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Judgment: approved by the Court for handing down

(subject to editorial corrections)

Delivered:	**31/5/05**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION

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IN THE MATTER OF N
(FREEING ORDER APPLICATION)

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GILLEN J

[1] Nothing must be reported concerning this case which would serve to identify the child or the family who are the subject of these proceedings.

Application

[2] In this case a Health and Social Services Trust which I do not propose to name ("the Trust") seeks an order pursuant to Article 18 of the Adoption Order (Northern Ireland) 1987 freeing for adoption a child born 19 April 2002 ("N"). The father of this child, R, has parental responsibility having been named on the child's birth certificate. H is the mother of the child. A care order has already been obtained in this matter after a contested hearing before His Honour Judge Rodgers on 30 July 2004. Other siblings include H1 aged 15, who is subject to a care order but is currently living at home with H and R, P who is 13 and is now residing with H and R having previously been in foster care and T who is aged 9 and in long term foster care.

Background

[3] The background in this matter up to July 2004 has already been outlined by Judge Rodgers in the course of his judgment at pp2-6. It contains a bleak summary of abuse of alcohol on the part of the mother with attendant depression and attempts at self-harm. Social services have been involved with the family for many years. Abuse of alcohol, domestic violence, marital problems, poor childcare standards and inappropriate parental care have punctuated the history of this family. Difficulties began after the birth of H1 in 1989. On 27 August 1993 a Fit Persons Orders was made in relation to H1

and to P in November 1993. The two children were returned to their mother in April 1997 and care orders were discharged in February 1999. However the situation deteriorated with the mother resuming the abuse of alcohol. Social services continued to support the children at home. In September 2000 the mother was admitted to a medical unit and the children were placed with their extended family. They were subsequently returned home but placed in care in September 2000. They returned to the mother in November 2000. Unfortunately her problems with alcohol surfaced yet again and the children were made subject to full care orders in October 2001. H then commenced her relationship with R. Domestic violence led in January 2002 to H obtaining a Non-molestation Order on the basis of an assault by R. The couple later reconciled. When H became pregnant with N, she continued to abuse alcohol throughout her pregnancy despite admonitions by social services. N was born 19 April 2002 and was immediately made the subject of an Emergency Protection Order, thereafter an interim care order and admitted to foster care. The mother was admitted to the addiction unit of a local hospital where she remained until 20 May 2003. In June 2003 both father and mother commenced a residential parental assessment in the Thorndale Centre. That assessment was positive and it was felt that the mother had progressed dramatically in her ability to reflect upon her previous inappropriate lifestyle and care of her children. Both father and mother demonstrated an awareness and acceptance that alcohol has been a major weakness in their lives. The community addiction team remained involved with the mother and she was attending Alcoholics Anonymous. The father was encouraged to attend anger management courses. Sadly history repeated itself yet again and concerns again arose in 2003, as before triggered by abuse of alcohol. Judge Rodgers records as follows;

> "Matters came to a head on 9 and 10 June 2003. On 9 June the mother telephoned social services to say that she was drunk. It is further alleged that she said she had never stopped drinking although this was denied. In any event a social worker went to the home and found the father there with [H1, T and N]. The mother was not present in her home. However she telephoned social services later in the evening and confirmed that she was with the children although it was clear that she had been drinking. On the evidence of both the mother and father the father gave an ultimatum to the mother on 9 June that if she did not stop drinking he would leave. In the absence of reassurance on this point he did leave and was absent from the house until the next day. On 10 June two social workers visited the mother's home but did not find her there. Evidence was given by one of the social workers … that she then called at the home of an MD. She found several males

> and one female in the home together with the mother, H1, T and N. There was a smell of alcohol in the house. It is worth noting that the grandmother described this house as 'a drinking den'. (The social worker) took N to her general practitioner. It was thought at first that her legs were bruised but it transpired they were simply covered with dirt. When they were washed they discovered she had eczema on her legs and bottom. She also had what (a social worker) described as the worst case of head lice infestation she had ever seen in a young child. It was at this stage that she was taken into care."

Judge Rodgers also dealt with the matter of domestic violence as follows;

> "Domestic violence by the father
>
> The father admits to only one episode of domestic violence. He agrees that in January 2002 he pushed the mother down some steps. He excuses this on the basis that she was the instigator of the violence. In any event the mother obtained a Non-molestation order before the parties were reconciled.
>
> The incident in January 2002 was, of course, prior to N's birth. I am more concerned, for N, by an alleged incident on 1 May 2003. The incident was reported by the mother and H1 to social services and more significantly to the police. In their police statements both the mother and H1 allege that the father initially attacked the mother and then when H1 intervened he attacked her. The confrontation ended when H1 struck the father with a glass. Both the mother and father gave evidence that this incident did not happen as described by them to the police although the mother accepted that she had described the incident to the police in terms recorded. Both said that H1 had been the instigator of the incident and that father had only tried to restrain her. The mother said that she had fabricated the account to cover her own drinking and the violence perpetrated by H1. It was suggested I speak to H1 in private to discover the facts of the incident. This course I considered to be a totally inappropriate method of dealing with a disputed question of fact. I was completely unconvinced by the

> mother and father's account as to why they had made a false statement to the police. I believe the incident on 1 May 2003 did occur as initially reported by the mother and H1."

The evidence

[4] The expert evidence

(i) Dr Allen

Dr Allen is a distinguished consultant adult psychiatrist employed by Buckinghamshire Mental Health Services Trust. He has been a consultant for over ten years and has received training in forensic psychiatry and psychiatry of substance abuse. He prepared a report dated 22 December 2004 having seen H on 7 December 2004. In essence the points that he made in that report and in evidence before me were as follows;

(a) H suffers from a border-line personality disorder which is a condition frequently found in people who have suffered abuse in childhood. This woman had suffered neglect and violence from her parents during her teenage years. It has left her with an absence of understanding of good parenting.
(b) She suffers from alcohol dependence syndrome but is not currently drinking according to her account and that of R.
(c) She now has good insight into her alcohol addiction.
(d) Work needs to be on her underlying persona. Essentially what she lacks are good foundations to parenting. She can learn techniques and reduce dysfunctional responses by not drinking alcohol. But what she has not addressed is that which she did not have as a teenager growing up and that is positive parenting leading to self-confidence, independence and a sense of self worth.
(e) She needs to do more work and the best way to start is to have some base-line counselling. If she is able to engage with this then she could benefit from doing more psychotherapy in about six months to a year's time. Recovery would be on a continuum. The overall period would be in and around two years. The key factor that she needs to be able to work out is why she drinks. She is not at that stage at all as yet. She was unable to assist Dr Allen with any real reason as to why she has returned to drinking in the past after several periods of abstinence. The whole area of border line personality disorder has been receiving more attention recently including from the government. No therapy is known to work but there have been a number of improvements in tackling the problem.

Increasingly services have been set up in the community to prepare people for more in-depth psychotherapy.

(f) Dr Allen was realistic to note however that the fact that this young woman is coping with a 15 year old H1 at the moment does not necessarily mean that she could cope with a further child. H1 already has problems and it is always possible that a second child might just be a difficulty to far.(The witness was of course unaware that a third child with behavioural difficulties was to join the family during this hearing)

(g) In cross-examination by Mrs Keegan, who appeared on behalf of the Trust, Dr Allen accepted the basic thrust of Dr Bownes (Consultant forensic psychiatrist retained on behalf of the Trust) when he said in his report of 22 April 2004;

> 'Clearly the likelihood of H not experiencing a de-stabilisation of her support networks or the onset of insurmountable pressures from the present day to the time N achieves independence is extremely unlikely. If one examines closely the periods in the past that H relapsed to a state of alcohol dependence it is probable that there was a critical shift in the dynamics of her life ….. and hence the periods of abstinence were not dependent solely upon her level of determination or commitment to avoid alcohol but rather her ability to cope with aversive external and internal negative influences.'"

Dr Allen indicated that this assessment 'hit the nail on the head' in identifying the problem. He however saw some potential for change. That however could not be before the time period he had already set out. She is not even yet at the first stage of counselling when the process of her understanding why she is drinking would commence. This would require her to meet regularly with her counsellor either weekly or twice weekly. After six to twelve months one could then see if the base-line counselling had moved her forward. He felt that in six months he could give some indication of how well she was progressing and there will be some indication of how well the psychotherapy would progress.

(ii) Professor Tresiliotis

Professor Tresiliotis appeared as a joint witness on behalf of the Trust/respondents and the guardian ad litem. He is a distinguished

professor of social work who has given evidence on many occasions in these courts and has written widely on subjects including attachment issues and post adoption contact. He had prepared two reports for the hearing before Judge Rodgers namely a report of 21 March 2004 and also 15 April 2004. Prior to giving evidence before me he indicated he had briefly read reports from Dr Allen, Dr Loughrey, from the Trust and the guardian ad litem together with the statement of H.

