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This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the child[ren] and members of their [or his/her] family must be strictly preserved. All persons, including all representatives of the media must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

No. BT13C00039

IN THE FAMILY COURT	

Barnet County Court
Regents Park Road

London N3 1BQ

Tuesday, 19th August 2014

Before:

HER HONOUR JUDGE LEVY
(In Private)

- -

B E T W E E N :

LONDON BOROUGH OF BARNET
Applicant

- and -

THE MOTHER

Respondent

- -

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MR. C. MILLER (instructed by the London Borough of Barnet) appeared on behalf of the Applicant (Local Authority).

MISS L. SCOTT (instructed by Bindmans and Partners) appeared on behalf of the Respondent (Mother).

MISS S. BRADLEY (instructed by Goodman Ray) appeared on behalf of the Guardian.

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J U D G M E N TJUDGE LEVY:

1 I am giving Judgment this afternoon in public law proceedings which concern one child, (referred to as "A"), who was born on 7th September 2013 and is now 11 months old.

2 The proceedings are issued by the London Borough of Barnet. A's mother will be referred to as the "mother". His father's identity is not known. His guardian in these proceedings is Christine Payne.

3 The parties' positions at this final hearing are as follows. The Local Authority seeks a care order and approval of a final care plan for A to be adopted by his foster carers, therefore they also seek a placement order. The guardian supports the Local Authority's applications. The mother agrees that the criteria to establish threshold have been established. The threshold document is set out at pp.A90 to 92 in the bundle, and I accept that threshold is established on that basis and the threshold as found by me and agreed by the mother will be attached to my order in this matter.

4 The mother seeks A's immediate return to her care with the support of the Local Authority under a supervision order. Her second preference would be to be placed with A in either a mother and baby unit, or a mother and baby foster placement. Her third preference would be for A to remain with his current foster

carers, as long term foster carers under a care order and for her to have generous and regular contact with him. I have also been asked to consider the possibility of a special guardianship order as an alternative to adoption. It is fair to say that the mother sees advantages for A remaining in the care of his current foster carers (whom he has known since he was four days old) if he cannot be placed with her. If I make a placement order she seeks direct contact once or twice a year.

5 The final hearing in this case was originally listed to take place before me on 13th May, but at that time the mother had not been able to give instructions to her solicitors and it was therefore adjourned to this week, starting 18th August with a time estimate of four days - in fact, it has been completed within two days.

6 In preparation for the hearing I have read two bundles of documents and I heard short oral evidence from the allocated social worker, Nikki Claybrooks, from the mother, and from the guardian. The parties have been represented as follows: the Local Authority by Mr. Miller, the mother by Miss Scott, and A through his guardian, by Miss Bradley.

7 Threshold having been agreed, and found by me, I have to consider what placement is in A's best interests, reminding myself that his welfare is my paramount concern, and taking into account the welfare checklists in both the Children Act 1989 and the Adoption and Children Act 2002, so that my concern today is with A's welfare throughout his lifetime. In considering what placement would be in A's best interests I have to consider all the options available for him and I am aware that I should make the least interventionist order that I can make.

8 The Local Authority's concern with regard to the mother, and the reason for their issuing these proceedings is that, sadly, she has a history of severe mental illness, and a diagnosis of schizophrenia and it is her illness which led to the events as a result of which the Local Authority issued these proceedings. The

history of her ill-health goes back to 2009 with the first psychotic episode in December of that year. The history is set out in full in Dr. Taylor's report at p.E13 in the bundle, and I am not going to repeat it in this short judgment.

9 In August 2010 the mother was referred to a crisis team for medication and I think at that time was receiving depot medication. In September 2011 she told the Early Intervention Psychosis Team that she was going to Nigeria, and it was quite some time, at least a year before they had contact with her again. The chronology set out at p.A1 in the bundle starts in February 2013 with a request on the mother's behalf for housing and concerns that, as she was then pregnant with A, she was not receiving antenatal care, and also concerns about her ability to care for herself.

