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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION

OFFICE OF CARE AND PROTECTION

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Between:

A HEALTH AND SOCIAL CARE TRUST

Applicant

-v-

A MOTHER

-and-

A FATHER

Respondents

IN THE MATTER OF UR and NG (FEMALE CHILDREN AGED 12½ AND 8½ YEARS)

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Ms L Murphy BL (instructed by the Directorate of Legal Services) for the Trust
Ms N McGrenera QC with Ms Walkingshaw BL (instructed by GR Ingram & Co solicitors) for the mother
Ms S Simpson QC with Ms P McKernan BL (instructed by Gus Campbell solicitors) for the father
Ms B Cleland BL (instructed by Paul Haughey solicitor) for the guardian ad litem ("GAL") on behalf of the children

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McFARLAND J

Introduction

[1] This judgment has been anonymised to protect the identity of the children and other family members. I have used various abbreviations. I have referred to the children using randomly selected ciphers UR and NG. These are not their initials. Nothing can be published that will identify the children. I have referred to the

various family members as follows:

M	The mother of C1, C2, C3, C4, UR and NG
F	The father of C3, C4, UR, NG, C7 and C8
C1	A male child of M now aged 27 ½ years
C2	A female child of M now aged 23 years and mother of C7 and C8
C3	A female child of M and F now aged 16 ½ years
C4	A female child of M and F now aged 15 ½ years
UR	A female child of M and F now aged 12 ½ years
NG	A female child of M and F now aged 8 ½ years
C7	A male child of C2 and F now aged 6 ½ years
C8	A male child of C2 and F now aged 4 ½ years

The guardian ad litem is referred to as "the GAL."

[2] As the abbreviations suggest, there is a complex family background. M is aged 48 years and F is aged 38 years. Before meeting F, M had two children, C1 in 1994 and C2 in 1998. She then met and married F and bore him four children, C3 in 2005, C4 in 2006, UR in 2009 and NG in 2013. C2 then aged 16 years and living with M and F fell pregnant in 2014 and later bore C7 in 2015 and then C8 in 2019. F is the father of C7 and C8. In due course M and F separated. The current position is that M is living at an address which she will not disclose to the Trust or the court and F is living with C2 although the exact nature of their relationship remains a matter for conjecture. F asserts that it is platonic in nature.

[3] Social services involvement has been ever present with this family since the late 1990s. C1 and C2 were the subject of care orders and had been placed in foster care, although both returned to live with M and F. C3 has been adopted and C4 resides with her maternal grandmother under a residence order.

[4] The Trust has issued care order proceedings in respect of C7 and C8 and those proceedings are yet to be concluded. On 3 February 2020 the Trust issued care order proceedings in respect of UR and NG and after a hearing, an interim care order was made on 26 February 2020 and this resulted in UR and NG being removed from their parents' care and into foster care. They are currently in a joint foster care placement

and the care plan for both is that they remain in that placement on a permanent basis. The application for the care order based on this care plan has the support of the GAL. It is opposed by M who wishes the children to be returned to her care. F also has an aspiration that the children can be rehabilitated to his care, but he acknowledges that a care order is required at this stage, and does not oppose the Trust's application.

The hearing

[5] The hearing was originally fixed for 1 December 2021 and on that morning M's counsel applied for an adjournment. Her application was based on M's stated desire to attend the hearing and to give evidence but that she was prevented from doing so by virtue of the fact that she was now living in a residential unit and although she had tested negative for Covid-19, the residential unit, which housed vulnerable members of society, was in a voluntary lock-down and isolation. The court, taking into account the contents of a psychological report on M and acknowledging the strong desire to bring a conclusion to the matter, vacated the hearing date and directed a rapid re-listing on 6 January 2022.

[6] On the morning of 6 January 2022, M again applied for an adjournment. She had now left the residential unit (having been told to leave before Christmas) but was now suffering from toothache. It was reported that she had attended a dentist, although no name was provided and no corroborative evidence concerning her attendance was available. An indication was given by the court that the case would not be adjourned again because of the pressing need to bring finality to the matter. There was a short adjournment to enable M to consult with her legal representatives by remote link and it was reported back to the court that M would be able to attend the hearing remotely by audio/telephone link but not video link.