He reminded the court that before Judge Rodgers he had indicated that he felt it would be catastrophic for N if, having been returned to her mother, H relapsed into drinking. He concluded at that stage that the child should not be returned to her mother. In essence the points he made before this court were as follows;

(a) N is a very troubled and needy child who requires optimum parenting in order to obtain the bonds that she now misses. Whilst waiting a further six months might not be vital, anything beyond this he felt was "a rubicon" point where the possibility of making up what has been lost in the past will recede exceedingly. It was his view that if there was a 90% chance now of being certain this woman would not take drink, he would be prepared to recommend the child being returned. It was his view however that no one was saying that and the two year process suggested by Dr Allen was in his opinion simply too long given the implications for N if there is failure. He felt that there were too many "hypotheticals" having in mind where the child is now. He stated on a number of occasions that time was not on the side of this child.

(b) He agreed that the child had a significant bond with her mother, taking care to distinguish this from a strong bond. He recognised that in this case the child probably has stronger attachments to the parents than to the foster carers. He felt that this may well have been contributed to by the fact that in the foster home problems arose with the presence of another child of roughly the same age as N. He had observed this other child taking up the attention of the foster carer and this was inhibiting the child forming bonds with the foster parents. Professor Tresiliotis exhorted the Trust to find a childless couple to adopt this child.

(c) Any future placement should if possible be child free for optimum results. The present foster mother is expecting a new child and this will perhaps serve to exacerbate the current problems. Rather than transferring the child to another temporary home, which will make a current fragile situation even worse, it was Professor Tresiliotis's view that more

support should be given by the Trust to the current foster carers.

(d) Professor Tresiliotis reiterated that if this woman remained abstinent then the child could be returned. The problem was that she is likely to give way under stress and the time span for this woman to fully and satisfactorily repair herself is too long.

(e) There is a danger that N will not attach herself to other carers but given her young age and the support that can be given to adoptive parents, he was optimistic. Contact, if carried out properly with the birth mother, could help this process in that she could give the child permission to attach herself to other adoptive parents.

(f) Professor Tresiliotis conceded in cross-examination that it was asking a lot of adoptive parents to take N into their family. She does have behavioural difficulties, she is somewhat behind her peers developmentally and there may be a possibility of ongoing symptoms of foetal alcohol syndrome. However it is his experience that adoptive parents do take on children with physical disabilities and learning difficulties. Experience has shown that they often do better than the average adoptive family simply because they are particularly committed and often have experience of this kind of condition. We are starting here with an insecure child with no strong attachments to anyone but because of her young age there is room for optimism. All of this was in his opinion an argument for commencing the process of adoption as soon as possible.

(g) Professor Tresiliotis was sceptical of Dr Allen's timetable because the initial six months were preliminary. That is what would have to pass before the psychotherapy could take place. The child is getting older and the prospects of resolution more remoter with the passing of time. He produced research illustrating that with the passage of time fewer children in care return home successfully to the extent that only 14% of those who have been in care for 2 years are able to return home after two years. After that there is scarcely any return. In other words with the passage of time the prospects of rehabilitation are dramatically reduced. It was his view that after two years, the chances of N being rehabilitated are remote.

This witness concluded that adoption was the preferred option for this child.

Whilst this witness agreed with the Trust proposals for the child to be freed by way of adoption, there was initially a clear conflict between his views and those of the Trust/guardian ad litem with reference to contact in a post freeing/adoption situation. He was ad idem with the Trust in agreeing

that if the child is freed for adoption contact should be reduced but where the issue arose was in the realm of post adoption contact. It was his unequivocal view that there should be post adoption contact with the parents perhaps three/four times per year. He drew attention to five/six studies which showed that direct contact after adoption can work well in appropriate circumstances. The only risk is if the birth relative tries to undermine the placement. If the birth parent can accept the new position and help the child to settle down without undermining the placement, this can be of great assistance. Initially he expressed the view that contact could be as paramount a factor as actually finding an adoptive family. He is about to publish a new book which records the feeling of rejection and loss suffered by 50% of adopted children in a survey taken over 30 years. This is a particular risk in the present case because N has come to experience her parents whereas the survey he carried out was of children who had never known their parents. If the child is now cut off from her mother without further contact, it could generate feelings of rejection and loss. This child he felt is old enough to have known her parents and for them to disappear now would be tantamount to a rejection. The child may not say so, but feelings of loss will be into her sub-conscious.

Professor Tresiliotis was unable to complete his evidence for some days due to other commitments. Upon returning, he was cross-examined by Ms Collins on behalf of the guardian ad litem. In light of what he said, I then permitted both Ms Lynch on behalf of the first named respondent and Mr Hutton on behalf of the second named respondent to cross-examine him further. The following emerged:

(a) Contrary to his earlier view when he had indicated that post adoption contact was so important with this child that if it could not be obtained then long term foster care should be invoked, Professor Tresiliotis now indicated that if the court could be assured that all efforts had been made to obtain post-adoption contact but it was to no avail, then he would advocate adoption, albeit with some regret. However, he indicated that he thought the process should not take more than six months from the date of any freeing order because he did not think that the case should be allowed to drag on and he also felt that a family would be found who could comply with the post-adoption requirement.

(b) In his view the principal factor was the pattern over the last 10/12 years of the effects of alcohol and recurrence of alcohol abuse even after lengthy periods of abstinence with the child being returned to care. He had observed that this had been very unsettling for the older children and he was profoundly concerned that N would be exposed to the same pattern. He emphasised that this child was now almost three years of age. Children of this age can secure family attachments and settle well. However this is a particularly needy, insecure and troubled child who lacked core attachments.

When he had observed her at the foster parents home and also with the natural parents, he found her attachment to her parents was stronger than it was to the foster carers. This was an unusual situation. He felt it was due to the frequency of contact with the natural parents and also the circumstances in the foster home where a child of the same age resided and N had to fight to get attention. It was only in the last few months that the foster mother had been able to give her sole attention.

(c) Professor Tresiliotis felt that N needed to be moved to permanent placement as soon as possible, but this should be one where unlike the current placement, there is not another child of similar age.

(d) He strongly recommended direct post-adoption contact with the parents based on what he had observed and the kind of attachments which he considered to be significant. Every adult entering the adoption process should bear in mind this factor. He was particularly concerned that if direct contact was not arranged in this case, this child would have no direct contact for over 15 years. He recognised that contact can cause disruption although there appears to be no evidence of that in this instance. It has been his experience that prospective adoptive parents with appropriate preparation can change their minds from initial opposition to acceptance of post-adoption contact, but his experience was that not many people take up this stance in the first place. Most adoptive parents nowadays are receptive to post-adoption contact.

(e) He had changed his mind on the question of long term foster care because he now felt that with a promise of proper advertisements and comprehensive steps being taken to persuade adopters to permit post-adoption contact, adoption offered the better outcome for this child. It was his view that there should be a presumption in favour of post-adoption contact.

(f) This witness did make some criticism of the Trust indicating that he had some doubts about their lack of experience, how they had gone about the issue of post-adoption contact and indeed he registered surprise as to how his concerns about N being placed with a foster family with a child of comparable age to her had not been picked up by social workers. When pressed as to why he had changed his mind about the question of adoption being the preferred option even if post-adoption contact could not be found, provided all appropriate steps had been taken, Professor Tresiliotis recognised that this was a matter of fine judgment. However he reiterated he had to think of N's age. If it had been an older child, he would not have changed his position. However taking account of her age and how often long term foster care can break down, he came down in the favour of a comprehensive acceptance of adoption as a preferred option irrespective of post-adoption contact being available. This conclusion reflected in essence

Professor Tresiliotis's view that if N were rehabilitated to her parents, and H resorted to drink once again, even in 2 to 3 years time, it would then be too late to secure an adoptive family for her and the results of course would be quite catastrophic for this child given her particularly troubled and difficult situation.

Dr Loughrey

(iii) Dr Loughrey was a distinguished consultant psychiatrist who also gave evidence before me. He had supplied reports and he had of course given evidence before Judge Rodgers in the care order proceedings. Since then he had read the social workers' reports and other expert reports now before the court. In essence the points that he made in his reports, and in evidence before me were as follows:

(a) Whilst he hesitated to say that there was no evidence, he felt that what evidence there was fell short of that which was necessary to make a diagnosis of personality disorder in R's case. In particular the stable relationship which now exists with his older children and ex-wife illustrates this. In his view personality disorders normally result in people having trouble early in life and not settling as time goes on. The current position in which he now seems to have a reasonably good relationship with his first family, is seeing his daughter and maintaining a good relationship with ex-wife, albeit an account which is not corroborated, is contrary to a personality disorder.

(b) He noted that R had attended anger management counselling on six occasions with Ms D who works for the Advisory Men's Project. He felt this indicated he was capable of making change and was aware of the impact of his behaviour on others. That he was reflecting on the impact of his behaviour on his wife and child was encouraging.

(c) R had indicated that the domestic violence was a reaction to stress/provocation and not unprovoked. In other words it was his view that where the situation has now changed and his wife is no longer drinking, and the situation therefore rendered more calm, the risk of further domestic violence is reduced. He did not appear to have an enduring history of domestic violence and the significant trigger in his previous history overwhelming all else was H's drinking. H's account to the effect that problems were intertwined with her alcohol problem was consistent with what R had told him.

(d) It was Dr Loughrey's view that if H did commence drinking again, the pressing need was to ensure that there was an early warning system. It would be necessary for R to report the matter to a third party if he was concerned although he had not dealt well with her drinking in the past. Contrary to what Dr Bownes had said about his underlying personality based

inadequacy, Dr Loughrey said he could not identity any underlying personality based inadequate feelings. He was unaware of any specific issue of humiliation or infidelity in the past but he did recognise that it was possible that if alcohol was "on board" things could be misinterpreted and this could provide a trigger.

