A LOCAL AUTHORITY v A (NO 2) [2011] EWHC 590 (Fam)

Family Division

Ryder J

15 March 2011

Care proceedings – Expert evidence – 'Hot tubbing' – Benefits when dealing with multiple experts – Welfare of child in kinship placement – Relevance of acknowledgement of risk – Importance of ability to work with professionals

When the child was 7 months old, she was hospitalised with an apparent respiratory illness. Shortly before she was due to be discharged, she suffered a cardio-respiratory crisis while in the mother's care on the ward. The crisis left the child severely neurologically impaired; she was likely to be severely disabled for the rest of her life and her life expectancy had been significantly reduced. The judge found that the cause of the child's initial respiratory problem was unknown, and that this was probably a natural but unexplained event, but went on to find that the mother had subsequently smothered the child intentionally, possibly to avoid an imminent discharge from hospital. The child now required multi-disciplinary professional help with her care 24 hours a day; she was currently living in a specialist care unit in the hospital. Change unsettled her, and was likely to have a significant effect on her emotional welfare. The local authority's initial care plan was for the child to be placed with specialist foster parents or in a group home, whereas the guardian supported a placement with the maternal grandparents, who were the only family members actively seeking to care for the child. The maternal grandmother had almost daily contact with the child, with whom she had developed a secure attachment. The father, the maternal grandfather and the paternal grandparents also had very positive regular contact with the child; the mother had similarly positive contact with her, albeit supervised. It was agreed that regular contact with all family members should continue wherever the child was placed. It was accepted that the maternal grandparents had excellent parenting skills; however, the local authority was concerned about their failure to acknowledge the mother's role, and queried whether they would be able to work with the various professionals who would have to be involved in the child's future care. The court dealt with the expert evidence as to the suitability of a placement with the maternal grandparents by employing a device known as 'hot tubbing', which involved all three experts giving oral evidence together. The first step in the process was that the court derived an agenda of topics relevant to the key issues, to which counsel were asked to contribute; then the expert witnesses were sworn together and the court asked each witness the same questions under each topic, taking one topic at a time; the experts were then encouraged to add or explain his own or each other's evidence, so that a healthy discussion ensued, chaired by the court; finally, each advocate was permitted to examine or cross-examine, and, where appropriate, re-examine each witness after the court had elicited evidence on a topic. The evidence, which might have been expected to take 2 days of court time, was completed within 4 hours. The consensus arrived at by the experts was that the maternal grandparents would be able to meet the child's needs.

Held – making a care order on the basis of a care plan placing the child with the maternal grandparents, with contact to other family members –

(1) The maternal grandparents were capable of providing for the child's physical and emotional safety. It was important that the experts considered there was no likelihood that the maternal grandparents would invite the mother into their house or

offer her unsupervised contact, and that they would not breach boundaries with the mother so as to place the child at risk (see paras [30], [31]).

(2) On balance the maternal grandparents would be able to work with professionals, but they had to be clear that conflict with the professionals involved in the child's complex needs would cause the child significant harm from which she might never recover (see para [38]).

(3) The child already had primary attachments to the maternal grandparents, who could provide her with a degree of consistency and care that might not be available in a professional placement (see paras [40], [41]).

Per curiam: the use of the 'hot tubbing' device had resulted in a marked coherence of evidence and attention to the key issues (see para [23]).

Cases referred to in judgment

A Local Authority v A (No 1) [2010] EWHC 28 (Fam), [2011] 2 FLR 137, FD

Mary Lazarus for the local authority
Alexa Storey-Rea for the mother
Barbara Slomnicka for the father
Anna McKenna for the child

Cur adv vult

RYDER J:

[1] On 28 January 2010 judgment was handed down after a fact-finding hearing in care proceedings concerning a child, Baby X, who was born on 19 December 2007. Her mother is Ms A and her father is Mr B. The care proceedings were instituted by A Local Authority and Baby X is represented by a children's guardian.