10 On 12th April 2013, the mother assaulted an elderly man, who appears to have taken pity on her and offered her a temporary home, and she also assaulted a member of the public. As a result she was charged with two counts of assault and remanded in custody. Her case concluded on 28th May 2013 with an order that she be detained under s.30 of the Mental Health Act 1983, and she was moved to Bewick Ward in Cygnet Hospital, Beckton. In hospital at first she presented as difficult to manage and aggressive. In June she assaulted a member of staff, but by August 2013 she had settled well, her health was stable, she was compliant with anti-psychotic medication. She applied for a hearing before the hospital managers who, on 18th September, did not discharge her and she accepted that decision without incident. Subsequently, she was further detained for six months under s.3 of the Mental Health Act 1983, and she made an application to a Mental Health Review Tribunal which discharged her but deferred her discharge until either 9th or 12th December 2013. That decision was made against medical advice and Dr. Taylor said that, as a result, it was likely to increase the risk for her of non-compliance with medication and of relapse. During this time that the mother was at Cygnet Hospital and on 7th

September she gave birth to A.

11 The Local Authority was involved with the mother and did a considerable amount of pre-proceedings work. There was a Legal Gateway Meeting on 7th July 2013 and the Local Authority then attempted to identify a place for the mother and A, either in a mother and baby unit for assessment, or in a mother and baby foster placement. Referrals were made to the units at the Homerton Hospital, the Coombe Wood Hospital, and the Bethlehem Royal Hospital, all of which ultimately declined to accept the mother and A. The Local Authority was unable to find a mother and baby foster placement which would accept them.

12 These proceedings were issued on 10th September 2013. There have been a number of hearings and assessments, which I will come to. On 26th June 2014 the Local Authority issued its application for a placement order.

13 I want to say a few words about A, and I rely particularly on the account given by the guardian in her final analysis. She notes at para.28 of her report that four days after his birth A was removed from his mother's care and placed with his current foster carers, who have provided him with an extremely high level of excellent care. She notes that very positive attachment behaviours have been established between them and says:

> "This has allowed A to develop into a very happy and content baby who is making good progress in his development. He smiles easily, is very responsive towards others, and clearly enjoys exploring the world around him. He readily turns to his carers for reassurance and comfort and they are clearly committed to ensuring that he has every opportunity to engage in new experiences. Indeed A is currently attending swimming classes once per week, and he is now at the early stages of walking independently."

I note that A is a child of African heritage which he shares with his foster father.

14 A number of assessments and reports have been carried out throughout these proceedings and I want to look at them briefly. The mother does not challenge the medical evidence but I think it is important to set it out in this short judgment, at least in outline.

15 Dr. Richard Taylor is a Consultant Forensic Psychiatrist, and was the mother's treating psychiatrist at the Cygnet Hospital. He has provided reports dated 9th September 2013, and answered further questions on 18th September, and also provided reports on 18th and 20th November 2013. In his first report of 9th September he confirms his diagnosis of schizophrenia. He reported that the mother responded to medication in hospital. He considered that she had limited insight into her illness and its effects on her and noted that she had stopped taking medication whilst in the community in the past. His prognosis was that her mental state would be stable whilst on medication but there was a risk of relapse if she did not comply with her treatment or if she used illicit substances. In reply to questions on 18th September he said in his view that the mother needed in-patient low-secure rehabilitation under s.37 of the Mental Health Act for another six to twelve months. In his report of 18th November he updated the history following the mother's return to hospital after she had given birth to A. He was still of the view that it was unlikely she would comply with medication because, although she said she would take it, she did not believe then that she needed it, and she did not accept the descriptions of her behaviour which others gave her behaviour with she was unwell. Following that she was further detained under s.3 of the Mental Health Act and subsequently discharged by the managers.

16 Dr. Lucja Kolkeiwicz, is a Consultant Forensic Rehabilitation Psychiatrist, who provided reports dated 13th December 2013, 21st March 2014, and 14th August

2014. When she saw the mother on 23rd November 2013, the mother said that she would willingly take medication for as long as necessary, and Dr. Kolkeiwicz formed the view that she had partial insight into her past mental health problems. She agreed the diagnosis, she noted that the mother had made a very good response to medication and when she saw her, her positive symptoms had remitted and the negative symptoms of schizophrenia were minimal. She said:

> "If the mother could maintain her current level of mental health by co-operating with the psychiatric treatment team and taking her medication, then the impact on her ability to care for a child will be minimal." [E91]

She put the risk of relapse, if the mother did not take her medication, at 18 per cent. She recommended that the mother should undertake a course of 10 to 20 sessions of cognitive behavioural therapy to address her attitude towards medication and to develop an early warning system for anticipating her relapses. She said that the mother would benefit from supported accommodation and her current insight was superficial.