(e) Dr Loughrey indicated, in cross-examination by Ms Keegan, that the benefits of anger management were not in his opinion of fundamental importance in the context of domestic violence because clinical experience revealed that the principal issues are relationship problems almost invariably involving support for the couple, mental illness, alcohol or drug dependence. In other words if drink was reintroduced, any lessons learned at the anger management sessions would tend to be lost. Therefore it was Dr Loughrey's opinion that it is not always necessary for the patient to accept the full truth. In other words if someone has a problem with alcohol, it is not absolutely necessary for him to accept that he has a problem so long as he accepts that the consequences of taking alcohol result in problems. This in his view can take you to the next phase. He conceded that R does not accept much responsibility for the domestic violence, as indicated by the judge in the lower court and indeed he puts all the blame for this on H indicating that he is not sorry for it. Nothing has changed with regard to that attitude and indeed the judge indicated that he had been telling lies about some of incidents of domestic violence. The anger management that had taken place occurred in 2002/2003 and he was not aware of any anger management steps taken by R since then. When speaking to him about the matter, R was cautious and guarded mainly because Dr Loughrey formed the view that R did not think there was anything that he should be seeing a psychiatrist about. He felt that now that as he did not drink, and H did not drink, there was no problem. He felt that incidents in the past had been exaggerated by H1 and that the social services' attitude was led by her accusations and those of H. It was Dr Loughrey's view that R's responses to Judge Rodgers to the effect that attending the anger management courses were "a bit of a laugh" and "to get out of the house" were instances of bravado. The fact of the matter was that he did attend six sessions. It was put to him by Ms Keegan that it was highly significant that he did not appear to accept the domestic violence, that he had not engaged in any meaningful critical analysis of his domestic violence and that he exhibited no change in respect of this attitude to Dr Bownes, social services or the court. Dr Loughrey conceded that R does not take domestic violence as seriously as he should and repeated that in any event if alcohol becomes a problem again, any lessons he has learned from Ms D were of negligible importance in contrast to the need to immediately seek assistance. Dr Loughrey repeated that if R was to realise that gravely adverse consequences would attend upon his failing to report alcohol he must be able to change his behaviour. In other words whilst he may not have seen the error of his ways, he does realise he has to "toe the line" however begrudgingly he may feel about that and thus recognises the need to contact

social services under threat of a severe sanction if he fails to comply. Whilst Dr Loughrey conceded that he may not have done this in the past, for example 10 June 2003 when it appeared he did not telephone social services on an occasion when H had been drinking, he felt the fact that he had attended on Dr Bownes, himself and was here today illustrated a commitment to the relationship, albeit that he had lived in the house when she was drinking and had failed to protect the children from that.

(f) In answer to Ms Collins on behalf of the Guardian Ad Litem Agency, Dr Loughrey indicated that learning to accept punishment is different from an internalised normality. He conceded that R has an attitude to domestic violence with which many would find fault with and that changing that would require a fundamental change. That does not mean however in his opinion that his behaviour could not change provided that he has learnt from past mistakes that consequences adverse to him would follow upon a failure to do so. The fact that he has raised a family and has worked steadily does suggest that he can be sufficiently disciplined to learn from past mistakes. He does not in Dr Loughrey's opinion suffer from any diagnosable psychiatric condition and is clinically normal, albeit he had not demonstrated the capacity to put the needs of N above his and H's needs in the past.

Dr Bownes

(iv) Dr Bownes is a consultant psychiatrist and had prepared two reports both dated 22 April 2004 on R and H respectively. In those reports, and in the course of evidence which he gave before me, both in examination-in-chief and cross-examination the following points emerged:-

Re R

(a) On examination Dr Bownes found R to be rather evasive and to provide minimalist answers to most of his questions.

(b) In his view R is likely to have underlying personality based inadequacy feelings. When stressed by extraneous circumstances or increasing demands or requests for independence by their partner, dependent individuals often react by becoming violent, controlling and then attempt to make their partners dependent upon them as a psychological defence against the shame of their inadequacies becoming apparent to others. I must say that this was precisely the picture that I formed of R through the papers that I have read and I found Dr Bownes' evidence to be compelling on this matter.

(c) Unfortunately R refused to consider that he has ever had an inherent anger problem and his attitude regarding the efficacy of an anger management program he previously attended at the behest of social services at the interview with Dr Bownes was at variance with his descriptions of the

usefulness of the programme to other professional writers. This of course tied in with the answers that he gave to Judge Rodgers (and recorded at page 20 of his judgment) when asked about the anger management course when he stated that he did it for the social services rather than for his own good, that he considered it "a bit of a laugh", and that he did it to "get out of the house". I agree entirely with Judge Rodgers that these show a lack of commitment to controlling anger and reflect Dr Bownes' view that he simply does not acknowledge that the incidents of domestic violence have occurred or the contextual circumstances of the domestic violence reported in the papers before me. It does not reflect the necessity to take on board the need to protect this child against incidents of domestic violence. It also serves to tie in with the more general point made by Dr Loughrey at page 4 of his report where he records that R has a somewhat incurious attitude towards H's difficulties and plays down the responsibility he had for monitoring her drinking in the past. I therefore agree with Dr Bownes conclusion that "he does not really want to upset the apple cart" and does not want to disturb the relationship too greatly because of his own needs. This attitude is redolent of the view expressed to Dr Bownes that whilst he was presently abstinent of alcohol from March 2004 (although of course there is evidence before me that he relapsed for example December 2004), he felt the issue of relapse or reversion to a state of significant alcohol misuse was of little relevance. It is that which leads Dr Bownes to the conclusion that R has less than robust strategies that he can engage in the face of stressful and demanding situations to prevent recurrence of the previously suspected significant level of alcohol abuse. Consequently he tended to provide minimalist answers to questions regarding issues of the psychological effects of alcoholised violence in young children.

(d) Dr Bownes made the interesting point that whilst alcohol may well be a very significant factor here, the risk of domestic violence is not minimal if the parties start trading insults, albeit alcohol makes an explosive reaction more likely. Whilst the principal problem may well be alcohol, it is necessary to address the underlying factors of personality disorder which control the underlying dynamics of the relationship.

(e) Dr Bownes was concerned at R's inability to draw upon the lessons of the past in providing security and stability in the situation in the future.

(f) This witness was pessimistic about the prospect of R's preparedness to report a deterioration in any aspect of either his or H's behaviour in respect of alcohol abuse or other negative behaviours. He felt that H would consider:

(i) Is anyone outside the immediate family circle aware of the issue?

(ii) That reporting of any aversive event no matter how minor is likely to ultimately result in a recurrence of accommodation for the children.

(iii) That the episode would probably pass.

Dr Bownes therefore concluded that the prospect of overt conscientious reporting of difficulties to any case worker is likely to be at best minimal or sub-optimal or at worst completely absent.

Re H

(a) Dr Bownes felt that the present period of relative psychiatric symptom quiescence is only likely to continue until there is demonstrable upset regarding the cumulative and interactional effects of her life's dynamics. Should this occur, H is likely to quickly return to a state of unstable mental well-being characterised by disturbance of her mood, and negative appraisal of her situation and inter-personal relationship dysfunction. In terms he felt that given her track record, her inability to cope with the stresses and demands of domestic life are extremely unlikely to be satisfactorily maintained. At page 12 of his report he states:

> "If one examines closely the periods in the past when (H) relapsed to a state of alcohol dependence it is probable that there was a critical shift in the dynamics of her life and hence the periods of abstinence were dependent not solely upon her level of determination or commitment to avoid alcohol but rather her ability to cope with aversive external and internal negative influences."

(b) Consequently until H fully understands the origins and nature of her tendency to self-harm and the need to engage in more appropriate strategies to deal with her difficulties it is probable that where the various dynamics in her life alter to a state that she cannot tolerate, further self-harm episodes as an expression of a maladaptive coping mechanism are inevitable according to Dr Bownes. Alcohol is therefore the self medication to deal with her intrinsic deficiencies and extraneous stressors. To that extent therefore Dr Bownes was in agreement with Dr Allen. Her borderline personality disorder requires therefore an initial minimum of six months assessment where her life is stable with no drink and when she takes her medication in order to create a level playing field to enter further therapy. Thereafter a further year at least would have to be spent addressing aversive incidents leading to psychological trauma. In terms therefore it would be a minimum six months period for motivation, and thereafter at least 12 months psychological therapy. It was Dr Bownes view that 18 months is the best possible scenario before one could begin to have any confidence that she would then be able to apply these strategies to her situation on an ongoing basis. That time scale could well require to be extensively lengthened. Additional factors

previously unknown may emerge during the course of the psychotherapy and could lengthen the whole process considerably. The psychotherapy would take 12 months provided the level of the motivation was high and there was a determination to work on the deficits indicated in Dr Allen's report. In practice the whole operation could continue for 2/3/4 years depending on the issues that emerged. In essence it was Dr Bownes' view that 18 months was a minimum period that would have to pass before one could form a view that this woman could care for this child.