[2] I do not propose to repeat the detailed findings I have made which are contained in that judgment reported as *A Local Authority v A (No 1)* [2010] EWHC 28 (Fam), [2011] 2 FLR 137. On the basis that the reader will have regard not just to the summary but also to the context and detail described in that judgment, it is sufficient to summarise the facts as follows:

(a) on 31 July 2008 Baby X suffered an apparent life threatening event (ALTE) when in the sole care of her mother. It is likely that this was a natural but unexplained event: an unexplained ALTE;

(b) in the early hours of 7 August 2008 Baby X suffered an hypoxic ischaemic encephalopathy which occurred as a consequence of a prolonged cardio respiratory arrest;

(c) the following propositions agreed by the medical experts relating to that incident and Baby X were accepted by the court:

  (i) she did not have a neurological disorder;
  (ii) she had no metabolic disorder and her organic acid tests were normal;
  (iii) her collapse on 7 August 2008 was not caused by an infection, including RSV infection or recurrent infections;
  (iv) she had no underlying immune deficiency and her low immunoglobulin levels were likely to be the consequence of her recent acute illness, not a predilection to infection;
  (v) she has no genetic chromosomal or mitochondrial

abnormality or disorder nor either of the two major autosomal disorders for which tests were conducted namely, reduced respiratory drive and cardiac ion channelopathies (which could cause serious or fatal cardiac arrhythmia);

(vi) there is no history to suggest she had cardiac arrhythmia and all other forms of cardiac disorder such as myocardial damage and congenital heart block have been excluded;

(vii) the length of the causative insult which was the cessation of oxygen delivery to the brain is likely to have been minutes rather than a brief event because of the hypoxic changes to the brain which can be observed.

(d) Baby X suffered a critical collapse which involved her not breathing for at least 2 or 3 minutes and likely 5 minutes or more;

(e) there was no evidence of toxin or bacteria and in particular transient bacterial toxins as a cause of her collapse;

(f) the evidence was not indicative of primary cardiac arrest but rather of upper airways obstruction and was inconsistent with reduced respiratory drive;

(g) there was no evidence of ineffective ventilation, ie poor resuscitation rather the contrary: bag and mask ventilation was effective;

(h) the mother's recollection of the events of the night in question was not accurate;

(i) Baby X's apnoea alarm was working effectively on the night in question and when the mother was woken by the sound of the alarm, there was then a delay of at least a couple of minutes before the alarm sounded again. That delay is accounted for by the mother switching off the alarm and then re-activating it at a time which was coincident with a dramatic decline in Baby X's condition. She did that to avoid detection;

(j) the mother caused the cardio respiratory arrest by intentional upper airways obstruction: she intended to and did smother her own child;

(k) the mother did not intend to smother her child to death;

(l) the mother has not acknowledged what she did or any responsibility for the serious consequences of her actions.

[3] It has been the father's position since well before the fact-finding hearing that Baby X's significant care needs are beyond him as a sole carer. I remarked in judgment at the conclusion of the fact-finding hearing that Mr B struck a poignantly sad and vulnerable figure. It is no criticism of him to say that he never sought responsibilities of the kind that he has had to face and that objectively he could not undertake the care of Baby X. His relationship with her is of the utmost importance to him and to Baby X and no one suggests that the court and the other parties should do other than protect and promote that relationship so that Baby X's welfare might be safeguarded. Despite this, he has a propensity for violence and a history of drug abuse with

custodial consequences. Although Mr B will co-operate, an assessment would be needed if it is suggested that his contact should develop in any significant way.

[4] At one remove the same can be said of Mr B's parents, the paternal grandparents as respects their overall position. At an earlier stage they withdrew from the possibility of seeking to care for Baby X themselves for very understandable reasons. Their relationship with Baby X is, like their son's, of considerable importance. There must be no diminution in their contact or any lessening of the importance that should be attached to their relationship and that of a paternal link and extended family for Baby X.

