Neutral Citation No: [2018] NIFam 4	*Ref:* **SMY10673**
*Judgment: approved by the Court for handing down (subject to editorial corrections)**	*Delivered:* **01/06/2018**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

_____

FAMILY DIVISION

_____

IN THE MATTER OF AN APPLICATION UNDER THE CHILDREN (NORTHERN IRELAND) ORDER 1995

A HEALTH AND SOCIAL SERVICES TRUST

Applicant;

-v-

MR X

AND

MRS X

Respondents.

_____

HER HONOUR JUDGE SMYTH

The nature of the proceedings

[1] This is an application by a Trust for care orders in respect of three children who I shall refer to as Philip, Freddie and Carl and who are aged 13, 11 and 7. There is also an application in respect of another child, Joseph who is aged 15, but for reasons which will become apparent in the course of this judgment, that matter has been adjourned to a later date on the application of the Trust. I have anonymised this judgment because it involves children and no report may be made of this judgment that could lead directly or indirectly to the identification of any of the children or any family member.

The background

[2] The parents are Mr and Mrs X. The Trust has been involved with the family intermittently since 2003. The issues have related to neglect, poor school attendance,

domestic violence and aggression within the home and significant alcohol misuse on the part of Mrs X in particular.

[3] The children's names were placed on the Child Protection Register in July 2013 due to the unsatisfactory home conditions. The situation appeared to improve and the children's names were removed from the register in December 2013. The situation deteriorated again in 2015 when the family moved home and the children were not registered in local schools until there was educational welfare involvement. In the school year 2015 - 2016, Philip's attendance was 44.9%, Freddie's attendance was 61.7% and Carl's attendance was 59.4%. The older child Joseph's attendance was most concerning, amounting only to 4% of the school year. Educational welfare involvement occurs when attendance drops to 85%.

[4] One of the children, whom I shall not identify, recounted stealing food from shops when he was in the care of his parents and described "weed" wrapped in toilet paper holders in the home. Philip has a particular health issue which was not attended to by his parents and there are also concerns that the children were not being supervised by their parents with Carl, aged four, being found on a main road. On a number of occasions, Mrs X was inebriated and on some of those occasions was hospitalised as a consequence.

[5] There have been reports to police of aggression within the home since 2011 and both parents have displayed hostility and threatening behaviour towards social workers and other professionals in the children's presence. Serious threats of harm to individual social workers have resulted in a court conviction in respect of Mr X, and social workers have required the protection of the police in order to attend the home.

[6] On 23 June 16, there were reports of excessive noise in the family home during the night. When social workers, along with police officers attended they discovered that the kitchen roof had collapsed and the home conditions were inappropriate with no sheeting on the beds and the smell of stale urine evident. All four children were removed into the care of the Trust.

[7] Since then, the parents have refused to cooperate with professionals and have repeatedly disrupted the children's placements. On one occasion, the parents engineered the situation where one of the children left his placement after contact and followed his parents to the bus stop. Trust personnel intervened and he was returned safely. The parents have behaved inappropriately during contact visits, whispering in the children's ears and encouraging negative behaviour including non-attendance at school. At times they have been heard to make derogatory comments towards the younger children.

[8] Their behaviour culminated on 17 March 2018, when the oldest child Joseph was removed from his placement by his father and despite a Recovery Order from

the court, his whereabouts are unknown. Police and Social Services have attempted to trace him and there has been information that he is currently in the Republic of Ireland. The application in respect of Joseph has been adjourned at the request of the Trust to enable further consideration of his care plan.

[9] The parents have threatened to remove the younger children from their placements also and in order to protect them, this court suspended contact until further order.

