



Neutral Citation Number: [2021] EWHC 2844 (Fam)

Case No: PR21C50003

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/10/2021

Before :

THE HONOURABLE MR JUSTICE HAYDEN

Between :

Lancashire County Council	<u>Applicant</u>
- and -	
M	<u>1st Respondent</u>
- and -	
F	<u>2nd Respondent</u>
- and -	
W	<u>3rd Respondent</u>
- and -	
Lancashire Clinical Commissioning Group	<u>Intervenor</u>

Miss Samantha Bowcock QC and Miss Danielle Woods (instructed by **Lancashire Local Authority**) for the **Applicant**
Miss Frances Heaton QC and Ms Jo Mallon (instructed by **Paul Crowley Solicitors**) for the **1st Respondent**
Miss Lorraine Cavanagh QC and Ms Kerri O'Neill (instructed by **Morecrofts Solicitors**) for the **2nd Respondent**
Mr Paul Hart (instructed by **Vanguard Law Solicitors**) for the **3rd Respondent**
Mr Nigel Taylor (instructed by **Hill Dickinson**) **Intervenor**

Hearing date: 11th October 2021

Approved Judgment

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

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered in private, by way of a video conferencing platform. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the child 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.

The Honourable Mr Justice Hayden :

1. I am concerned with W, a boy aged 12, who is the subject of an application for a Care Order. The application first came before the Courts in March 2021. There have been a number of interim hearings which it is unnecessary to review in this judgment.
2. W has serious disabilities arising from a genetic defect. He requires the use of a wheelchair at all times. He has several diagnoses which include epilepsy and a condition known as Aerophagia, a swallowing disorder. W has been known to self-harm and occasionally to hold his breath to the point where he loses consciousness. This raft of disabilities necessitates W having one to one care at all times during the day and two to one care for moving and handling. P's breath holding sometimes causes hypoxic episodes. He also has a Mic-key button device (gastrostomy feeding tube) to his abdomen.
3. A private care group were responsible for delivering professional care to W. However, they encountered a great deal of resistance and what they perceived to be combative interference with their staff, by W's parents. In particular, it was said of them:
 - (i) They have insisted on having oversight of the training of carers at all times;
 - (ii) They have required the removal of two of the carers from their position on unreasonable grounds;
 - (iii) They alleged, without proper foundation, serious misconduct by the paediatric nurse with oversight of [W's] care package and demanded her de-registration before their allegation had been investigated;
 - (iv) They have declined to co-operate with a review of [W's] care package despite having complained that he is not being adequately supported by trained health care staff;
 - (v) On 03.03.21 [W] suffered a hypoxic episode in which his saturation levels dropped to below 85%. The threshold for calling emergency services during such an episode, according to his care package, was three minutes. The parents allegedly refused to permit the care staff on shift to call for an

ambulance immediately after the threshold had been reached, causing him to remain dangerously desaturated for ten minutes.

4. On 4th March 2021, the agency indicated that they would no longer be prepared to offer a service to W, due to the magnitude of these identified difficulties. This decision was triggered by an incident the day before when W had experienced a hypoxic episode. W's parents are said to have refused to allow the care staff on duty to call for an ambulance immediately which had the consequence of placing him at risk as his saturation levels fell below the key threshold. W's mother, M considered the readings normal for W. When the ambulance service attended, they found W to be well. There was a planned admission for W to Alder Hey Children's Hospital to investigate the hypoxic episodes. The parents were said to have been distrustful of the care staff who felt "*undermined and belittled*". The parents' behaviour at Alder Hey was also said to be "*highly concerning*" although they were described as "*appropriate and respectful on the ward*".
5. The parents were, in my assessment, genuinely shocked when the care agency withdrew. They considered that they had an excellent working relationship. M acknowledged that she had been very emotive, but she emphasised her concern and passion. She also recognised that she was a prolific emailer. When W was born, he was given a limited life expectancy which he has already vastly exceeded. M believes that her advocacy of W's interests and rights has played a large part in W thriving to the extent he has. I have no doubt that, at least to a very significant extent, she is correct.
6. It is a sad fact that the Family Court, from time to time, encounters parents of profoundly sick children or children with disabilities who become drawn into high octane conflict with the raft of professionals who seek to support their child's care. Many judges, over the years, have speculated why this scenario arises with such regularity. Sometimes, it may be a displacement of loss and accompanying anger which lands upon the medical and other professionals in the absence of any other target. Often, it may reflect a parent's sense of powerlessness. Hedley J described the challenges faced by parents in these circumstances in **Re LBH (A Local Authority) v KJ & Others [2007] EWHC 2798 (Fam)**. In particular, he was sceptical as to the utility of State intervention:

"20. Perhaps one can refine the issue by indicating what the law cannot be. It cannot be the case that a single parent exposes herself to a compulsory state intervention in family life simply on the grounds that a particular child's needs are beyond the capacity of one parent (or indeed even two parents), however assiduously they devote themselves to the care of the child. The only exception to that could be where a child can properly be said to be beyond parental control. They may (and usually will) have obligations to other children. It is usually strongly conducive to the welfare of a seriously disabled child to be brought up in a family with siblings. (Not least is that an advantage because thereby family is preserved beyond the death of parents). In those circumstances a disabled child may have to accept that the promoting of the emotional needs within a functioning family may involve some detriment in the achievement of their maximum personal potential. It is well recognised that sadly this tension between needs

of family and disabled child is all too often destructive of family life and relationships.”