(c) Having had the opportunity to see H in the witness box, as I will describe later in this judgment, I share entirely the view expressed by Dr Bownes that she demonstrates "pseudo insight" with regard to the destructive nature of her own behaviour and the effects that this had had on her children. While she is able to rehearse the issues competently to the interviewer, Dr Bownes and indeed to this court, freely making statements of acceptance of her past mistakes, observing her carefully I formed precisely the same view as Dr Bownes, namely that she does not demonstrate a high level of understanding at the emotional level. In other words she says what she considers has to be said but that this does not reflect her genuine beliefs at an emotional level.

Two other witnesses

Ms R

[5] Ms R was a Social Worker with the Trust. She had care responsibility in this case from 5 August 2004 although she had some previous experience of the family in August 2002 at the time of the Thorndale assessment. In the course of her evidence she made a number of points;

(a) Prior to the birth of N, H had been warned on a number of occasions of the dangers of drinking during her pregnancy. She indicated however that she simply could not stop drinking despite being told the damage that was being done. At that stage she was consuming just short of a full bottle of alcohol per day. After the birth the child was tested for foetal alcohol syndrome. Dr Martell has indicated that the physical characteristics of this syndrome are present but the behavioural characteristics are not. In essence it is uncertain whether or not the child has this condition.

(b) This witness drew attention to the number of periods of abstinence that the mother has had throughout the years, all of which have proved transitory. In particular she drew attention to the situation after the birth of N when initially an emergency protection order and subsequent interim care order had been obtained. The parents were then assessed in Thorndale and Ms R was the Social Worker responsible for the case conference report. She had been impressed by the progress that was made at Thorndale and indeed

had sanctioned the couple leaving the parental assessment centre early. Ms R said that H was extremely convincing about her determination to give up alcohol. Sadly however once again she returned to drinking. Incidents were occurring from January 2003 and eventually as a consequence in May 2003 a new care order was obtained. On 9 October 2003 H had indicated to a senior social worker that she had never stopped drinking.

(c) It was this witness's evidence that in her opinion any future therapeutic counselling for either R or H was beyond the timescale for N's welfare. She felt as much as possible had been done. H had been given previous warnings even during the period of her pregnancy with N and there had been lengthy periods of abstinence which all proved to be transitory. It was her view that if efforts were now made to obtain adoptive parents, even that might take 6-9 months and the child would be approaching four years of age. To postpone that 18 months or longer would be impossible from the child's point of view.

(d) Ms R felt that there had been insufficient change over the last 18 months to merit a change of care plan.

(e) Dealing with the question of the likelihood of adoption, it was her evidence that prospective adopters will be told that the birth parents were hostile and antagonistic though it would be made clear that this had not occurred during positive contact visits and the child care assistants were never shown hostility. Hostility had been exhibited to her with phone calls often ending abruptly or with abusive comment. She acknowledged that the relationship with the social worker SM had been better with reference to his relationship with H, but he was not a field social worker and that is where the problem had arisen.

(f) The witness accepted that no counselling or psychotherapy had been introduced for the benefit of H at an earlier stage. However she felt that significant help had been given and the Trust would have now embarked upon this further psychotherapy only if it had been felt that it was within the timescales conducive to N's welfare. She accepted that the proposals from Dr Allen would be beneficial for H but outside the timescales for N.

(g) Although H1 was now at home, this was because the Trust at that stage felt that there was very little option left for this 15 year old girl. The choice was that she either came home or else be placed in a children's home. This was a wholly different situation from N, because if H or R misbehaved, at least at 15 years of age H1 could take some remedial step to escape. H1 is an extremely troubled, difficult child who has already had ten placements and problems are already surfacing. For example, in November 2004 she indicated if she was not taken into care she would harm herself. It was recognised that H1 was very unhappy at the prospect of N being taken into

care as had happened with the other children, but this was only one factor to be considered, albeit an important one.

(h) It was this witness's evidence that even since the time when Professor Tresiliotis had seen the child with the foster carers, that situation had improved. The attachment to the foster carers was now even greater and they had agreed that notwithstanding the arrival of a new baby in the household, N could stay there until a permanent carer was found.

Ms McC

Ms McC is a senior social worker in the adoption team with the Trust. She is a senior worker with responsibility for adoption in that area. In essence the points that she made in her report, examination-in-chief and cross-examination were as follows:

(i) She felt that it was likely that N would be adopted for the following reasons:

(a) She was very young.

(b) Although this child has a number of difficulties eg. speech defects, developmental defects, characteristics of alcohol foetal syndrome, she has demonstrated that she can make attachments and has done so throughout her life.

(c) Ms McC had had experience of children with difficulties and needs being successfully placed and adopted in many cases. These needs included problems arising from multiple moves, attachment difficulties, abuse and violence in the family.

(d) She produced a table showing that from 1997/98 to date, 38 children had been placed for adoption in this area. Of these children, 16 had suffered with alcohol abuse problems, and four had suffered from foetal alcohol syndrome. Of the four with foetal alcohol syndrome, three had been placed with current foster carers. In those cases some period of time had been taken to obtain a diagnosis but the foster carers were so committed that they put themselves forward after the diagnosis had come along. A fourth child, who was then about two years and seven months when adopted, had been adopted to a previously unknown carer after the diagnosis was made. Of the sixteen children who had been exposed to alcohol abuse, four were placed with current foster carers and twelve outside. The majority had been adopted between the ages of two and four.

(ii) Ms McC was with a team that was under-resourced and accordingly had sought the assistance of the Family Care Society. This assistance had

been sought after she had identified that the chairperson of the Adoption Panel for both this Trust and another Trust, did not have a couple identified for N at that time. The Family Care Society (FCS) is a voluntary adoption agency which has been involved with the Trust over a number of years when their services have been utilised. I pause here to observe that I ruled as inadmissible evidence from Ms McC her assertions that the FCS had indicated to her that they were optimistic that the child could be placed for adoption within a few months. The Trust indicated that they did not intend to call any witness from the FCS because it is a voluntary agency who tend not to become involved in court proceedings. Nonetheless I felt that if Ms McC was to rely upon this statement, without being able to give me the specific reasons why FCS arrived at this conclusion, it would operate as an unacceptable intrusion into the rights of the respondents pursuant to Article 6 of the European Convention on Human Rights and Fundamental Freedoms which guarantees a fair trial. It seemed to me that the inability to cross-examine the basis of this conclusion in the absence of the FCS would have placed an impossible burden on counsel for the respondents to deal with it.

However, Ms McC was able to indicate that in her experience she had not come across a child as young as N whom this Trust had failed to place. In her experience only two children (one aged 6 and the other 7), had been failed to be placed, both being substantially older than N. It was her experience that younger children are much easier to place. One child of six who was failed to be placed was diagnosed with autism and severe learning difficulties but had remained with her current carers who wished to look after the child on a long term foster care basis. So far as the child of seven who was not placed is concerned, that child had severe behavioural problems, and had been placed with a couple who did not wish to take on the responsibility of adoption. Nonetheless the child had remained in that placement now for a lengthy period.

Ms McC firmly asserted that whilst the Trust would rely on the FCS to find a placement, it would of course interview and consider any placement found before approving it. Once the FCS identify a couple who will be suitable, then the Trust will interview them and the various relevant factors dealt with. It is the Trust who will decide if they are suitable. Ms McC felt confident that this could be achieved. I observe at this stage that I found Ms McC a highly professional and convincing witness. I was satisfied that I could repose confidence in her conclusions.

(b) Turning to post-adoption contact is, it seemed to me that during the course of this case Ms McC's evidence before me had moved on from her original position. Originally, as contained in the reports, the Trust's view seemed to be that there should be no direct contact between the parents and N in a post adoption situation. Having heard Professor Tresiliotis, I am satisfied that that position has now changed and that it is Ms McC's view, and

that of the Trust, that they recognise that the optimum situation will be to find adoptive parents who would be receptive to post-adoption contact 3/4 times per year if that can be achieved. However, as Professor Tresiliotis himself recognised, this can only be achieved if the parents behave in a manner that is likely to reinforce that placement and not undermine it. A great deal of cross-examination was taken up pressing Ms McC with the proposition that the failure to make that a sine qua non at this stage before the FCS produced any potential placements was vital. Ms McC's view was that this was not the proper procedure and that the question of post-adoption contact should only be raised with a couple once they had been identified and there was an opportunity to explain the whole situation to them. Otherwise one might lose a potentially very suitable couple simply because they had rejected the notion of contact before having the whole situation re advantages and disadvantages explained to them. Ms McC indicated that it was her experience that birth parents are often initially very hostile to social services (as is the case in this instance) but that after an order has been made freeing the child, they take stock of the process, recognise what needs to be achieved and with the benefit of counselling and support often change their earlier views. I found this to be a wholly sustainable position to hold.

(iii) In the course of her evidence she indicated that H and R had refused to avail of any counselling or support services, rejecting any mention whatsoever of adoption. She recognised that the issue of post adoption contact had not been raised by her team as an entirely separate issue either orally or by way of letter but felt that perhaps any such approach had been frustrated by the hostility shown by these parents.I agree with this.

Ms McC's view was that it was her earnest hope that a placement for N could be found by the summer especially in light of the young age of this child.