The children

[10] Dr Philip Moore, Consultant Clinical Psychologist prepared a report in August 2017 in respect of the family dynamics and the individual therapeutic needs of the children. All of the children have displayed significant emotional distress and behavioural dysregulation. Philip, Freddie and Carl have displayed sexualised behaviour and language, inappropriate language, physical aggression towards others and concerning behavioural issues such as defecating and urinating on the floor and property. Freddie has made threats to seriously self-harm and has enacted suicidal scenarios. The inter-sibling relationships are complex and in many respects destructive, as can be seen in Freddie's encouragement to his younger sibling Carl to seriously self-harm.

[11] Philip is now 13 and has been in residential care since he was removed from his parents' care. There have been incidents where his behaviour has been out of control. He has hurt a staff member with a pen and has also been the subject of police involvement due to his behaviour. He has a Statement of Special Educational Needs due to moderate learning difficulties, emotional and behavioural problems. When he was in the care of his parents his attendance at primary school was poor and he has continued to refuse to attend school on a regular basis. He has been enrolled with the Education Other Than At School (EOTAS) programme and difficulties with attendance continue. He and his siblings have been brought up in a home where education was not valued and attempts by professionals to motivate him have met with limited success.

[12] Philip expressed his wishes and feelings in an email for me to consider. I have read and reflected on what he said. He said:

> "I don't like [the children's home] it is too big I don't like the town and the home and I want to see more of my [siblings].
>
> I want to move back home to my mum and dad I don't like care at all".

It is the Guardian's view that Philip does not give the impression of disliking his placement and that he participates in arranged activities. Nevertheless, I am

mindful that these are the feelings that Philip has expressed, perhaps not surprisingly given the trauma that every child suffers when separated from his parents and siblings even when his parents have not provided good enough care. Residential care is never a good option, but it may be the best option available to safeguard his welfare, if the court finds that the threshold is crossed for intervention.

[13] Freddie is now 11 years old. He and his younger brother Carl, now aged 7, are in a specialised residential placement because of their particular needs. Freddie and Carl were initially cared for in a foster home but that broke down within a week because of sexualised, aggressive and dysregulated behaviour. There have been serious concerns about Freddie's attempts to self-harm. He has demonstrated aggression towards staff and has had great difficulty settling at school and sleeping at night, requiring specific reassurance.

[14] Although there were emotional and behavioural difficulties when Freddie was removed from the care of his parents, he is now more settled and more emotionally regulated both in school and in his placement. It has been reported that Freddie's concentration in school has improved, he is integrated with his peers and appears motivated to learn. He is also involved in extracurricular activities including Gaelic football.

[15] In terms of his wishes and feelings, Freddie has expressed a desire to live in a foster care environment although his views have varied. Because of the improvements in his presentation it is hoped that in the future a foster care placement will be found. Dr Moore considered a report from Pauline Mahon, Principal Child and Adolescent Psychotherapist at the Family Trauma Centre which made specific recommendations regarding any future placement. He noted from the nature of those recommendations the extent of concern regarding the well-being of Freddie and Carl and supported their separation because of the negative influence of Freddie upon Carl. Currently they remain placed together.

[16] Carl is now 7. In August 2017, Dr Moore described his behaviour as a "*source of extreme concern*". The concerning behaviour displayed when he was first admitted to care has settled to a large degree although recently his behaviour deteriorated after an explanation of the reasons for his placement in care. Carl has expressed the wish to move to a foster home although he says he likes his current placement.

[17] Like his siblings, Carl's early education has suffered due to poor school attendance but a period of home education earlier this year with opportunities to explore activities which clearly he missed preschool, has been of assistance. An educational psychology assessment has indicated that Carl's ability to learn has been negatively impacted by his early experience of trauma and neglect. His specific educational needs have been identified along with strategies to meet those needs. A classroom assistant has been recommended and it is expected that this assistance will be provided in the school year commencing in September 2018.

The assessment of the parents

[18] It is the parents' contention that there were no deficiencies in their care of the children and that they were not suffering, nor were they likely to suffer significant harm in the future as a result of the care afforded to them. They deny any alcohol misuse or any aggression or violence in their relationship. They maintain that there were no difficulties in their relationship. In particular, they insist that the concerning presentation of the children only arose as a result of their removal from parental care and, despite evidence to the contrary, that school attendance has always been satisfactory.