7. Several years later, Hedley J returned to this point, which was plainly of concern to him and, if I may say so, reflected his characteristic and compassionate insight into the challenges faced by families of profoundly disabled children with complex needs. Hedley J considered that the management of these challenging cases did not sit comfortably or indeed entirely appropriately within the scope of Part IV of the Children Act 1989, even where the criteria, on a literal construction, appeared to be met. In Re: **K and Ors (Children) [2011] EWHC 4031 (Fam):**

“30. Cases of severely disabled children do not, as I have indicated, sit easily or conveniently within the scope of Part IV of the Children Act 1989. In this case proceedings were issued primarily to address the breaking of a deadlock between Local Authority and parents. The proceedings may well have achieved that aim, though not before they had first further embittered and embattled that key relationship between the parents and the Local Authority. It seems to me that legal proceedings will often, at best, have a very limited contribution to make in cases like this. Whatever its deficits may be perceived to be, the family unit, if functional, is of central importance to the permanently disabled for it is the one fixed point in the constantly moving waters of state care provision. The welfare of such children over a lifetime is closely bound up with the ability of the family to remain a functioning and effective unit. By the same token, it must be emphasised that resort to litigation to advance one family's interests at the inevitable expense of others is to be deeply deprecated. As a general rule, as I have said, litigation rarely contributes to the resolution of these issues.

8. I entirely agree with Hedley J's approach, although it is necessary to emphasise that the central importance of the family unit depends entirely upon whether it is functional and able to meet the welfare needs of the child to a sufficient degree.
9. When this case last came before me, as it happened on W's twelfth birthday, I approved the instruction of Dr Kate Hellin to provide a psychological assessment of both parents, in the hope of achieving a better understanding of some of their interactions with the professionals. Dr Hellin's work is both well known to this court and highly regarded. This said, I did not expect to receive a report that so comprehensively captured the dynamic of this kind of conflict. It is, in my judgement, a landmark report, the analysis of which requires wider dissemination. Today, this interim hearing, which it was anticipated would be contested, has resolved, by agreement of the parties.
10. I heard briefly from the parents and was struck not merely by how much more relaxed they seemed than at the earlier hearing, but by their renewed and regenerated resolve to work constructively with the professionals. Equally, it was clear that this response had been met with enthusiasm by the professionals. This progress arises almost entirely in consequence of Dr Hellin's assessment. All the advocates in this case supported Dr Hellin's analytical approach and were rightly keen that it be made available more widely.

11. Dr Kate Hellin has a distinguished curriculum vitae. She is a Consultant Chartered Psychologist and Psychotherapist; an Associate Fellow of the British Psychological Society (BPS); she trains a range of practitioners including Clinical Psychologists, Lawyers and staff in the charity sector.
12. Dr Hellin did not consider that either parent had any sign of mood related problems, personality disorder or serious mental illness. M was assessed as a *“balanced, thoughtful woman with considerable psychological resilience”*. There was nothing to suggest that she has *“health anxiety or abnormal illness behaviour”* rather, her psychological state had deteriorated in consequence of W’s health needs and the demands placed on her, particularly as those needs had become more complex. M’s mental health had become acute when W had a crisis involving a bowel intussusception and brain haemorrhage, in December 2019. At that time Dr Hellin considered that M would have met the criteria for post-traumatic stress disorder, which she would no longer now meet. Nonetheless, this acute episode left a legacy of a *“heightened level of resting anxiety”*. As Dr Hellin points out in clear and unambiguous terms, this anxiety is *“rational”* and based in the *“cumulative reality of life-threatening medical events in [W’s] life and the uncertainty of his condition and prognosis”*. M’s response to the very challenging circumstances she faces are said to be *“normal”* and Dr Hellin would expect *“a similar response in even the most psychologically robust person”*.
13. In his interview, F described how he was worried about W for most of the time. When he is anxious Dr Hellin says, *“he worries excessively”* and *“adheres to routine and to rigid lifestyle practices which help him to feel more in control”*. Dr Hellin goes on to describe how W’s needs and extensive disabilities cast the parents own lives deep into the background:

“They live with ongoing intense chronic and acute stress, day-to-day anxiety about his survival, the uncertainty regarding his future and their limited sense of control, at times, in the face of complex commissioning and care/medical delivery systems.”
14. The couple has different coping mechanisms. M has attempted to take control when faced with bewildering uncertainty and what have been, on occasion, life and death situations. Dr Hellin is clear that in these circumstances *“this is a psychologically healthy way of responding to adversity”*. F is more avoidant, though particularly adversely affected when M becomes overwhelmed. Inevitably, all this has placed a strain on their relationship, though they strike me as committed to each other and phlegmatic.
15. Echoing some of Hedley J’s observations above, Dr Hellin was clear that the court would not be best assisted by evaluating the issues in terms of the parent’s perceived failures or any mental health difficulties. It requires a recognition by the professionals that these are ordinary parents dealing with extraordinary circumstances. Dr Hellin considered that the entire aetiology of these challenging circumstances is better understood within *“a different paradigm”* and should be considered from *“a systemic or organisational perspective”*.
16. Ms Cavanagh QC and Ms O’Neil, on behalf of F, submit that this assessment has unlocked this case. It is rare for one assessment to change the landscape so

comprehensively, but I entirely agree with their submission. Dr Hellin's conclusions have been conveniently summarised thus:

“There are certain features of the system around [W] which make it more, rather than less, likely that problems will arise in it. First, it is a very complicated system.

Second, the stakes are very high. Ultimately, this is about keeping a child alive and ensuring his best possible quality of life.

Third, commissioners face what many would consider to be impossible decisions about resource allocation.

Fourth, care work is intrinsically stressful, and the pressures on health professionals and care staff have been vastly increased by the Covid-19 pandemic.

These factors all affect the emotional climate of the system around [W] and the relationships between those components of the system.

The system around [W] has become sensitised and inflamed. Feelings have run high and perspectives have become polarised and entrenched.

[M] and [F], individual professional staff and their organisations have become stuck in polarised beliefs about each other.

It has become difficult for the parents and for professionals to respond moderately in ways that sooth rather than exacerbate the dynamic tensions between the different parts of the system.

I hope it will be apparent that this analysis does not apportion blame.

The family, commissioners and health and social care providers are all affected by the dynamic context in which they are trying to do their best.

Rather than looking to change the parents, I recommend a systemic intervention drawn from organisational psychology, psychodynamic psychotherapy, group analysis and systems theory.

The intervention would assist all agencies and the parents to understand the dynamic processes that have led to the current difficulties, to step back from mutual blame and recrimination, to establish working practices which will contain and diminish sensitivities and optimise collaboration between the different parts of the system. (my emphasis)

I recommend that an organisational or a systemic supervisor/consultant is employed to work with the system and facilitate systemic meetings within which the aims set out in the paragraph above would be addressed.

The involvement of the Court has radically shifted the dynamics of this system.

The involvement of their legal representatives and of the Court, a neutral authority, has diluted the emotional intensity of the polarised “them and us” dynamic which previously existed between the parents and the health/care providers.”

17. Already it is clear to me, before any work is undertaken, that this exposition of the dynamic has helped both the care workers and the parents better to understand the challenges that each face. The Court is all too acutely aware of the colossal pressure placed on limited resources. This is a day to day reality for the medical and caring professions. It has endured for many years but has been cast into stark relief by the pandemic. Dr Hellin considers this backdrop serves further to inflame the environment around W. Perspectives had become polarised and difficult to placate. Dr Hellin’s proposals are predicated on promoting mutual understanding and diminishing mutual blame. At risk of repetition, I emphasise that even though work has not yet started, the manifest sense of the approach is compelling and has already diluted the emotional intensity and significantly bridged the polarity that has impeded progress in this case for many months and which has undoubtedly been inimical to W’s care.
18. Dr Hellin’s analysis resonates clearly with the applicable legal framework in the Children Act 1989:

31 Care and Supervision

(1) On the application of any local authority or authorised person, the court may make an order—

(a) placing the child with respect to whom the application is made in the care of a designated local authority; or

(b) putting him under the supervision of a designated local authority F1. . .

(2) 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—

(i) 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

(ii) the child's being beyond parental control.

19. It is important to emphasise that the provision “*not being what it would be reasonable to expect a parent to give*” is not to be regarded as an abstract or hypothetical test but must be evaluated by reference to the circumstances the parent is confronting i.e. what would it be reasonable to expect of a parent in these particular circumstances, recognising that in a challenging situation many of us may behave in a way which might not objectively be viewed as reasonable. The test is not to be construed in a vacuum nor applied judgementally by reference to some gold standard of parenting which few (if any) could achieve. On the contrary, it contemplates a range of behaviour, incorporating inevitable human frailty. The reasonableness of the care given requires to be evaluated strictly by reference to the particular circumstances and the individual child.
20. I would add that a similar dynamic and frequently for the same reasons identified here, arises in the Court of Protection when dealing with incapacitated adults. This is a particularly common situation in the context of young adults in their late teenage years and early twenties, but by no means confined to it.