[7] The hearing then proceeded under the provisions of Schedule 27 to the Coronavirus Act 2020. It took the form of a hybrid hearing as there was limited capacity within the courtroom. All counsel were able to be present in person. Solicitors attended remotely, although M's solicitor was physically present. Two social workers attended remotely but entered the courtroom to give their evidence, F was not required to give evidence and the GAL gave her evidence by live video link. M was able to attend by live audio link, and she gave her evidence by that method. Other interested parties attended remotely. F was physically present for part of the proceedings and voluntarily absented himself after lunch.

[8] Given the vulnerabilities of M, the court was conscious that she should be afforded an opportunity to participate in the proceedings, notwithstanding her decision not to attend physically whatever the state of her dental pain. The court facilitated M's legal representatives with short adjournments to enable them to take instructions particularly in relation to cross-examination of witnesses and with M giving evidence.

[9] I am satisfied that M was able to participate in the proceedings, she was able to hear the evidence of the social workers and the GAL and she was able to give her own evidence. I consider that given the situation as it developed on 6 January 2022, all parties, including M, were afforded an opportunity to participate in the hearing at an adequate level, notwithstanding the obvious shortcomings of the court not being able to see a witness when giving evidence.

Threshold

[10] The purpose of the finding of threshold relates to the provisions of Article 50(2) of the 1995 Order. This provides:

> "A court may only make a care or a 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;
>
> (ii) … "

[11] Leo Tolstoy in the opening lines of Anna Karenina said that "All happy families are alike; each unhappy family is unhappy in its own way", and so it is that when considering the position of unfortunate children it is necessary to study the specific dynamic and issues within the family. There can be no room for a broad brush approach.

[12] The burden is on the Trust to prove the underlying facts and to prove that the child has either suffered, or is likely to suffer, significant harm from the care given to the child or likely to be given to the child. The relevant date is the date of intervention, in this case February 2020. The Trust must prove these facts on the balance of probabilities. The court is required to make findings of fact in respect of disputed evidence. These findings will include the facts supporting the case that the child has suffered actual significant harm, and, if the second limb is alleged, the facts upon which the court can predict that the child is likely to suffer significant harm should it remain in the care of the parents.

[13] In accordance with established practice, the Trust prepared a draft statement of threshold. Discussions took place between the Trust, F and the GAL and a

threshold document, based largely on the Trust's draft statement, has been agreed. In summary, this document includes the following:

a) Significant and lengthy social services involvement regarding his older children, including court determination of neglect;

b) A dysfunctional relationship between M and F with frequent arguments and disharmony;

c) A history of drug and alcohol misuse;

d) Longstanding mental health problems including a diagnosis of dependent personality disorder, with the use of inappropriate coping strategies;

e) Inappropriate sexual boundaries within the home, including skewed views of relationships, morals and attitudes to social norms within the family;

f) Neglectful parenting of UR and NG including adverse parenting experiences within the home, exemplified by detriment to their physical needs, educational needs, developmental needs, emotional needs and social needs;

g) Failure to engage appropriately with professional staff including aggression, obstruction and a failure to be open and honest;

h) Failure to react and intervene when observing M's responses to professional staff.

[14] M could not agree such extensive threshold facts. She had made certain concessions and on her behalf an amended threshold document was prepared by her legal representatives. The content of that document sets out the nature of M's concessions. The Trust, and the GAL, do not accept that it fairly summarises the factual situation at the date of intervention. In summary, M's concessions include the following:

a) She is a 'vulnerable' adult;

b) The surrogacy arrangement presented a risk of sexual harm to, and to the psychological wellbeing of, UR and NG;

c) Failure to engage appropriately with some professional staff including aggression, volatility and abuse if she perceived that she was being spoken down to;

d) A history of using medication over many years;