After this case had terminated, and before judgment had been given by me, counsel on behalf of the mother and father indicated that certain developments had occurred which required the court to be re-constituted and further evidence to be given. In essence the position was that subsequent to the hearing the child P, now 13 years of age, had insisted on leaving the foster care where he then was and returning to live with H in February 2005. On 9 March 2005 a review child protection case conference and an initial child protection case conference was convened by the Trust in order to review the cases of H1 and P. In the course of this case conference, H1s name was removed from the child protection register and P's name was not added to that register. Ms R gave evidence again before me and issue was joined as to the reason for this decision about the child protection register. She told me that there was a division of opinion at the conference but that the adolescent care team who are responsible for H1 since January 2005 and will have responsibility for P were of the view that there was a damage limitation

programme to be initiated given that the children had a negative view of the social services. It was better therefore to start with a clean slate if the team was to engage them. Ms R described how she had struggled with that concept but eventually she did see the benefit of the children not being on the register because perhaps this simply served to highlight the need for protection without being of any further assistance. Since the children were subject to care orders, there would be continual review of them and therefore that degree of protection was still afforded.

[6] The Trust evidence was that both H1 and P were continuing to display behavioural problems. P had stated that he wanted to be home with his mother, and that if he was made to return to foster care or placed elsewhere he would run away and sleep in a ditch. Since his return, the principal of the grammar school which he is attending, has indicted that his attitude and achievements had deteriorated recently and there were grave concerns within the school as to whether his place can be maintained if he persists with this attitude. On Saturday 26 February 2005, P attended a local disco. He got extremely drunk and H was contacted to come and collect him. He has also been mitching from school. On 2 March 2005 H was contacted by the school as P had been involved in an incident and had bitten another boy's ear. She was asked to collect him immediately from school and as she was unable to do so, having no transport, P was taken home by the vice-principal. H's account to me of this incident was that it had merely been some horse-play. I do not accept this because if it was some innocent horse-play then I do not understand why the child would have been obliged to go home. H responded to this by asserting that it was his reaction to the school teacher. In any event, whatever was the trigger, his behaviour was so unacceptable that he had to be excluded from the school.

On 8 March 2005 he exempted himself from school spending the day in a local town with another boy. H1 has been giving problems also. She is now out of school and refusing to return after what the Trust alleged has been a period of fighting, suspensions and increasing difficulties that can no longer be managed within the school setting despite the efforts of the school to support her in light of the family situation. There had also been contact with the police and concerns that H1 had been drinking. She has also been missing from home including overnights on occasions resulting in a placement for respite care. Whilst there H1 absconded with another resident and concerns were expressed as to the company they were in when they were found in the early hours of the following day. She was missing for 3 days on one occasion. At the case conference H stated that H1 is out of control and that she will continue to welcome any help offered to her to deal with H1's behaviour. Since P has returned home, H had advised the Trust of a number of fights between the two young people which had been difficult to manage. I also believe that she told the Trust social worker that since P had returned, "things have been going down hill."

[7] In evidence before me H played down this whole matter indicating that the two of them were acting simply as teenagers. I reject this entirely and I have no doubt that these children are acting out as damaged children would do and that the damage has been caused to them by the previous history engendered by the behaviour of H and R. I think it is correct for the Trust to have characterised H1 as "an extremely damaged young person who is becoming increasingly resistant to social work support." Hence an adolescent team was brought in with the hope of building relationships with H1. These children had of course been in and out of care throughout their formative years and their current behaviour is in my opinion simply an almost inevitable out-growth from their damaged past and their life experiences. The prospect of returning N to this setting is thus profoundly concerning.

[8] At the case conference on 9 March 2005, as I have indicated, a decision was taken not to add P's name to the register of protected children and to de-register H1. I believe the evidence of Ms R that there was discussion by the adolescent team of the need to create a clean slate in order to try and engage these children in the social work process. I also believe that another factor was the reduced risk in the home as a result of H's abstinence from drinking. The guardian ad litem gave evidence that he was concerned about the decision that these children should not be placed on the child protection register given the contents of what had been going on. Ms R made it clear that she had struggled with the conclusions and that the adolescent team would not have had the detailed history of this family and the medical evidence that I had had. Note taking of the meeting was not as accurate as I would have hoped, but I watched Ms R very carefully during her evidence and I was satisfied that her recollection of this recent meeting was sound . She said that if H commenced drinking again, then P and H1 would be placed in residential care because there was no hope of a fostering placement. She drew attention to the fact that on 16 February 2005, a significant interview/event report records H engaged in a conversation with a social worker as follows:

> "On the way back to ………, H and P talked about home – P stated that he would like to come home to live with H. H told him he would be home in the future but not just yet. She stated to me she did not feel she was ready for him to come him yet. She said the timing was not right and did not want the same problems occurring that had him into care the last time. H1 made a comment that H did not want P – H told her to be quiet and she walked ahead."

Despite H's denial to me in the witness box that this conversation was accurate, I see absolutely no reason to doubt its content. The detail is such

that I am satisfied it is true. It also fits the pattern of the past. I am satisfied that H did not believe that the timing was right for P to come home and that she recognised that there was a real danger here of stress occurring as a result of his arrival. A denial to me was simply indicative of the fact that she realised that the truth would be damaging to her case. The fact of the matter is that there is a greatly added stress factor now that P is home. P and H1 have a volatile relationship. This is the very matter that in March 2003, on H's own evidence, contributed to her returning to drinking once they had come home. At that time in March 2003 T, another child, had been phased home and was doing well. H1 and P had then refused to return to foster care and although H argued that the Trust had not given her sufficient support, she was simply unable to manage all 4 children and returned to drinking. I think that when P returned to home in 2005 H was well aware of the history and has genuine fears that she may not be able to manage the situation. I share the view of the guardian ad litem who gave evidence to me that the evident stress of P's presence, is another factor which increases the danger at this time of this woman returning to her past pattern of behaviour and abuse of alcohol. I believe that the situation in which P and H1 are demonstrably presenting such challenging behaviour adds to the danger of risk to N if she were to return home. From the evidence before me H indicated that she was perfectly happy to accept the present situation and that she did not find it stressful. I simply do not accept this. If it is true, it is indicative of her inability to understand at an emotional level the dangers facing N. However I think that she realises that what she has said is untrue and this is but another example of where she says what she considers has to be said without it reflecting her genuine beliefs at an emotional or practical level.

[9] In the course of this aspect of the case, my attention was draw by Ms Quinn on behalf of H to the fact that the Trust has hitherto been refusing to provide counselling for her. I share the view of the guardian ad litem that counselling should be provided to this woman at the very least to provide help for H1 and P in their present challenging position. Even without N, she needs to take the steps outlined by the medical witnesses in this case in order to properly care for and meet the needs of H1 and P. I therefore recommend that the Trust look again at this whole issue of counselling in the context of the new situation.

The first respondent H

[10] I have read the statements of H in this case and in addition I had the benefit of trial bundle 3 which comprised, inter alia, letters from Dr G B O to the effect that, as a member of the community addictions team, she is prepared to continue offering ongoing support and that as at 30 November 2004 she had continued to remain free from alcohol and was hoping to continue in this manner into the foreseeable future. In addition there were statements from her GP Dr Brady of 17 January 2005 in which it is said that

he was impressed with her attitude and her determination to remain off alcohol. There were also statements from members of AA indicating the efforts that she was making to remain clear of alcohol. That file also contained a statement from CD from the men's advisory project in Belfast indicating that he had worked with R for approximately 6-8 sessions during 2002/2003 and that at the end he had expressed satisfaction at having found ways of controlling his anger. In addition there were statements from R's children by a previous relationship indicating that he had always been supportive and thoughtful. SM, senior social worker, had provided a statement indicating that he had been working with H1 since September 2004 in the capacity as family support worker. He said it had been clear in his work with H and H1 that there has been a rising level of stress within the family associated with the present case. Much of the stress for H1 was the fear of not seeing her sister again. He felt it reasonable to conclude that this was probably one of the significant factors impacting on her current behaviour. He added that there were other factors to be considered such as her history of numerous case placements and the fact that at 15 it was not uncommon for a young person to be testing boundaries in line with normal adolescent development. The file also contained a statement from H1 asking that her views be taken into consideration insofar as she adamantly wished N not to be freed for adoption. She indicated that she had faith and trust in her mother that she would never drink again and in her evidence before me H indicated that H1 had sat up half the night writing this letter. I have taken care to read that letter on several occasions.

[11] In the course of H's evidence-in-chief and cross-examination, together with the statement which she has made in writing, the following matters emerged:

(i) She emphasised that she had now been clear of alcohol for 18 months and she felt there had been a fundamental change in her attitude to alcohol, her self and her lifestyle. She stated that the change came about some weeks after N had been placed in voluntary foster care in June 2004 at a time when her physical health had been suffering because of alcohol abuse. She extolled the benefits of membership of AA embarking on a closed meeting programme which involved facing and accepting her problem including addressing her fears and the reasons why she was drinking. She has been gaining assistance from her community addictions nurse JM as well as her GP.

(ii) She openly admitted that there had been domestic violence in the household when she was drinking but stated there had been no violence since N was born. She continues to deny the incident that involved H1 and herself with R and the findings which Judge Rodgers made.

(iii) She asserted that the Trusts had not availed of every opportunity for her to parent N as only ten days after obtaining an interim care order on 7 July 2003, at a LAC review on 17 July 2003 the decision was taken to refer N to the permanency panel.