17 In her addendum report of 21st March 2014 Dr Kolkiewicz noted that the mother said that things were looking up. She had remained in remission in response to treatment and she said that the prognosis was good if the mother could engage with her community care plan, but she was likely to require psychiatric rehabilitation support for 12 to 18 months.

18 Mr. Peter Townley is an independent social worker, who was instructed to provide a parenting assessment of the mother and reported on 10th March 2014. His view was that the mother's insight was developing, she had some understanding of her mental illness, but she also lacked a depth in her understanding of her current situation and she seriously underestimated the difficulties for her of functioning independently, let alone looking after a child.

[E144 paras. 22- 23] He was concerned as to whether and, if so, how quickly the mother would recognise changes in herself which indicated a deterioration in her health and whether she would seek help immediately. He noted that the mental health professionals spoke of a lengthy process of rehabilitation with support and guidance and said it was hard to see how A's needs fit with the mother's circumstances. [E146] He was surprised, indeed, he said "perplexed" that CBT, which had been recommended by two psychiatrists, was not part of the mother's care package following her meeting with psychologist, Emma Williams. I will revert to the subject of CBT later in this judgment.

19 Mr. Townley was asked whether he was aware of any provision that could cater for the mother with her mental health condition, and enable her to care for A on a medium to long term basis and said that he was not, apart from a foster placement which was not what he recommended. He said at para.47:

> "Having carried out my assessment my view is that the mother is doing very well. She appears to be motivated, engaging with services provided and complying with her medication. It is however still very soon since she left hospital, just 12 weeks. Her mental health history is serious and goes back to 2009 and as recently as November 2013 the mother did not accept that the index offence was related to mental health problems, nor did she believe she will need further contact with mental health services. She is not living independently and is likely to need to remain in a supported environment for quite some time. As mentioned, she is compliant with her medication but she has not yet reached the stage of self-medication, let alone shown herself able to do so over a lengthy period. This is not a criticism of the mother – I do not see that she could have done anything more than she is doing."

He said, and I think this is worth noting in particular:

> "It may be stating the obvious but if the mother had responded as she has

done and there was no child involved, I have no doubt that those professionals involved in her care and recovery would have very positive views about her progress."

He spoke as somebody who had worked recently as an approved mental health practitioner. He concluded:

"However when looking at the situation as an Independent social worker within these proceedings I also see A, a child whose needs, both immediate and long term, call for plans to be made and implemented."

At para. 48 he said that he was of the view that the potential costs for A, of the mother being given an opportunity to see whether looking after him would work, are too great.

"The uncertainties about the mother's continued recovery and the inevitable, at this stage, unknown answers as to whether she can remain compliant and motivated, along with whether she can demonstrate the ability to live independently with a stable life style and meet A's needs, seem to me to be too substantial. I say that, even though she has made and appears to continue to make good progress, but the unknowns, in my view, are so considerable that it is hard to see that A, as a six month old baby, should be put in such a position. In essence I consider the timescales for the mother's recovery and for that to be satisfactorily demonstrated, and for A to have the stability and security he needs are sadly not compatible."

20 There have been a number of developments in the course of this year. When the mother left Cygnet Hospital in December 2013 she went to live in supported accommodation run by Dana Care in Golders Green. She had the support both of staff and of Miss Chisenga, an approved mental health practitioner and social worker, who was and remains her care co-ordinator.

21 At the end of March there was concern that the mother missed some of her antipsychotic medication which she was taking in the evenings. There is a detailed report from Miss Chisenga, which sets out the events over a period of some four days between 27th and 31st March from which it appears that the mother missed at least one lot of evening antipsychotic medication. On 31st March she also attended an outpatient appointment at the Dennis Scott Unit at Edgeware Hospital, where she did not engage very well and left early, and a referral was made to the Crisis Resolution and Home Treatment Team.