[15] Reference has been made to two surrogacy events, the discovery of which by the Trust triggered the intervention. It is important to bear in mind that C7 and C8,

who were both stated to be born as a result of surrogacy events, are the subject of separate care order proceedings. C2 and F are the respondents to those proceedings. C2 has made two statements, F has made one statement and M has made three statements in respect of the surrogacy events. C2 is not a party to these proceedings. All the statements have been made in respect of the other proceedings. It is therefore difficult for the court to conduct a full fact finding exercise in respect of these arrangements. For the purposes of these care order proceedings involving UR and NG, the court has been invited by the Trust (with the agreement of the other parties) to make basic findings of fact. No oral evidence was given on these issues. There are some differences between the parties in the various stories given and there are some internal inconsistencies within the versions given by C2 and by M. Bearing all this in mind, I find the following facts in respect of the surrogacy events:

a) F allowed the use of his sperm to impregnate C2, at a time when she was aged 16 and lived in the family home in circumstances where he had a parental role in respect of her;

b) C2 was a child in care at this time and M shared parental responsibility with the Trust for C2;

c) M knew of the arrangement, she took no issue with same, she failed to protect C2 and failed to advise the Trust;

d) No surrogacy counselling was sought by any party;

e) After the birth of C7, C2 handed over parental responsibilities for him to M and F;

f) C7 was treated as a child of M and F and a brother to C2, UR and NG within the family;

g) No application has been made under the provisions of the Human Fertilisation and Embryology Act 2008;

h) A similar course of action followed in respect of C8, although by that time C2 was no longer a child in care having achieved her majority and the Trust did not share parental responsibility for her;

i) During the course of the care order proceedings relating to C7 and C8, DNA tests were ordered, which determined that F was the father of both boys. This resulted in the removal of F from the family home and the instigation of a police investigation.

[16] In the making of these findings, I reject the position now asserted by M (as set out in her concession document in relation to threshold) that she was exploited by F and (by implication) C2. The statements furnished by M, F and C2 form no basis for

such a suggestion that M was misled and exploited by F.

[17] Ms McGrenera QC submitted that the court should not consider other matters occurring before the intervention date of February 2020 outside the surrogacy events, as the intervention itself was triggered by the revelations concerning the surrogacy and in particular F's role as the father. This raises what can be a difficult issue, namely how the court deals with a triggering event when there are underlying existing problems. It is not as straightforward as is asserted on behalf of M. Very often, Trusts will tolerate neglectful parenting in an effort to keep children living with their parents, applying the principle of 'good enough parenting.' Triggering events can be 'straws that break the camel's back', as they will very often expose underlying and pre-existing problems, and the existence of those problems will exacerbate the impact of the triggering events. In such cases, courts should make findings in relation to these other problems, as it will be necessary to determine whether or not the child has suffered actual significant harm, and the cause of that significant harm, at the time of intervention, and if it is necessary for the court to make a prediction as to future significant harm, then these findings will also be important.

[18] The Court of Appeal (Judge LCJ, Neuberger MR and McFarlane LJ) in *Re J* [2012] EWCA Civ 380 dealt with a case of a new family unit with the mother having been previously been found to be in a pool of perpetrators of fatal injuries to a younger child. McFarlane LJ gave the lead judgment, and at [81] stated:

> "A judge hearing a fresh [Article 50] application, some years later, about a new family unit which involves a parent about whom adverse findings have previously been made in another family context, should be exposed to the full detail of the available evidence and be permitted to come to her own overview and determination taking into account all of the material insofar as she considers it to be relevant and giving it such weight as she may see fit at the time of her determination. Artificially to limit the judicial exercise in a manner which invites the court to ignore part of the evidence in the case, might well set up the legal point for determination in a clinically clear and legally accessible manner, but it cannot, in my view, represent a proper exercise of the judicial task. In determining whether the threshold criteria are satisfied in relation to each of these three children as at 3rd March 2011 a judge must be under a duty to acquaint herself with all of the available evidence and then bring it to bear on the ultimate question of whether, in the context of this case, each or any of these three children can be said to be "likely to suffer significant harm" attributable to failures in parental care likely to be

given to him as at that date."

The context of this case is different from the present case, but the principle is the same. There is a duty on the court to acquaint itself with all the available evidence and to use it to determine whether a child has suffered, or is likely to suffer, significant harm.

[19] I therefore consider that the court must consider certain historic facts relating to M and her parenting ability insofar as they relate to the position of UR and NG at the time of intervention. In doing so, I have taken into account the position adopted by the Trust in relation to F's threshold as, in fairness to M, any concession on a point applying to both, that is made to F, should also be available to M.