[19] Mr X was assessed by Dr Sharkey, Consultant Psychiatrist in September 2016 for the purposes of criminal proceedings including drink-driving. Although he denied any previous mental health problems there is a reference in his medical records to one previous contact with psychiatric services. He appears to have attended with his sister who expressed concerns about his mental health and his very restricted day-to-day life. Another appointment was arranged but Mr X did not attend.

[20] Dr Sharkey's opinion was based on an interview with Mr X and background material and he accepted that additional information would have enabled a better understanding of Mr X's lifestyle and general day-to-day functioning. He concluded that Mr X probably has some mental health difficulties but that the discrepancy between his account of events relating to the care afforded to the children in particular and that of professionals, was more likely to be due to a failure to acknowledge the reality of the situation rather than a consequence of mental illness.

[21] Mr X was also assessed by Dr O'Neill Consultant Psychiatrist in January 2017 in respect of these proceedings. Dr O'Neill agreed that he did not present with a diagnosable mental health disorder or any clear personality disorder. Having reviewed his GP notes and available records from a treating psychiatrist, he concluded that there were multiple discrepancies between Mr X's recollection of his previous medical and psychiatric history and the details recorded in the GP records. Dr O'Neill agreed that his ability to parent does not appear to be influenced by a mental health disorder. However, he shared Dr Sharkey's view that Mr X is an inconsistent historian and considered that he would benefit from further assessment by adult mental health services over time.

[22] Mr X and Mrs X were also assessed by Dr Joanne Quinn, Specialist Clinical Psychologist regarding their levels of functioning in order to inform future assessments and work which might be undertaken. She noted that Mr X is illiterate and has had minimal formal education. Thus, he would have limited experience in classroom type skills such as pencil use, familiarity with copying tasks and mark making which are known to have an effect on performance on cognitive testing. She considered that the lack of formal schooling and illiteracy may have had a bearing

on her assessment which indicated a discrepancy between his cognitive and adaptive functioning. In short, she concluded that his level of cognitive functioning is higher than the assessment indicated given the range of skills he has in other areas. Although she did not consider that he met the criteria for learning disability diagnosis, it is likely that strategies relevant to the learning disability population may assist Mr X.

[23] In respect of Mrs X , Dr Quinn opined that her cognitive level of functioning falls just outside the remit for classification as a mild learning disability and that her social and adaptive functioning is well above what would normally be seen within the learning disability population. For that reason, she was not assessed as meeting the diagnosis of learning disability.

[24] Dr Moore, Consultant Clinical Psychologist also assessed both parents. He opined that there was little evidence that Mr X appreciated the complexity of his children's needs including their educational needs or the impact of intense emotional expression on their well-being. In the course of interview he made no reference at all to his youngest child, Carl. Dr Moore referred to contact records which recorded minimal interaction between Mr X and the children. It appeared that he expected the children to initiate any interaction and so invariably he sat impassively through the meetings. Against social work advice, he regularly whispered into his children's ears and would not provide any information about what was said.

[25] Dr Moore concluded that Mr X has significant processing difficulties that result in both limited comprehension and an inability to manage a number of concepts simultaneously. His cognitive style is concrete; dealing with the "here and now" is his priority rather than reflecting on the complexity of specific situations and their consequences. Dr Moore relied on Dr Quinn's assessment of his cognitive functioning but disagreed with her conclusion that poor schooling may have significantly affected his test score. He considered that there were areas of cognitive difficulty that must be factored into any interaction with Mr X.

[26] He also referred to the historic note in the medical records that Mr X had attended a psychiatrist with his sister due to concern about his day-to-day functioning and concluded that there may have been an awareness of his learning difficulties throughout his childhood and into adulthood. He concluded that Mr X may have significant support needs that may have a bearing on his ability to care independently for his children.