22 The mother was having contact with A, as she had throughout the time since his birth, and there was an incident on 14th of April 2014 during contact, when she was considered to be over affectionate with A, attempting to breast feed him even though she had never breast fed him. She was said to lose focus and zone out. As a result contact was suspended. There was a contact review meeting on 7th May and contact then resumed, three times a week for one and a half hours each time. There were no concerns until a contact on 15th May when it was reported that when A pulled his mother's hair she pulled his hair. She shouted at him, screamed in his face, put her finger in his ear, held him roughly and shook him. Her comments were described as random and nonsensical. As a result A was reported to become distressed, he was crying and his mother did not comfort him. She also threw him in the air and, according to the contact supervisor, called him 'Matilda', although I note that the mother said in her most recent witness statement, that she was calling him 'Mimo'. After that contact she assaulted a member of staff at her supported accommodation.

23 On 19th May the mother was detained under s.2 of the Mental Health Act 1983 for four weeks, and there is a report that while she was in hospital she assaulted a nurse. Her application to a Mental Health Review Tribunal was heard on 28th

May and refused. She was discharged on 13th June 2014. She requested that contact resume. There was a contact review meeting on 18th June when Miss Chisenga advised that it was too soon to restart contact and the Local Authority should obtain an opinion from a psychiatrist. Contact was therefore suspended pending a risk assessment, and finally on 18th July a report was obtained from Dr. Acosta- Armas who said that if contact took place it should be closely monitored and supervised over a long period of time while the mother continued to comply with treatment, and both her engagement with and her abstinence from illicit drugs should be tested further. In his opinion the mother was likely to act violently again in the future and he advised that if she became ill again she should be given depot medication.

24 There was a contact review meeting on 7th August, and contact was reinstated on 14th August, and so at the time of this final hearing there has been only one contact, but that went well and gave rise to no concerns.

25 As a result of these developments both Mr. Townley and Dr. Kolkeiwicz were asked to provide addendum reports. Mr. Townley's report is dated 9th August 2014, he noted that the mother's situation and circumstances did not suggest that she is in a better position to demonstrate that she can safely and appropriately care for A than had been the case when he had reported previously. Dr. Kolkeiwicz's report is dated 14th August. She noted that the mother had relapsed. At p. 3 of her report she said:

> "In my opinion, the mother's level of insight into her mental health difficulties is fluctuating with periods of good insight and periods of limited insight resulting in fluctuating concordance with treatment, and frequent relapses associated with violent behaviour resulting in paranoid beliefs."

She said at p.4 para (b):

> "In my opinion the mother's recent relapse is an indication of the fragility of her mental state, despite the provision of staff support to ensure concordance with the antipsychotic medication she is prescribed at the maximum recommended dose, and despite the support she is receiving from her mental health team, and the staff at the supported accommodation."

She said that the mother was able to describe her relapse signature to the clinical psychologist, Dr. Williams, who had reported in March 2014. Dr. Kolkeiwicz was concerned that just two weeks later the mother refused a urine drugs screen, and was unable to identify the relapse before it resulted in inappropriate behaviour towards her son A, physical violence towards a member of staff at her unsupported housing and towards members of ward staff, and re-detention under the Mental Health Act. She noted that the relapses are short-lived, and the positive symptoms of schizophrenia make a good response to antipsychotic treatment, and that the mother's insight into the importance of complying with treatment improves as her mental state improves. On p.5 she said:

> "The mother is currently unable to care for her child or for herself independently. Even with an optimal therapeutic response to full engagement with her current care plan, including continued concordance with antipsychotic medication, continued abstinence from illicit substance use and continued engagement with staff interventions at the supported accommodation and engagement with the WRAP Group ----"

- that is the Wellness and Recovery Action Planning Group a group to which the mother has recently been referred:

> "-- in my opinion The mother is unlikely to be able to care for her child for the next 18 month period, and during that period she would need to

remain medication compliant, and motivated."

26 I referred earlier in my judgment to the psychologists. Dr. Williams reported on 18th March 2014 and did not recommend the mother for a course of CBT because she could not identify any negative thoughts or behaviours which the mother wanted to change and therefore found that CBT was not appropriate. The Local Authority therefore obtained a further report from Dr. Rachel Gibson-Dunt, who is a highly specialised clinical psychologist. She assessed the mother on 30th July 2014 for the purposes of CBT treatment, and agreed with Dr. Williams. She said that the mother did not present with distressing symptoms of psychosis or unhelpful beliefs, and she was able to give a coherent account of her psychotic experiences. She recommended that the mother be assessed for the network's WRAP Group.