[20] In this context, I consider that the following facts are appropriate for consideration in the threshold criteria in relation to M, and based on the evidence placed before the court, I find, on the balance of probabilities, the following as facts:

a) Significant and lengthy social services involvement regarding her older children, including court determination of neglect;

b) A dysfunctional relationship between M and F with frequent arguments and disharmony;

c) A limited ability of M to protect her children from risks and harm;

d) M's diagnosis of borderline personality disorder and a potential diagnosis of attention deficit hyperactivity disorder. She has limited cognitive functioning and inappropriate coping strategies;

e) Inappropriate sexual boundaries within the home, including skewed views of relationships, morals and attitudes to social norms within the family;

f) A failure to protect C2 for whom she had primary care;

g) Neglectful parenting of UR and NG including adverse parenting experiences within the home, exemplified by detriment to their physical needs, educational needs, developmental needs, emotional needs and social needs;

h) Failure to engage appropriately with professional staff including aggression, obstruction, volatility and a failure to be open and honest;

i) Exercising coercive control within the family home;

j) M's cognitive functioning had a significant impact on her ability to parent and care for UR and NG without substantial support. M was unable and unwilling to accept support from others, particularly professional staff;

k) M responded aggressively and in a volatile manner in the presence of UR and NG;

l) M was unable to provide appropriate role modelling to UR and NG;

[21] In reaching these decisions on M's threshold, I have accepted the report, and the opinion, of Dr Fullerton, a psychologist retained by M. M has essentially rejected the content of this report, although offers no evidence to counter Dr Fullerton's expert assessment.

[22] The Trust has alleged that M failed to protect C2 from sexual abuse within the home being perpetrated by F. It is a generalised rather than a specific allegation. There is no credible evidence placed before the court to prove this allegation, and in particular to prove that any sexual abuse was being perpetrated within the family home and within M's knowledge. The Trust rely on a statement from M that F and C2 "were sleeping together." M is a witness of dubious reliability and, in any event, C2 was 16 or over at the time, and thus a consenting party to any sexual activity, had it occurred. As the Trust have not sought to include in F's threshold document that he was a perpetrator of sexual abuse against C2, it is unfair that M should somehow be condemned for failing to protect C2 in the circumstances.

[23] M has sought to explain or justify her interaction with professional staff on the basis of whether she likes or dislike the person. I do not regard this as an appropriate explanation. It is not open to M to decide as to how she will engage with professional staff based on assumptions on her part. The Trust have a statutory duty in respect of children, and the functions of the Trust are carried out by its staff, and others retained by it. M cannot dictate which individuals she will engage with and which individuals she will not.

[24] The evidence clearly supports the view that M exercised coercive control within the family. She accepted, in accordance with the opinion of Dr Fullerton, whose report she has rejected, that she is open to exploitation by others. Exercising coercive control and being susceptible to exploitation are not mutually exclusive propositions.

[25] For the purposes of threshold in respect of both M and F, my findings are set out in Annex 1 (for M) and Annex 2 (for F).

[26] I am satisfied that there is ample evidence to suggest that at the time of the intervention both children had suffered significant harm. Harm is defined in Article 2 of the 1989 Order as including "the impairment of health or development" and includes both physical and emotional harm. I am satisfied that the surrogacy events and the treatment of the new children within the family would have resulted in significant emotional harm being visited upon UR and NG, as the conduct of M and F fell well outside any appropriate standard of family relationships, morals and attitudes. F has appeared to have reflected upon his conduct and recognised that

what he did was wrong, but for M it has not been such a remorseful journey. She appears to have conceded that there was a risk of sexual harm to UR and NG as a result of her conduct, but her general conduct and attitude since has reinforced the view that should UR and NG return in her care, then it is likely that they too could be subject to a similar arrangement. It is therefore likely that they would suffer from significant harm.

[27] The matter does not stop with the surrogacy events. The situation at the time of the intervention was not ideal and whilst it was understandable that the Trust had not yet intervened, the evidence was available for them to do so. Even without the surrogacy events, I am satisfied that significant harm was likely. I have based my prediction relying on the guidance provided in the House of Lords in *Re H and others* [1996] 1 FLR 80 and in particular the speech of Lord Nicholls at 97G:

> "[The second limb of Article 50(2)(a)] is concerned with evaluating the risk of something happening in the future: aye or no, is there a real possibility that the child will suffer significant harm? Having heard and considered the evidence and decided any disputed questions of relevant fact upon the balance of probability, the court must reach a decision on how highly it evaluates the risk of significant harm befalling the child, always remembering upon whom the burden of proof falls."