[27] In respect of Mrs X, Dr Moore opined that there was minimal consideration of her children's needs and she was dismissive of any suggestion that there were any difficulties within the family unit. He described her presentation as highly emotional throughout the assessment to such an extent that she often disregarded or failed to register what had been asked. Her only concession was that she was at times overprotective towards the children. Contact records did report that Mrs X engaged

with the children during contact meetings, reading to the youngest child, Carl, and attempting to initiate play.

[28] Mrs X told Dr Moore that she had attended special school for moderate learning difficulties and denied any mental health difficulties or the use of either alcohol or drugs. That is despite the fact that her medical notes evidenced a history of overdosing on prescription medication as well as alcohol. Dr Moore opined that Dr Quinn's assessment of her cognitive functioning was a good reflection of her presentation to him as a woman whose ability was likely to be within the borderline/low average range of functioning. In particular, he concluded that her verbal comprehension limitations must raise concerns about her full appreciation of information emanating from social services. This difficulty is compounded by a high anxiety state, a lack of attention and limited school attendance.

[29] Dr Moore opined that there are no obvious cognitive factors that would impinge on Mrs X's ability to parent responsibly and safely. His concern was that she may have difficulty understanding all of the advice given to her by Social Services and methods of communication may need to be modified in order to assist her. However, her mental health and her coping ability is a concern because she appears to fixate on past events to such an extent that current cognitive and emotional processing are affected. Dr Moore referred to her volatile behaviour with professionals and opined that her " *inability to inhibit such emotional expressions within a professional environment that is highly monitored and recorded, does not auger well for parental ability to contain emotions within less regulated environments.*" In this regard he noted the unacceptable levels of expressed emotion to which the children have been exposed.

[30] It is significant that Mrs X recounted domestic violence and alcohol misuse during her childhood which Dr Moore noted can be deeply traumatising for a young child with enduring effects on psychological development that persist in adulthood. He noted evidence from multiple studies of particularly high anxiety and depression rates amongst those exposed to such behaviour.

[31] Dr Moore concluded that she is highly motivated to resume full-time care of the children and that it is her only focus at this time. However, her ability to provide appropriate care for the children will require her to engage in collaborative work with social services and others. This must inevitably involve an acceptance of certain shortcomings in the quality of the care received by the children and a willingness to address such shortcomings without undue emotional expression. He said:

> "*at this juncture, I must conclude that Mrs X has little if any capacity to understand and appreciate the seriousness of Trust concerns. Nor has she the ability <u>at the moment</u> to accept advice and instructions from professionals. Under the circumstances, parenting work would seem without merit as Mrs X does not recognise the need for such. Work should instead focus on assisting Mrs X to appreciate the*

origins of her perception of reality – why she, for example, finds it difficult to accept that she may need support in certain areas."

[32] He recommended counselling to assist her to process past traumatic experiences and cognitive behavioural therapy to equip her with alternative coping strategies. The latter would also address heightened expressions of emotion that only serve to derail any proposed work. He considered that contracts with the family would seem to have little merit until such fundamental work is completed. She also requires input from addiction services to deal with her inappropriate use of alcohol which, despite her denials, is a problem clearly evidenced by the repeated hospital admissions.

The law

[33] In *Re DAM* (*Children*) [2018] EWCA Civ 386, the English Court of Appeal stated that judges hearing care cases "*are engaged in one of the most difficult of all judicial tasks*". In every case, the requirement is to answer four questions [6]:

- What are the facts?
- Has the threshold been crossed?
- If so, what order is in the Childs best interests?
- Is that outcome necessary and proportionate to the problem?

[34] Article 50 of the Children (Northern Ireland) Order 1995, states that the threshold will be crossed where the court is satisfied, on a balance of probabilities, that the child is suffering or is likely to suffer, significant harm and that the harm, or likelihood of harm, is attributable to the care given to him, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a person to give to him.