27 Turning then to the Local Authority's final care plan for A. On 24th March 2014 A's foster carers put themselves forward as prospective adopters. Their assessment was successfully completed on 18th June, and I understand that on 21st September the Local Authority will take their case to the Agency Panel for approval and for matching with A. The Local Authority hopes that A will be placed with his concurrent foster carers, in other words he will remain with them, but he will be placed with them for adoption in September.

28 The Local Authority's proposals for contact between A and his mother are set out in their final care plan dated 18th August as amended. Given a recent change in date for the matching panel, there would be two contacts prior to that meeting on 21st September, and a 'wishing you well' contact thereafter, or monthly contact in the event that the proposed adopters are not approved by the Panel, which the Local Authority considers unlikely.

29 Post adoption the Local Authority proposes twice yearly letterbox contact

between A and his mother. The Local Authority believes that continuing direct contact is not in A's interest and is likely to undermine the stability of his placement in view of the fragility of the mother's health. In addition, the mother will be provided - and today at court has been provided - with information about the Adoption Plus service and, at my suggestion, also the name and contact details of a person she can speak to there.

30 Miss Claybrooks has prepared a detailed witness statement. The Local Authority bases its case on her observations, on the history of the mother's mental illness and on the various assessments and reports to which I have referred. I conclude that the mother cannot care for A now, or within the next 18 months, even if she remains well and engaged with her mental health treatment team, is compliant with medication and develops greater insight; that will not be within the timescales for an 11 month old baby, especially given how recently The mother was unwell.

31 Mr. Miller described the process of the deterioration of the mother's health, which causes particular concern: the onset is very rapid; as she becomes ill the mother loses insight into what is happening to her and she withdraws from co-operation with various support services, or isolates herself, so that the support services are unable to help her, but also unable to assess the situation, identify what is happening, and protect A if he were in her care.

32 I should mention that Mr. Jubril Lawson, who is the mother's father, put himself forward as an alternative permanent carer for A, but the viability assessment was negative. The then social worker, very early indeed - before proceedings were issued - had discussions with two of the mother's aunts, Mrs. Wummi Lawson and Miss Delana Lawson and they declined to be assessed as alternative carers for the baby.

33 The mother, as is very clear and is accepted by everyone involved in this case, loves A very much and wants the best for him. I note that she cared for A

immediately after his birth for the first four days of his life in a way which was reported to be appropriate, loving and caring. She has been very committed to having contact with A. While she was still a patient on Cygnet ward she had contact twice a week, subsequently it was increased to three times a week, and she has sought to resume contact as soon as possible on both occasions when it has been suspended. The quality of her contact with A, when she is well, is reported to be good, although I note that she could not always sustain the two hours which she was allowed, and contact was reduced to one and a half hours on each occasion, and also that it was the foster carer who provided A's needs in terms of food and snacks and nappies.

34 The mother's current circumstances are that since 8th July she has been living in supported accommodation in a small unit in Palmers Green. She tells me that she is compliant with her medication, she takes Olanzapine 20mg a day. She co-operates wither care co-ordinator, Miss Chisenga. She has joined a 'Rethink' group to which she was introduced by the mental health team, and she has attended at least one practical session which she found helpful. She is free of illicit drugs, and she has been accepted for a degree course at London Metropolitan University to study sociology and social policy, which she proposes to start at the end of September.

35 In preparing for this hearing the mother had to confront a lot of very difficult evidence, and I do not underestimate how hard that must have been for her. She decided that the threshold criteria were met. She did not challenge the medical evidence. She gave evidence in court calmly, clearly and with great dignity. She was able to concede in the course of her evidence that if she did not take her medication - and she does not accept that she has not taken it - but if she did not, she would become ill very quickly. Broadly, she accepted Dr. Kolkeiwicz's opinion that the time scale for her to be well and stable is 18 months and that it could be longer, before there could be any thought of the mother being placed with A, and she was able to accept that it was reasonable for the foster carers to be concerned about direct contact at present, and agreed that it should take place

when they think the time is right and when she is well. I found her to be an honest witness, who told the truth, and made concessions even though they were painful to her.