Care Plan

[28] The care plan is one of long-term fostering, with contact with F twice a month, currently one physical and one remote, and physical contact with M once a month. Consideration of the care plan and the making of the care order does require the court to consider the 'welfare checklist' contained in Article 3(3) of the 1995 Order:

> "(a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);
>
> (b) his physical, emotional and educational needs;
>
> (c) the likely effect on him of any change in his circumstances;
>
> (d) his age, sex, background and any characteristics of his which the court considers relevant;
>
> (e) any harm which he has suffered or is at risk of suffering;

(f) how capable of meeting his needs is each of his parents and any other person in relation to whom the court considers the question to be relevant;

(g) the range of powers available to the court under this Order in the proceedings in question."

[29] As the care plan involves permanent foster placements, notwithstanding the requirement placed on the Trust to continue to consider rehabilitation throughout the duration of any care order, it is a clear engagement of the Article 8 (respect for family life rights) of both M and F as well as the children. The court must consider whether the care plan is proportionate taking into account the provisions of Article 8(2) of the ECHR which states -

> "There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

This permits the court to take into account not only issues of health but also issues of morality, however in the context of this case, the issue of the morality of M and F, must be seen and considered in the overall ambit of the welfare of UR and NG, and should not be considered in isolation.

[30] F agrees with the care plan, M does not. It is inconceivable that either, or both, children could return to the care of either. F states that he is currently sleeping on a sofa in C2's home. He recognises that he cannot care for the children.

[31] M refuses to state where she lives. She presents no credible evidence as to the residence's suitability as a home for the children, or who else is living there or frequents it. The absence of an address means that there would be no means of social work staff to visit or monitor the residence raising significant safeguarding issues concerning the children's welfare. Even if the address was known and was regarded as physically suitable, given the history of M's conduct there would be a compelling need for supervision. Constant supervision would be necessary and even if the M were minded to accept this, and nothing suggests she would, it would be an impossible burden on the Trust and not in either child's best interests.

[32] There is no credible evidence placed before the court that M would be capable of looking after UR and NG and providing for their welfare. On the contrary, there is overwhelming evidence that the needs of both children are being adequately cared for and promoted in their current placement. It is a stable placement and both children have informed the GAL that they wish to continue living there. Both are of

an age that would allow the court to take into account their expressed wishes and feelings.

[33] Given the stability of the current placement and the likely substantial negative impact on both resulting from any change in their circumstances should they leave that placement and return to the care of either parent, the welfare of both children would be compromised. Neither parent has displayed an ability or aptitude to care for either or both children at this stage.

[34] The care plan provides for the continuation of contact between both parents and the children. Contact is not without its difficulty but the Trust recognise that efforts must be made to ensure that it continues at a meaningful level. The proposed frequency is set out at [28]. M seeks additional and more frequent contact. In particular she seeks parity with F.

[35] Contact has to be considered in the context of each child's welfare. Parity between parents will very often be a starting point, but will not be a determining factor. Consideration has to be given to the quality of contact itself, and in particular how each child benefits from the contact. Evidence has been placed before the court that the foster carer is reporting that the children are displaying unsettled behaviour following contact with M. This is not at such a level that would necessitate stopping contact, but it does require to be monitored. The current plan of fortnightly contact is appropriate as it seeks to maintain the relationship between M and the children but allows sufficient time between contact sessions for the children, and their foster carer who is required to manage the behaviour, to recover. An increase of frequency would not be in the interests of the children at this stage.

Conclusion

[36] Having found that both children have suffered significant harm in their parents' care and were likely to have continued to suffer significant harm had they remained in their care, it is necessary that the Trust exercise parental responsibility under the auspices of a care order. I further consider that the care plans of long-term joint foster placements are in the best interests of both children.

[37] There will be a care order in respect of both children, with no order as to costs. There will be a taxation order for legally assisted parties. The GAL is discharged.

Annex 1
Threshold findings in respect of M

1. M had had significant and lengthy involvement with Social Services regarding all of their children for over twenty years (from July 1999). The Court determined that M has neglected each child's needs, in particular in respect of the children's health, education and living environment and there was domestic violence within relationships. C3 has been adopted and C4 lives with her maternal grandmother.