[35] If the threshold is crossed, the court must consider the order that is in each child's best interests, taking into account the article 3 welfare checklist. The threshold is concerned only with harm, while the welfare checklist addresses a much wider range of factors and requires a proper welfare evaluation and a proportionality assessment.

Consideration

[36] The Trust has filed a statement of facts upon which it relies to establish the threshold for intervention. The Guardian agrees that the evidence presented by the Trust in its professional and expert reports is reflected in the statement. Since Mr X removed Joseph from his placement, the parents have not engaged with these proceedings. I am satisfied that they have both been notified, are aware of today's

hearing, and have chosen not to take part. The Trust and the Guardian adopted their reports as their evidence before the court.

[37] The statement of threshold records the following facts:

"

- The Trust has concerns about the basic care needs and safety afforded to the children.
  For example:

  The children are not registered with a G.P in the area, they do not have their medical needs reviewed regularly and there have been a number of missed medical appointments.

  Philip has a [health] condition. Dr B, G.P advised that he should be reviewed annually however there is no record of him having been reviewed.

  Freddie was known to an Orthoptist however was discharged in 2012 due to non-attendance. There is no record of any follow up.

  Ms G, School Nurse has been trying to make contact with Mr and Mrs X in relation to gaining permission to assess the children's health needs in school however she has been unable to make contact.

- The Trust has concerns with the high number of referrals made to the PSNI and Social Services in respect of poor supervision and criminal activity.

  For example:

  All of the children are known to the police although Freddie and Carl cannot be charged due to their young age.

  Philip has one case outstanding from 13 March 2016 regarding common assault and being seen with a knife. He is engaging in the Youth Engagement Clinic.

  Joseph was also required to partake in the Youth Engagement Clinic due to reported

incidents on 30 March 2016 (incident in family home whereby Joseph hit his mother and trashed the home) and on 11 April 2016 (an alleged incident of burglary, theft and criminal damage).

- There are concerns about Mr and Mrs X's ability to adequately supervise and provide for the children's basic care needs.

  For example:

  They do not always appear to know where the children are at all times and there appears to be relaxed boundaries within the home.

  The children spend a lot of time in the community not being supervised by an appropriate adult. This has been further evidenced when the PSNI have returned the children home following incidents of criminal activity or concerns regarding lack of supervision as reported by members of the public.

- There are concerns regarding poor school attendance for all of the children.

  For example:

  The family was first referred to Education Welfare in 2011 due to difficulty making contact with the family due to their lack of co-operation and numerous house moves. The case was taken to Court in June 2015 for parental prosecution and the parents were fined £2000. Philip's attendance is currently 43%, Freddie 62.3%, Carl 59.9% and Joseph 4%. Education Welfare is applying to Court for further parental prosecution.

- There are concerns regarding Mr X's mental health.

  For example,

- Mr X has phoned the PSNI on numerous occasions, 18 times in May 2016 requesting police assistance to the home alleging he is feeling threatened by terrorists outside home. These concerns have not been substantiated.

- There are concerns regarding the parental relationship.

  For example:

  There has been a history of referrals in relation to Mrs X's alcohol issue and she has been present in the home under the influence of alcohol.

  Mrs X appears to engage in rows and arguments with Mr X and it is unknown how much of this disharmony the children are or have been exposed to within the family home.

  Concerns have been raised on 16 March 2016. Mr X contacted the PSNI at 2.30am to request assistance as Mrs X was intoxicated and had caused damage to the home and was being aggressive. Police attended and brought Ms X to her father's home. At 8.33am a further report was made by Mr X to advise that Mrs X had returned to the home. When Police attended Mr X was aggressive and was subsequently arrested. Mrs X had stayed and returned to the family home in the morning to get the children ready for School. Mrs X was sober on her return to home.