36 The mother wrote a letter to me, a very good letter, and the first thing she wanted to say, and I want to read this into the record is that she will: "sincerely be sad and heartbroken if her son A was put up for adoption as a result of her not being able to care for him". She talks about her insight growing as she is growing. She says that, in a way, her recent detention in hospital has been helpful. She said that it was not due to a relapse but what she described as a reaction on impulse, for which she apologises. Having been in hospital has increased her insight and she is grateful for the referral to the Rethink Group and the courses that she can attend there. She tells me that she is complying with her medication and she is not taking illicit drugs. She has told her care co-ordinator that she is willing to undergo drug screenings if it will assist, and she set out her plan to study at university, which she is looking forward to. Finally, she tells me that if she were given the opportunity to care for A she would work with the Local Authority social workers in every way needed and, she adds: "I do plan on having my own family at a later stage in life and just hope my history does not affect this". It is a very good letter, a very moving letter and I am grateful to the mother for writing to me. She also told me that if I do not return A to her care she will support his remaining with the foster carers and I accept that she would support that placement and that is generally accepted.

37 The guardian has prepared two reports and analysis on 8th October 2013, including a detailed risk analysis which I accept, and a combined final analysis report on 15th August 2014. The guardian notes positives in the mother and her contact with A. She says at para.18:

> "When her mental health has been stable, the mother has consistently attended contact with A and has demonstrated warmth and affection towards him. She has also demonstrated some good skills in terms of

feeding, changing and interacting with A. The mother undoubtedly loves A and it is encouraging that she is again making a good recovery from her recent period of mental health relapse and it would seem that her insight into her mental health is improving. These factors would undoubtedly serve to reduce the chances of further relapse."

38 The guardian was asked as, indeed, the social worker was asked: what more the mother could have done. Miss Claybrooks said “nothing”, but the guardian takes a different view and I think it is important to repeat what the guardian said in the hope that the mother will consider it, particularly because she told me in her letter that she plans to have a family at a later stage in her life. The guardian thinks that the mother could have accepted her medication by way of a depot injection and she could have agreed to drug testing at an earlier stage which might have alerted professionals to her relapse sooner. Also, the guardian said that if she had remained at Cygnet Hospital - and there was a plan for rehabilitation set out in Dr. Taylor's early report - she might now be more stable and she might have greater insight. She also noted many positives in the mother, as I have set out. Nevertheless, her concern is that the mother cannot meet A's needs either now or within any reasonable timescale for him.

39 I have considered all the options for A. The first option put forward by the mother is that A should return to her care with the support of the Local Authority under a supervision order. I have set out in some detail the history of the mother's mental illness, including her very recent relapse. I accept the views of Dr. Kolkeiwicz, Mr. Townley, Miss Claybrooks, and the guardian that the mother cannot care for A, the risks are too great, and that a supervision order would not provide the level of safeguard needed.

40 I have considered the possibility of mother and baby unit or a mother and baby foster placement. Placement in a mother and baby unit is generally for the purposes of assessment. I have referred to a number of assessments. I find that there is no gap in the evidence. The reports that I have seen advise that the

mother needs to be well, needs to be motivated, engaged and compliant for at least 18 months, and therefore there would be no way forward in the immediate future from an assessment which would be likely to take six or 12 weeks. The same applies to a mother and baby foster placement. I noted that the Local Authority previously tried to identify either a mother and baby unit, or a mother and baby foster placement which would take the mother and A, and were unable to do so.

41 I have to consider A's needs. The professionals advise, and I accept, that he needs to belong to a family, he needs permanence and stability. When the guardian was asked to consider whether there is really any great difference between a long term foster placement and placement under a special guardianship order on the one hand, or adoption on the other, she said that in practical terms for A there is no great difference, but the emotional difference is very great in terms of his being a member of the foster carer's family and not different from his peers.

42 I have considered the suggestion that I should make a care order and approve a plan only for long term foster care. That would not be a permanent placement and A would not be a member of the foster carer's family, even if they treated him as though he were a member of their family. I accept Miss Claybrooks' view that this could place a strain on the placement and possibly affect the foster carer's commitment, though I have to say they have been very committed throughout the time that A has been with them. Of course, a care order would involve social workers in the life of A and the foster carers, possibly until his majority.