(iv) She claimed that she had asked her GP to look at Dr Allen's report and refer her for the necessary therapy. He had told her however that there was a long waiting list. She had sought assistance from the Trust but had received no response. She could not pay for the counselling and therefore had not started any such therapy yet.

(v) She was opposed to the child being freed for adoption and was ready for N to return. She felt that some of the therapeutic preliminary work had already been done with AA.

[12] In cross-examination by Ms Keegan, she acknowledged the lengthy history of drinking. During that time H1 had been in and out of care on approximately ten occasions and P, her son, had also been involved in a number of moves in and out of care all occasioned by her drinking. T had also a number of similar moves. She acknowledged that she was a recovering alcoholic and had been drinking during the pregnancy of N. She recognised that after the assessment in Thorndale, N had been living with her for approximately up until June 2003 when again her drinking caused the child to be removed. She blamed the Trust for the stress that was occasioned to her at that time because she was unable to cope without appropriate assistance from the Trust when the other children had come home at that time. A number of incidents had led to the incident in June 2003 which precipitated the removal of N.

[13] So far as domestic violence is concerned, a number of incidents were put to her which allegedly characterised the domestic violence which was part of the relationship between H and R. She agreed that the children in the year 2000 had witnessed and heard arguments but denied that in February 2001 H had accurately informed the social workers that R had hit her and thrown her on to a couch. Trust records recorded that in January 2002 R had assaulted H by pushing her down some steps and she had said she feared she might lose her baby. At that stage the Trust alleged that H had the locks in the house changed to prevent R returning home. A non-molestation order was thereafter obtained. H asserted to me that he had simply pushed her when she was on the second step and that she did not fall over and was not bruised. She obtained an non-molestation order simply because he had pushed her down two steps. As far as the incident of May 2003 is concerned, she held to the same story that she had placed before Judge Rodgers. My overall view was that she was clearly attempting to minimise the domestic violence in this household, either through a failure to appreciate the danger or a desire to protect the relationship with R.I regarded this as another

instance where she fails to prioritise the needs of her children over those of herself or her partner.

[14] Her alleged antagonism towards social workers was suggested to her and a number of recent incidents were dealt with in cross-examination by Ms Keegan. I found her untruthful and disingenuous in dealing with her clear hostility to social workers. She also underplayed deliberately the problems being caused by H1, asserting that she was simply a teenager having normal adolescent problems. Some of the matters put to her were as follows:

(a) On 30 July 2004 H had self-harmed herself and on Sunday went missing from the family home. She was found in Castlewellan Foster Park with drink taken, but refused to go home until the following day.

(b) On 24 August 2004 H1 was involved in an incident at Castlewellan Forest Park and was subsequently cautioned by the police who had also stated she had drink taken. H and R denied that H1 was drinking on that occasion and blamed the visit by the social worker for H1's behaviour.

(c) On 13 September 2004 R stated he did not want any social workers coming to his house.

(d) On 14 September 2004 a social worker was denied access to the family home on an agreed statutory visit to H1. H stated that she wanted no more dealings with social services. I do not believe H when she told me that she simply said she wished to have no dealings with the social worker who called, namely Ms R because H1 was in bad form. This is another example where clearly H was failing to face up to the reality of her hostility and is a clear indication to me that this couple simply do not recognise the extent of the help that they need to cope with these damaged children. It increased my fears of exposing N to such an environment

(e) On 6 December 2004 she acknowledged that she was hostile to Ms R on the question of taking H1 home. H acknowledged that she did find it difficult to work with Ms R but she rejected that there had been any hostility as such .

[15] R was not called to give evidence and Mr Hutton on his behalf indicated that he relied on the evidence of Dr Loughrey.I have carefully read R's statements and listened to and read the submissions on his behalf.

Guardian ad litem

[16] The last witness in this case was the guardian ad litem who had been allocated to the case on 16 September 2004. He had been N's guardian ad litem for the care proceedings in 2004. He supported the application to free

this child for adoption. He had filed a report on 10 January 2005. In the course of his evidence the following points emerged:

(i) Given the findings of Judge Rodgers, he said one question which needed to be addressed was whether or not the circumstances of H and R had changed to a degree which would enable them to parent N within a time span appropriate to the child. Sadly the parents in this case have failed to meet with the guardian ad litem at any time. I believe this is yet more evidence of their hostility to public authorities and their deep seated refusal to co-operate with advice about change. He had written to them on 25 October 2004 confirming his appointment as guardian ad litem and asking them to contact him to arrange a meeting to establish their views on the present application. He received a letter from their legal representatives on 11 November 2004 highlighting that whilst both parents were willing to engage with him in relation to his duties to the court, they were still upset and distressed by care proceedings compounded by the current application to free this child. The letter stated:

> "We should be obliged if you would set out what you wish to achieve by having a meeting as suggested and whether there are any representations that can be made on behalf of our clients that would dissuade you from recommending adoption and persuade you to recommend a managed and structured rehabilitation of N to her parents care."

That letter was responded to by the legal representatives for the guardian ad litem acknowledging the understandable distress of the parents, but pointing out the guardian did not have a pre-determined view on the case and was carrying out a specific role. Regrettably the parents did not make any contact with him and therefore he was obliged to complete his report without them participating.

(ii) He outlined the unhappy history of alcohol abuse since the 1990s together with the references to the number of breakdowns that had occurred over the years.

(iii) He made it clear that given the history and the professional assessments made, it was his view that H was not only not ready to care for N now, but that the time span outlined for her rehabilitation fell outside a time span conducive to the needs of N. Moreover it was his view that R would not be a protecting parent in the event of H relapsing to her drinking habits. He concluded that there was now increased concern due to the fact that P was at home together with H1. It was his evidence that this development constituted an extra stressor which increased even more the likelihood of relapse on the part of H.

(iv) He concluded that N should be freed for adoption.

Paragraphs 5.6 and 8.3 of his report of 10 January 2005 helpfully set out the arguments in favour of adoption as opposed to foster care. I found these arguments very impressive. He argued that N now required permanency and stability in her life given that she was still within the age span where good enough parenting could give her the basis to be able to function adequately in childhood. My attention was drawn to the research of Professor Tresiliotis in "Tresiliotis, J [2002] Long Term Foster Care or Adoption: the Evidence Examined. Child and Family Social Work 2002" pp.23 – 33. In that article the author commented that the difference between long term foster care and adoption appeared to be an issue of security, a sense of belonging and general well-being expressed by those adopted compared with those who had experienced long term foster care. The guardian made the point that at a recent seminar conducted by Professor Tresiliotis in Belfast, when he reviewed other research carried out in the United Kingdom over the past 20 years, the conclusion still confirmed the advantages of adoption over long term foster care in circumstances such as that of the age group of N.

[17] Dealing with post adoption contact it was his view that whilst there would always be a high level of tension between parents and professionals during freeing proceedings, he saw little evidence from the expert reports on the care in present proceedings to suggest that there was anything near the required co-operation of the parents for post adoption conduct to occur. He did not think this was likely in the future. He therefore concluded that the Trust was acting appropriately in phasing out parental and sibling contact post adoption in order to maximise the possibility of a successful adoptive placement for N.

Conclusions

(i) I remind myself of what I said in Re T (Freeing Without Consent: Refusal to Dispense with Agreement of the Parent) NIFAM 6 (Unreported, 11 February 2004);

> "14. I commence my deliberations on this issue by recognising the draconian nature of the legislation which is now being invoked by the Trust. It is difficult to imagine any piece of legislation potentially more invasive than that which enables a court to break irrevocably the bond between parent and child and to take steps irretrievably inconsistent with the aim of reuniting natural parent and child."

(ii) I recognise that the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life and that domestic measures hindering such enjoyment do amount to an interference with the right to such protection by Article 8 of the ECtHR (See Johanson v Norway [1996] 23 EHRR 33.) I also recognise that taking a child into care should normally be regarded as a temporary measure to be discontinued as soon as circumstances permit and that any measures of implementation of temporary care should be consistent with the ultimate aim of reuniting the natural parent and the child wherever possible.

(iii) I have derived great assistance from two recent cases in the Court of Appeal in Northern Ireland namely AR v Homefirst Community Trust [2005] NICA 8 and Homefirst Community Health and Social Services Trust and SN [2005] NICA 14. In AR v Homefirst Community Trust Kerr LCJ stated in the course of the judgment of the court;

> "It is unsurprising that research into the subject discloses that it is desirable that permanent arrangements be made for a child as soon as possible. Uncertainty as to his future, even for a very young child, can be deeply unsettling. Changes to daily routine will have an impact on a child's need to feel secure as to who his carer's are. It is not difficult to imagine how disturbing it must be for a child to be taken from a caring environment and placed with someone who is unfamiliar to him. It is therefore entirely proper that this factor should have weighed heavily with the Trust and with the judge in deciding what was best for J. But, as we have said, this factor must not be isolated from other matters but should be taken into account in this difficult decision. It is important also to recognise that the long term welfare of a child can be affected by the knowledge that he is being taken from his natural parents, even if he discovers that this was against their will.
>
> So, while there may be many cases in which prompt decisions as to the placement of children are warranted, this is not enviably or invariably the best course. …. We consider that in the present case there were sound reasons to postpone the decision as to where J should ultimately be placed. As the judge rightly observed, it might be many years before Mrs R could finally demonstrate that she had completely overcome her problems with alcohol and lack of insight, but it does not inevitably follow that no delay

> in deciding what should become of J was warranted. It was already cause for optimism and with close supervision of it at least distinctly possible that Mrs R would have been able to care for her son… although a decision in J's future that would have allowed permanent arrangements to be made was desirable, this did not, in our opinion, outweigh the need to give Mrs R the chance to prove herself. Taking into account 'the imperative demands' of the Convention in relation to her Article 8 rights, the need to have matters settled for J should not have been allowed to predominate to the extent that the mother's Convention rights could be disregarded."