  On 23 May 2016 at 2.45am, Mr X contacted the police reporting Mrs X had been drinking and causing damage to the home. The police could hear a woman screaming in the background. When police attended Mrs X had punched a glass photo frame causing injuries to her wrist. The police brought her to A&E at the hospital. Mrs X was reported to be very agitated, pulling clumps out of her hair and being aggressive towards police and A&E nursing staff. The

Trust is really concerned as to how the parents' relationship will impact on the children's emotional and physical well-being.

On 2 June 2016, Mrs X was arrested regarding an incident where she threatened a neighbour for disorderly behaviour. Mrs X was bailed but bail conditions preventing her from going within the area of the family home. The Trust is worried about the levels of aggression the children are being exposed to by their parents.

- The parents have failed to ensure the children attend school

  For example:

  Children's School attendance as of 27 May 2016

  - Philip 44.9%
  - Freddie 61.7%
  - Carl 59.4%
  - Joseph 4%

- On 23 June 2016 the Trust received an anonymous call reporting that the family were in the home and there was an awful noise reported from the house the previous night. A home visit was undertaken. Mrs X presented as irate and had to be held back from physically attacking social worker. Mr X's presentation was very concerning and he was talking about "cutting the head off the tramp". It is unknown who he was talking about. The ceiling in the kitchen had fallen down into the kitchen floor. Three of the children were at home and the Trust had serious concerns in relation to the unkempt presentation of the home and foul smell."

[38] Having considered all of the evidence in this case, I am satisfied that the threshold has been crossed for a care order.

[39] Turning now to the central question in this case which is, whether the court should make a care order with a care plan for residential care in respect of each of

the three children or whether the children should be returned to their parents' care. The care plan must meet each child's welfare requirements and be necessary for their protection. The Guardian supports the Trust application and considers that the care plan is a proportionate response to the situation.

[40] All three children have demonstrated extremely concerning behaviour both before and after removal from the care of their parents. Disclosures which they have made, along with the objective evidence of home conditions and neglect in terms of education, health needs and supervision satisfy me that their presentation is attributable to inadequate parental care.

[41] The expert assessments that have informed the Trust application have been comprehensive and have considered the abilities of both parents along with the family dynamics as a whole. There is a stark conflict in the accounts provided by the parents and those provided by the professionals. In the face of incontrovertible evidence of unacceptable school attendance, repeated incidents of aggression and a pattern of hospital admissions due to alcohol misuse in respect of the mother, Mrs X, the parents acknowledge no deficiencies in their care of the children.

[42] The lack of insight into their children's complex needs is perhaps best illustrated by the parents' reckless behaviour in removing Joseph to a place unknown, without regard for the impact upon him or his siblings. The children have been placed in the situation where they are uncertain when they will see either their parents or their elder sibling again which must impact upon their emotional well-being.

[43] Dr Moore's report highlights the reality of the situation, which is that the parents are currently unable to deal with the issues which affect their ability to care for the children because they refuse to recognise their existence. Unless and until their mind-sets change, there is no purpose in parenting work. The likelihood is that mind-sets will not change, particularly in respect of Mrs X unless she engages in counselling or other therapeutic work to address the underlying issues from her childhood.

[44] The impact of the inadequate care these children have received from their parents is demonstrated by the extreme nature of their behaviour, such that foster care even for the youngest child has not been possible. That is a sad situation and is a clear indication of the risks the children would face if returned to them. Freddie and Carl have required the support of a specialist therapeutic placement and they are responding positively to that environment. It will be some time yet before a foster placement is feasible but the signs are hopeful that this may be achieved in the future.

[45] As I have already stated, residential care is never a good option for a child. However, unfortunately, it is a better option than return to these parents who are

unable to protect their children's physical or emotional well-being and in whose care they have clearly suffered significant harm and are likely to do so in future.

[46] I am therefore satisfied that it is in each child's best interests that I should make a care order with a care plan currently of residential care. It is not possible to approve any contact arrangements with the parents while the situation regarding Joseph's removal and the threat to remove the other children pertains. That is a matter that must be resolved as soon as possible in the best interests of all of the children.