43 As regards a placement under a special guardianship order, that would involve an adjournment while an assessment was carried out and a report prepared for the court. The guardian told me that she has considered this option, her objections to it are similar to her objections to a long term foster placement, namely that A would not become a child of the foster carers', he would remain the child of the mother, and that would not give him the same degree of permanence and security as adoption.

44 An adoption order is a draconian order in any circumstances because it severs the legal ties between a child and his natural parent, and the case law is very clear that an adoption order must only be made as a last resort and if nothing else will do. I note that A has been with his foster carers since he was four days old and has thrived in their care, and that if he is placed with them for adoption there will, in fact, be no move for him, he will simply remain in their care.

45 It seems to me, from what I have read, that the foster carers have been sympathetic to the mother and her plight, and I have noted that the mother, albeit as a last resort, does support A remaining in their care, and an adoptive placement would provide the permanence of stability of belonging to a family that A needs.

46 Turning to the question of contact, the Local Authority plan is for letterbox contact twice a year, but the mother seeks direct contact, although not at any great frequency. Earlier in the year it was reported that the foster carers were open to the possibility of direct contact between A and the mother, that was at a point when she was well and things were, as she said, 'looking up'. But since her health relapsed the foster carers have reconsidered, as they told the guardian as recently as last Friday, and the social worker yesterday. At present, they cannot agree to direct contact taking place now, and they do not want to be tied to a date for a review which, in the circumstances, does not seem to me to be an unreasonable approach. The guardian told me that she would support post-adoption contact if it would be positive for A, because it is beneficial for a child to grow up with an awareness of his identity, but where the mother is sometimes unstable then such contact would not be beneficial. The guardian advised that if the mother can remain well, without relapse, for a significant period of time and demonstrate that she has a stable lifestyle then she thinks that direct contact could be considered, and her view is that the foster carers would then be open to direct contact, although they have also said that they would be guided by the Local Authority.

47 Having considered all the options, and also various proposals put forward with

regard to direct post-adoption contact, sadly, I conclude that adoption is the only option which will safeguard A and provide for his needs. As regards contact, I make no order because I do not know now what order I could make. It would not be appropriate for me to order contact now; I do not know when contact would be appropriate. I accept this means that the mother may make an application in the future and I hope that when she considers doing so she will bear in mind the guardian's views about what she needs to demonstrate. I make a care order to the London Borough of Barnet and approve the amended final care plan, dated 18th August 2014.

48 I turn to the application for a placement order. I cannot make a placement order unless the mother consents, which she does not and I understand that she does not/cannot consent to such an order being made. In the circumstances the Local Authority asks me to dispense with her consent. The test is whether the welfare of A requires the mother's consent to be dispensed with. I have referred to the case law. In addition I note that the President has described this test in the case of *Re BS* as a "stringent and demanding" test. I also note that when considering such an application I have to consider what is a proportionate response to the situation and to A's needs? I have had regard to the welfare checklist and, in particular, I have to be concerned with A's welfare throughout his lifetime. Of the matters set out in s.1(4) of the Adoption and Children Act 2002 I note in particular subsection (c):

> "the likely effect on the child (throughout his life) of having ceased to be a member of the original family and become an adopted person."

and subsection (f): "the relationship which the child has with relatives …". Taking the second matter first, as I have indicated, apart from the maternal grandfather, who received a negative viability assessment, no other members of the family have come forward and I am not aware of any other members of the family having sought contact with A in the past few months.

49 I have set out the Local Authority's plan to place A with foster carers, and the plan for letterbox contact with his mother twice a year.

50 In making a care order I have found that the mother cannot safely parent A now, or in the longer term, and his welfare, throughout his life requires a permanent family through adoption. He is 11 months old and I consider that his placement with adopters should not be delayed. In all the circumstances I am satisfied that A's welfare requires me to dispense with the mother's consent, which I do, and I make a placement order in respect of him. In doing so, I have considered Article 8 of the European Convention on Human Rights, which enshrines the right to family life, and I note that the preservation of family life is an important aim of the Convention, but that the interests of the child prevail. I accept that the orders I have made constitute a gross interference in A's right to life with his natural family and in his mother's right to family life, but I am satisfied that in all the circumstances this interference is justified in law. It pursues a legitimate aim, which is A's welfare throughout his lifetime and it is proportionate to his needs.