2. M is a vulnerable adult. Her ability to protect her children from risks and harm is limited, including her diagnosis of borderline personality disorder, potential attention deficit hyperactivity disorder, her cognitive functioning and style, and her inappropriate coping strategies.

3. M does not put in place appropriate sexual boundaries for example, the births of the children C7 and C8 occurred when C2 (who was a child herself at the time of C7's conception and birth) lived in the family home and F had a parental role in respect of her. M failed to adequately protect her vulnerable daughter when she had primary care for her and should have done so.

4. There are very skewed views of appropriate relationships, boundaries, morals, and attitudes to social norms within the family. There is the risk that the 'informal surrogacy arrangements', which M was an active party in may potentially expose UR and NG to a similar arrangement when they are of age or they would hold the belief that they might be so exposed. M was accepting of the use of her husband F's sperm to impregnate her daughter. This has the potential to be detrimental to the psychological wellbeing of the children who may view this as 'normal behaviour' and potentially being at risk later in life themselves.

5. M has neglected each child's welfare needs. Each child has suffered an adverse parenting experience wherein she has not benefited from a warm and nurturing home life and her needs have not been met. Examples include:

    - Physical needs- there was non-attendance at medical appointments, poor diet, significant neglect of dental hygiene (UR may have to have dentures due to number of adult teeth requiring to be removed), failing to recognise and act on concerns, refusal of treatment and pain relief and failure to ensure the child presented appropriately eg at school. The conditions of the home environment are not safe and are unhygienic for the children particularly on those occasions when the Trust are not involved with the family.

    - Educational needs – NG's ability at school has being highlighted and she

requires an individualised education plan. NG was moved schools due to M's dislike of the teacher in the previous school. This instability is not conducive to educational attainment at such a young age.

- Developmental needs – UR not having age appropriate awareness of body care and privacy. Each child's excessive use of screen time as a means of entertainment rather than direct interactions. The girls required ongoing assistance with play, personal space and social experiences when removed into care.

- Emotional needs – children being privy to adult conversations, the older children taking responsibility for the younger children's emotional well-being, stimulation, play and physical care. The children did not receive emotionally attuned responses and their needs were not met. M was openly very critical of C2 in front of the younger children and UR did not feel able to communicate the pain she was suffering with her teeth. M struggles to implement appropriate boundaries within the home as the children do not listen to her and therefore consistency in respect of boundaries and routines in the home is not being achieved.

- Social Needs – minimal interaction with other children outside the family home and no involvement in activities with others outside the family home.

6. M has failed to engage appropriately with the professionals involved - she presents as aggressive, volatile and abusive, she has failed to engage in supports offered and has minimised/dismissed the Trust concerns. The Trust have been refused entry to the family home and this has precluded them from being able to carry out welfare checks on the children. M has not been open and honest with the Trust which precluded earlier intervention to safeguard and protect the children.

7. M is unable to protect her children from harm

8. M is unable to put the needs of the children above her own needs. Due to her own difficulties and past experiences, she is quite self-focused and unlikely to be able to attend to the needs of the children when she is overwhelmed with her own difficulties, e.g., low mood, anxiety, interpersonal mistrust, etc.

9. M is a dominant person and she exercised coercive control within the family home.

10. M's cognitive functioning is likely to significantly impact on her ability to parent and care for her children, without substantial support.

11. M is unable to accept help and support due to her suspicion and mistrust of

the professionals. M's extremely low cognitive ability will reduce how much she is fully able to understand the needs of the children when they are complex and multifactorial, requiring multi-agency supports. M lacks any ability to positively solve conflicts and to appropriately gain control in her life through proper means of engagement with the professionals who seek to help her. Without substantial support, M will struggle significantly to parent her child/ren.

12. M uses inappropriate coping styles and mechanisms as a result of her experiences and extremely low cognitive ability. This includes a history of using medication (*e.g.* diazepam and anti-depressants) over many years.

13. M has a very limited support network and people upon whom she can rely for help, support and guidance. She moves quickly from one relationship to another and requires the support of a partner in her daily life. M is unable to manage her own emotions or responses. This reliance on other people is concerning, as M has no skill to do this for herself, and as a vulnerable adult, may well be exploited by others in this respect.