(iv) Equally so I recognise that in Yousef v The Netherlands [2003] 1 FLR 210 at 221, para. 73, the ECtHR stated;

> "The court reiterates that in judicial decisions where the rights under Article 8 (of the European Convention) of parents and those of a child are at stake, the child's rights must be the paramount consideration. If any balancing of interest is necessary, the interests of the child must prevail."

Accordingly it is important to remind myself that the Trust and this court, as public authorities, have an obligation to comply with the provisions of Article 8 of the European Convention on Human Rights (ECtHR) which was incorporated into our domestic law on the coming into force of the Human Rights Act 1988. Article 8 provides;

> "(1) Everyone has the right to respect for his private and family life, his home and his correspondence.
> (2) 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… or for the protection of the rights and freedoms of others."

I am conscious that the Court of Appeal in these two recent cases has been critical of Trust failure to comply with these rights. In JN, Sheil LJ said;

> "If the Trust in the present case had been fully cognizant of SN's rights under Article 8 of the European Convention, this court considers that it

> should have given her a further opportunity to prove herself by undergoing the further suggested therapeutic work in early 2003. That regrettably was not done thereby depriving her of the opportunity to prove that JN could be returned safely to her care. Having regard to the real progress which she had made in her life, despite not having the benefit of the further suggested therapeutic work, there was some real prospect that she might succeed in so doing although that would take some time to establish."

(v) In Re V (Care: Pre-birth Actions) [2005] 1FLR 627, the Court of Appeal in England dealt with a case where the fourth child of a mother was almost immediately after the birth made the subject of a care order. In the course of the judgment Ward LJ said at para. 30:

> "It is crystal clear from the decision of the European Court of Human Rights in Mantovanelli v France [1997] 24 EHRR 370 (para. 34) and some other authorities conveniently cited by Munby J in Re L (Care: Assessment: Fair Trail) at paras. (94-104), that in deciding whether or not there has been a breach of Article 6; '…the court has… to ascertain whether the proceedings considered as a whole, including the way in which the evidence was taken ,were fair…'
>
> It is thus manifestly impermissible, in my judgment, to isolate one alleged incident and use it as a basis for a finding there has been a breach of the parents' Article 6 rights."

I must be careful therefore to look at the overall situation here rather than concentrate on any particular incident other than in the wider context.

(vi) Article 9 of the Adoption (Northern Ireland) Order 1987 provides;

> "In deciding on any course of action in relation to the adoption of a child, a court or adoption agency shall have regard to the welfare of the child as the most important consideration and shall –
>
> (a) have regard to all the circumstances, full consideration being given to -
>
> (i) the need to be satisfied that adoption, or adoption by a particular person or

persons, will be in the best interests of the child; and

(ii) the need to safeguard and promote the welfare of the child throughout his childhood; and

(iii) the importance of providing the child with a stable and harmonious home.

The views and wishes of the child where the age is appropriate must also be taken into account.

Article 18 of the Adoption (Northern Ireland) Order 1987 provides;

"18(1) Where, on an application by an adoption agency, an authorised court is satisfied in the case of each parent or guardian of a child that his agreement to the making of an adoption order should be dispensed with on a ground specified in Article 16(2) - the court shall make an order declaring the child free for adoption.

(2) No application shall be made under para.(1) unless -

(a) the child is in the care of the adoption agency; and

(b) the child is already placed for adoption or the court is satisfied that it is likely that the child will be placed for adoption."

[18] In this case I am satisfied that adoption is in the best interests of this child. The history of alcohol abuse, and domestic violence over the years has caused enormous damage to H1 and P and also now N. Professor Tresiliotis gave chilling evidence in relation to the emotional damage to the other children of the family caused by the abusive behaviours and the risks to N, already a troubled and damaged child, are all too evident. I believe it is extremely unlikely that this mother will be able to come to terms with the stressors in her life within a reasonable time or, more importantly, a time appropriate to N. This case in my view is easily distinguishable from the two cases in the Court of Appeal in Northern Ireland to which I have earlier adverted because I have come to the conclusion that in this instance the medical evidence, and in particular that of Dr Bownes, has convinced me that there is no realistic possibility of H continuing to remain abstinent during N's childhood. Given the troubled background of this child and the damage that she has sustained to date, I am of the view that a further breakdown in this child's attachment would be catastrophic and that no court could reasonably

expose her to that catastrophic risk given the history of this case. I have concluded that the only way to safeguard and promote the welfare of this child throughout her childhood and provide her with a stable and harmonious home is through the avenue of adoption.

[19] I am must then turn to Article 16(2)(b) of the 1987 Order and decide whether the Trust have satisfied me on the balance of probabilities that each parent in this case is unreasonably withholding his or her consent. The leading authority on the meaning of the ground and the test that the court should apply is Re W [1971] 2 AER 49. During the course of the leading opinion, Lord Hailsham described the test in this way:

> "The test is reasonableness and nothing else. It is not culpability, it is not indifference. It is not failure to discharge parental duties. It is reasonableness and reasonableness in the context of the totality of the circumstances. But, although welfare per se is not the test, the fact that a reasonable parent does pay regard to the welfare of his child must enter into the question of reasonableness as a relevant factor. It is relevant in all cases if, and to the extent that a reasonable parent would take it into account. It is decisive in those cases where a reasonable parent must so regard it."

Lord Hodson at p. 718b stated:

> "The test of reasonableness is objective, and it has been repeatedly held that the withholding of consent could not be held to be unreasonable merely because the order if made, would conduce to the welfare of the child."

[20] In JN, Sheil LJ added at para. 26:

> "In many cases, and this is one of them, there is a tension between what is in the best interests of the child and the question of whether a parent is withholding his or her consent unreasonably. In Re F [2000] 2FLR at 505 – 509 Thorpe LJ referred to the joint judgment of Steyn and Hoffmann LJJ in the case of Re C (A minor) (Adoption: Parental Agreement; Contact) [1993] 2 FLR 268 – 272 where they stated;
>
> > 'The characteristics of the notional responsible parent have been expounded

> on many occasions; see for example Lord Wilberforce in Re D (An Infant) (Adoption; Parents' Consent) [1977] AC 602 at 625 ("endowed with a mind and temperament capable of making reasonable decisions").'

The views of such a parent will not necessarily coincide with the judges' views as to what the child's welfare requires. As Lord Hailsham of St. Marylebone LC said in Re W (Supra);

> 'Two reasonable parents can perfectly reasonably come to opposite conclusions on the same set of facts without forfeiting their title to be regarded as reasonable.'

Furthermore although the reasonable parent will give great weight to the welfare of the child, there are other interests of herself and her family which she may legitimately take into account. All this is well settled by authority. Nevertheless, for those who feel some embarrassment at having to consult the views of so improbable a legal fiction, we venture to observe that precisely the same question may be raised in a demythologised form by the judge asking himself, whether having regard to the evidence and applying the current values of our society, the advantages of adoption for the welfare of the child appears sufficiently strong to justify overriding the views and interests of the objecting parent or parents. The reasonable parent is only a piece of machinery invented to provide the answer to this question."

[21] I recognise that the reasonableness of the parents refusal to consent must be judged at the time of the hearing and I am doing that. I have taken into account all the circumstances of the case. I have recognised that whilst the welfare of the child must be taken into account it is not the sole or necessary paramount criterion. I have applied an objective test in the case of each parent. I have recognised that the test is reasonableness and nothing else. I have been wary not to substitute my own view for that of the reasonable parent. I recognise that there is a band of reasonable decisions each of which may be reasonable in any given case. I have come to the conclusion that both these parties are unreasonably withholding their consent for the following reasons:

(i) I consider that this is a classic case where a child cannot indefinitely wait for parents to change. That principle applies in all cases but never more so than in this instance where N is already a very troubled and needy child. In her particular circumstances, I accept entirely Professor Tresiliotis' view that a return to her mother's care, followed by a relapse into drinking, would be catastrophic for this child. This must be balanced against the need to explore all reasonable alternative measures to the drastic course now proposed by the Trust and to explore whether or not there is a realistic possibility in the context of this case that this mother can repair herself sufficiently so as to provide good enough parenting. This is not only a matter of protecting her Article 8 rights but also commonsense. I have concluded that her history is so replete with failure to do this and the prospects of future success so fragile that I cannot so conclude and risk permanent damage to this child. Too many opportunities for rehabilitation have been spurned in the past to allow me to embrace a realistic possibility of success in the future. This therefore is not a case where alternatives have not been explored. On the contrary the history is rife with such opportunities being afforded and spurned.

