequency of contact for S should also take into consideration the amount of therapeutic work S will be engaging with in foster care, in addition to engaging in a range of activities to enrich his home life and social life and to boost his self-esteem.

33. In respect of D, in my judgement, the Local Authority contact plan is in her best interests. On the evidence, for D to spend time with both her parents, directly and indirectly, is of undoubted benefit. This will involve daily telephone communication between D and her mother, in addition to D communicating daily by telephone with her father, on a flexible basis, as and when D wishes. I am satisfied that the Local Authority proposal for D to spend supervised time directly with her mother at a minimum of six times each year and to spend supervised time with her father a minimum of six times per year properly balances D's need to maintain a direct relationship with both her parents, whilst taking into consideration D's extreme vulnerability and the need for her to transition from her current Tier 4 AICU placement following discharge, into a Tier 3 residential setting. Additionally, the Local Authority contact plan will allow D to engage with the full program of therapeutic treatment and education she requires without that being impacted by too high a frequency of contact. The Local Authority contact plan is consistent with D's wish, as expressed to the Children's Guardian, to have good video contact with her mother. All parties accept that D contacts her mother

and father by telephone daily and all parties accept that this should continue on a flexible basis to assist with her recovery.

34. I accept the submission by the Local Authority, supported by the Children's Guardian and D's father, that to set a higher level of direct contact at this stage is premature, and is not in D's best interests, having regard to her current circumstances where she remains in psychiatric care and in circumstances where the first direct contact between D and her mother, since D was admitted to hospital, took place only last week. I am satisfied that the Local Authority plan aims to build on the progress made in respect of that recent direct contact, properly and adequately taking into consideration D's highly complex needs, whilst also taking into consideration the complexities of the mother's physical and mental health needs, the mother's need to develop suitable coping strategies and the matters identified in the parenting assessment, including issues of a lack of trust between D and her mother, the volatility of the relationship and the worries identified regarding the mother's empathy. Further, I am satisfied that the Local Authority plan properly takes into consideration the matters set out in the expert evidence of Dr Oppenheim. The Local Authority plan for contact between D and both her parents, focuses properly on D's recovery, contact being an important part of that, at a level that is sustainable and in her best interests. The Local Authority is committed to keeping the matter of contact under regular review, as is its legal duty, and the next scheduled review meeting is within a few short weeks. I find no reason to interfere with the Local Authority plan relating to D's contact with her mother and her father.

35. In respect of S, he too has very complex needs. The right frequency of contact, again, is important. The Local Authority's plan is for a minimum level of direct contact between S and his mother to take place monthly, as a starting point, balancing the need to maintain that important relationship with his mother who has been his primary carer throughout his life and to reassure S as to his mother's health, whilst also taking account of the evidence of the parenting assessor that the mother struggles to empathise with both children.

36. I accept the Local Authority's revised plan as being in S's best interests. I acknowledge that S is currently enjoying weekly contact with his parents and that the Local Authority plan amounts to a marked reduction to the current frequency. Monthly direct contact with his mother is, in my judgement, at a level that supports S in maintaining his sense of self and identity. It also takes account of the fact that S is being well supported in the management of his emotional regulation. Happily, he has settled well into the new school term and since his short period in interim foster care to date, there has been real and noticeable improvement in his self-esteem and general presentation.

37. The Local Authority contact plan for S is at a level where S can understand he is not going home, which accords with his wishes and feelings. The combination of monthly direct contact with his mother and six-times-per-year contact with his father, making a total of eighteen separate direct contact dates each year for S, remains at a high level and accords with his wish to have good contact with both parents. Additionally, the Local Authority plan includes indirect contact between S

and both parents fortnightly. Having regard also to his planned social activities, after school activities and health appointments, I accept the Local Authority submission that to set a higher frequency of contact for S would be too great a burden for him. In my judgement, the Local Authority plan for contact to remain in a contact centre on a supervised basis at this stage remains the right one and again accords with S's wish. As with D, the Local Authority is committed to keep the plan under regular review, in accordance with its legal duty. Clearly the plan with benefit from flexibility, particularly as S grows older and will quickly outgrow the confines of the contact centre.

38. Dr Oppenheim's professional opinions in respect of the principles of contact were entirely open to her to make and I find no reason to depart from them. Dr Oppenheim was at pains to make clear in her oral evidence that she would not be drawn on expressing an opinion in respect of the detail of contact, as that fell outside her expertise. Within that context, where Dr Oppenheim made observations in respect of contact, those observations were entirely open to her to make. I accept Dr Oppenheim's concern that S is young boy with his own complex needs, who has only recently moved to foster care and who has experienced difficulty with irregular paternal contact in the past. I accept Dr Oppenheim's expert opinion that S lacks capacity to think through issues in respect of contact and that it is not enough to accept S's current views on contact when thinking of placement stability for him. S has enjoyed contact with his father. Contact has at times also become complex and enmeshed in the difficulty of the parents' relationship prior to S being received into foster care. Further, I find no reason to disagree with Dr Oppenheim's observation that S's welfare needs justify a different frequency of contact between S and his mother, compared with that of S and his father, whilst still maintaining that important relationship with his father. In all the circumstances, I am satisfied that the Local Authority plan for contact for S and both his parents is in his best interests, including the proposed transition from the current frequency of contact. I find no reason to interfere with the that plan.

39. The Local Authority care plan supports the principle that there is benefit in maintaining contact between these siblings who plainly have a bond. S wishes to have contact with his sister. Presently, D does not wish to have contact with her brother. D made clear to the Children's Guardian, however, that she would wish to have contact with S in the future. Both D and S wish to have contact with their older siblings, including O. The Local Authority plan seeks to promote contact between D and S initially through letters or cards with a view then to attempting video contact. Plainly this should be encouraged. Once D has transitioned back into the community and is more settled in her new placement it would be reasonable to reintroduce contact, beginning with indirect contact, thereafter moving to direct contact. The Local Authority proposals also encourage contact with the older siblings, in accordance with the shared wishes of D and S.

40. The Local Authority social work in this case has been sensitive, measured and supportive. I am satisfied that, upon the making of a Care Order for both children, the issue of contact is best managed by the Local Authority, without the need for an Order setting out the terms of contact.

Conclusion

41. The Court makes a Care Order in respect of both children.

42. The Court approves the Local Authority care plans.

HHJ Middleton-Roy
11th September 2020