14. M's coping style and maladaptive coping strategies would have an impact on her parenting capacity. M responds aggressively and explosively to many things, which the children witness and this could be very frightening for them. The children do not experience appropriate 'modelling' from M and therefore could similarly respond to situations which adversely impacts on their emotional wellbeing, their inability to communicate their distress or feelings and how they solve problems.

15. The children will be unable to develop their own emotional regulation skills as M cannot assist them to do this. In addition, the very public way in which M responds to situations has had a significant impact on the children, in terms of their emotional wellbeing, potential alienation from their peers, and them being judged due to M's behaviour and emotional responses. This has caused and is likely to cause an adverse impact on their identity formation and sense of self for these children

16. M is unable to provide appropriate care for each child, whether together as a couple or separately.

Annex 2
Threshold findings in respect of F

1. F has had significant and lengthy involvement with Social Services regarding his older children since before the subject children were born. The Court determined that the children's needs were neglected. The parents' relationship was dysfunctional and there were frequent arguments and disharmony.

2. F has a history of drug and alcohol misuse. There is noted improvement in this and F indicated that he only continues to take drugs (cannabis) on an 'irregular basis.'

3. F has longstanding mental health problems. He has been exposed to many adverse childhood experiences and trauma in his childhood and later life which adversely impacted on his mental health and he used inappropriate coping strategies. He is prescribed anti-depressant medication which he has been taking all his adult life. F meets the diagnostic criteria for dependent personality disorder.

4. F did not put in place appropriate sexual boundaries for example, the births of the children C7 and C8 occurred when C2 (who is the mother and was under the age of 18 herself when C7 was born) lived in the family home and F had a parental role in respect of her.

5. There are skewed views of appropriate relationships, boundaries, morals, and attitudes to social norms within the family. F was accepting of the use of his sperm to impregnate his step daughter. This has the potential to be detrimental to the psychological wellbeing of the children who may view this as 'normal behaviour' and potentially being at risk later in life themselves.

6. F has neglected each child's welfare needs. Each child has suffered an adverse parenting experience wherein she has not benefited from a warm and nurturing home life and her needs have not been met. Examples include :

    - Physical needs- there was non-attendance at medical appointments, poor diet, significant neglect of dental hygiene (UR may have to have dentures due to number of adult teeth requiring to be removed), failing to recognise and act on concerns, refusal of treatment and pain relief and failure to ensure the child presented appropriately e.g. at school. The conditions of the home environment are not safe and are unhygienic for the children particularly on those occasions when the Trust are not involved with the family.

- Educational needs – NG's ability at school has being highlighted and she requires an individualised education plan. NG was moved schools due to M's dislike of the teacher in the previous school. This instability is not conducive to educational attainment at such a young age.

- Developmental needs – UR not having age appropriate awareness of body care and privacy. Each child's excessive use of screen time as a means of entertainment rather than direct interactions. The girls required ongoing assistance with play, personal space and social experiences when removed into care.

- Emotional needs – children being privy to adult conversations, the older children taking responsibility for the younger children's emotional well-being, stimulation, play and physical care. The children did not receive emotionally attuned responses and their needs were not met. M was openly very critical of C2 in front of the younger children and UR did not feel able to communicate the pain she was suffering with her teeth. F struggles to assert himself within the relationship with M and the home. He cannot implement appropriate boundaries within the home and therefore consistency in respect of boundaries and routines in the home is not being achieved.

- Social Needs – minimal interaction with other children outside the family home and minimal involvement in activities with others outside the family home.

7. F has failed to engage appropriately with the professionals involved – historically he has presented as aggressive, he has failed to engage in supports offered and has minimised/dismissed the Trust concerns. The Trust have been refused entry to the family home and this has precluded them from being able to carry out welfare checks on the children. F has not been open and honest with the Trust which precluded earlier intervention to safeguard and protect the children.

8. The foregoing factors impaired F's parenting capacity and ability to meet his children's needs.

9. The children will have reduced ability to develop their own emotional regulation skills as their parents cannot assist them to do this. In addition, the very public way in which M responds to situations has had a significant impact on the children, in terms of their emotional wellbeing, potential alienation from their peers, and them being judged due to M's behaviour and emotional responses. This has caused and is likely to cause an adverse impact on their identity formation and sense of self for these children. The F has been unable to take appropriate actions to prevent and protect the children from exposure to these behaviours.

10. F is unable to provide appropriate care for each child, whether together as a couple with M or separately.