(ii) N is approaching 3 years old and has suffered a disruptive background. A troubled child, without core attachments requires now desperately to move on and re-establish permanent attachments in a final move. The present placement cannot remain permanent. A new baby has arrived in this household and she is now sharing a room with a child slightly older than her and another child aged 8. That latter fact above renders this placement unsuitable long term. These foster carers will keep her pending any resolution of finding an adoptive couple, but this is not a long term solution. She is going to have to make a move and I believe that that move must now be a permanent one given her age. All the literature relied on in this case indicates that the crucial period of attachment for children is between 6 months and 4 years. The time span for resolution of H's problems is simply too long for this timescale. N has already been in care for a substantial period and Professor Tresiliotis illustrated that the longer this persists, the remoter the chance of rehabilitation.

(iii) H has a personality disorder, characterised by mood instability, impulsivity and aggressitivity, poor tolerance of stress or boredom, poor ability to cope with demanding situations, demands for attention, and thoughts of self-harm whenever a negative emotional state is encountered. Her drinking is a consequence of her damaged past. She requires 6-12 months baseline counselling. Although the mother indicated that some of this work had been done with AA, I am not persuaded of that and the expert counselling which must now take place is I suspect on quite a different professional level. Even if that was successful, it must be followed up by at least 12 months psychotherapy. The work could therefore take a total of 18 months or longer but prospects of success are not good.

(iv) The danger of history repeating itself here is overwhelming. H1 and P have both suffered the consequences of the historical inability of H and R to meet the very problems that still confront them. I have seen concrete evidence of the consequence of the damage that has been caused to these two young children and how they are suffering today. The history of their current behaviour is testament to the damage that they have suffered. I must ensure that N does not suffer a similar fate albeit that she already is a troubled child as a result of her treatment to date.

(v) When sober both H and R are very competent when dealing with N (see Thorndale report of August 2002). H has had long periods of abstinence in the past (see for example the evidence of Ms R) but sadly has returned to abuse of alcohol. As I listened to the evidence I considered I was watching history repeating itself having failed before in 2003 in precisely the circumstances that now obtain and which led to yet another return to drinking. The return of P and H1 provided an overwhelming circumstance for H and their challenging behaviour I believe contributed strongly to her return to drinking. This is precisely the scenario that now arises. While it may well be that the real problem that she suffers is now diagnosed, the remedy will take too long in order to protect this child, N. I remain convinced that H and R will not be capable of dealing with the challenging behaviour of H1 and P and the addition of N, would in my view, be a recipe for disaster. H's insistence on minimising and externalising the problems that are presented by these children merely serves to underline my deep concerns. I am entirely convinced that Dr Bownes is correct to conclude that if she is confronted by any substantial upset she is likely to return to a state of unstable mental welling which I believe will trigger her excessive drinking again.

(vi) Counsel on behalf of the mother and father argued that the late diagnosis of the underlying problem that H faces constitutes a legitimate grievance on their part. In other words her argument is that the Trust had not diagnosed this problem at an earlier stage, steps had not been taken to address it, and it is only now at a belated stage that the matter has been addressed. Even now the Trust are refusing to provide her with counselling. The Trust answer of course is that despite a number of experts having intervened in this case, the step of addressing her underlying problems which have contributed to her drinking had not been looked at. Over the years the Trust has provided a range of services including community addiction treatment, Cuan Mhuire, Thorndale assessment and family centre work. Moreover mental health professionals had been involved with H for several years. The Trust can do no more than rely on the expert evidence that has been given to them. Their case for not providing counselling was that it was all too late for N and that whilst counselling would be helpful to H personally, it could not avail N. I do not believe that there is a legitimate

grievance here. H cannot place the burden of her problems on to the Trust. She has her own responsibilities and if she wished to address this problem of drinking she cannot leave it entirely up to the Trust. Failure to ascertain the root of her problem lies partly at least with her own actions. The welfare of this child cannot be sacrificed to the need to address her problems of alcohol. Moreover I am satisfied that the Trust had taken all reasonable steps to afford her professional and expert help and it cannot be blamed if only now yet another alternative remedy is postulated. I believe it is too long a timescale to address all these problems at this stage and I am not prepared to endanger the future of N simply to meet the lateness of the prognosis of H's problems. To do so would be to give H a priority far in excess of the needs of this child. She has shown in the past that she is not prepared to accept advice even though the consequences have been spelt out for her. An example of this was her continued drinking when pregnant with N notwithstanding the warnings given, she has rejected social service intervention in September 2004 and more recently refused to discuss matters with the guardian ad litem. I am satisfied that this case resonates with instances where hostility to advice and assistance from informed advisors has been manifest on the part of H and R.

(viii) I reject the attempts to minimise R's propensity for domestic violence simply because Dr Loughrey at one stage described this as "a reaction to a troubled relationship and family situation rather than to any inherent deficit in (his) personality" and opined that alcohol misuse in the home was the trigger. Domestic violence is inexcusable in any circumstances and his cavalier attitude to anger management training which he betrayed to Judge Rodgers illustrates his lack of insight into the problem.

(ix) I recognise that H1 is unhappy at the prospect of N being adopted. I have read a letter which she asked the court to consider. The needs and feelings of other children are factors which the reasonable parent can properly take into account (see Re E (a minor) (adoption) (1989) 1 FLR 126 at p. 132). On the other hand it is only one factor which, when the reasonable parent weighs it against all the others, would fail to have a significant impact.

(x) It was argued that the reasonable hypothetical parents in this instance would be justified in withholding consent until they could be assured that any prospective adoptive parents chosen would agree to post adoption contact and that the Trust should have taken steps to identify such a couple before proceeding with this application. I reject that proposition. I am satisfied that the need for adoption for this child is so pressing that whilst it would be preferable that some limited measure of post adoption contact should be established if possible nonetheless adoption must proceed even if this cannot be achieved. Otherwise both parents could operate a veto on adoption by behaving so badly that no one would agree to post adoption contact. The crucial difference between the present case and the fact specific

authorities to which Mr Hutton drew my attention eg. Re P (Adoption: Freeing Order) (1994) 2 FLR 1000 and Re C (minors) (adoption) (1992) 1 FLR 115, is that I share the view of Professor Tresiliotis that if all reasonable efforts to find a couple who will embrace post adoption contact fail then the circumstances of the historical events of the past still make it imperative that the adoption should proceed. Any reasonable parent in my view would readily understand that. This is not inconsistent with Article 8 of the ECHR but rather a careful consideration of the rights of this child as well as the rights of the adults.

(xi) It was submitted on R's behalf that the reduction in contact by the Trust prior to the presentation of the application now before the court was another factor which induced a sense of grievance on the part of the parents. This is entirely unsustainable. I accept that the decision to reduce contact was entirely consistent with the court approved care plan and the facts that then obtained.

(xii) I am satisfied that this Trust has afforded due consideration of this couple's rights under Article 8 of the ECHR and that every reasonable consideration has been given to the prospect of rehabilitation. However the Trust have also taken into account the rights of this child to a family life and have in my view correctly concluded that this can only be done by following the route of adoption. I consider therefore that their response has been a proportionate one to a legitimate aim namely to protect the welfare and interests of this child. I am satisfied therefore that the Convention rights of the parents have been adequately recognised and that no outcome other than that which it has decided on could have been reasonably contemplated.

[22] Turning to Article 18, I am satisfied that this child is in the care of an adoption agency pursuant to the care order previously made. I have been very impressed by the evidence of Ms McC found at p. 17-19 of this judgment. I have found her a most convincing and experienced witness and I accept entirely the reasoning and the factual evidence that she presented. For the reasons that she so ably set out and I am satisfied that it is likely that this child will be adopted.

[23] Whilst it is inappropriate for me to look at the question of the contact post adoption until this child comes before the court for adoption, I feel it is appropriate that I should say that I accept entirely the view expressed by Professor Tresiliotis that it is important that if at all possible this child should have the benefit of continued contact with both parents at the frequency suggested by Professor Tresiliotis for the reasons that he set out. I have read carefully what he has said and listened to his evidence and I was completely convinced by its tenor and content. (See pages 5-9 of this judgment). If these birth parents can accept the new position and help this child to settle down without undermining the placement, I believe this can be of great assistance

to this child now and in the future. Obviously if any attempt is made to return to the previous behaviour of which I have been so critical, or any attempt is made to undermine the placement, then continuing contact will of course need to be re-examined and perhaps stopped. I also sincerely hope that the prospective adoptive parents when they are chosen will be carefully counselled as to the views of Professor Tresiliotis concerning the benefits of post adoption contact but obviously if after all reasonable efforts have been made by the Trust for a period of six months or so, and no such couple can be found, then I am of the opinion that the benefits of adoption will outweigh the benefits of post adoption contact.

[24] Finally I am satisfied that both parents have been afforded the opportunity to make the requisite declaration pursuant to Article 17(5) of the 1987 Order and have chosen not to do so.

[25] I am satisfied that a freeing order in this case is a proportionate response to the legitimate aim of ensuring the welfare of this child. I have sought to balance the Article 8 rights of both parents, reminded my self that this draconian remedy should only be resorted to where no alternative avenue is open and where the interests of the child clearly require it.

[26] In all the circumstances therefore I have come to the conclusion that this child should be freed for adoption.