[5] The paternal family have been excellently represented through counsel for the father who has striven, very properly and with considerable eloquence to ensure that the evidence in the case has been scrutinised and the paternal position put with clarity and appropriate feeling. They can never accept what happened and they should never be expected to do so. The only meeting of minds there could ever be would be in a mutual recognition of and respect for all of those who bring their love and skills to bear in giving Baby X as high a standard of care as is possible. I do not ask them to understand how this might be possible in the same family as the perpetrator of the harm but I do ask them to consider, and I hope eventually accept, that Ms A's parents are capable of providing the care that Baby X needs.

[6] Ms A remains an inscrutable mask. She does not accept the court's judgment on the facts, she does not acknowledge her responsibility but equally she has not subjected the paternal family and her own parents to the indignity of an adversarial dispute about Baby X's care. At this hearing she has accepted the almost inevitable consequence of the court's findings and has not sought to put a positive case that she should care for Baby X. She seeks contact, which for the same reasons as that afforded to Mr B and his parents is of the utmost importance to her and to Baby X, but she has not sought to argue that there should be any consequence other than a care order to safeguard Baby X and she accepts the protections around her own contact which are sought by the local authority. Ms A has been diagnosed by Dr Bass as having 'some characteristics of a person with emotionally unstable personality disorder (borderline type) as well as evidence of antisocial personality traits'. All the experts agree Ms A poses a serious physical risk to Baby X's future safety. The guardian summarises the evidence relating to her in a way with which I agree:

> 'Ms A's fragile emotional and mental health, associated with unresolved grief and loss issues and sexual abuse is likely to compromise her capacity to meet Baby X's emotional needs at all times.
>
> - It is likely Ms A will require sustained psychological treatment to address these "unresolved" problems.
> - The nature of Ms A's past volatile and emotionally charged intimate relationships and the risks posed to Baby X through Ms A's inability to separate from an abusive partner such as Mr B.
> - Ms A's inability to provide Baby X with a safe and secure environment is which to live.

- Ms A's reluctance on occasion to meaningfully and openly work with professionals

The above factors are clear contra-indications of Ms A's capacity to safely care for her daughter at this time.'

[7] The issue which remains is who should care for Baby X? No-one questions the need for the local authority's continuing involvement both as the agency which can co-ordinate the many and various facets of Baby X's care and which will have to hold the ring between the maternal and paternal families and be the ultimate arbiter of whether Baby X as a very vulnerable young girl is adequately protected. The threshold was found proved by the court. Neither the paternal family nor Baby X's mother seek day-to-day care. The question which remains is whether Baby X should be cared for by her maternal grandparents or by foster carers selected and approved by the local authority under the auspices of a care order. Although the court was asked to indicate a view, it is now common ground that in either circumstance contact orders should be made to protect and promote the contact positions I have described.

[8] Mr JA and Mrs SA, the maternal grandparents, were made parties to these proceedings after the fact-finding hearing. They are un-represented but have proved more than adequate to the task of presenting their own position. With all the professional determination and skill of their employments which I am sure are a reflection of their inner capabilities, they have explained, argued and doggedly pursued their very firm belief that Baby X's welfare would be best safeguarded by care within the family, ie by themselves. They have not sought to excuse or explain their daughter, indeed they do not strictly acknowledge what she did. In contrast, they bring their own risk assessment skills to the table and argue that they are a match for the theoretical risks described by the experts which they are prepared to accept and which they have no doubt they are able to guard against. In doing so they have argued with social care professionals and have run the risk that their controlled and controlling personalities will be viewed as too dogmatic for the task, too inflexible to be able to work with professionals and the paternal family. It is these issues with which the court has been concerned in this hearing.

[9] A very great deal of evidence has been filed by way of welfare assessment material relating to Baby X, Ms A and Mr JA and Mrs SA. That relating to Baby X is not and never has been in question and I shall describe it very briefly to set the context, which is that no one says other than that Mr JA and Mrs SA have excellent parenting skills which are more than adequate to provide for Baby X's special needs involving her health care needs and emotional nurture.

[10] I need not dwell any further on the assessments of Ms A in the circumstance that she does not put herself forward as a carer. She will not have contact with Baby X which is not supervised (ie she will not be left alone with Baby X) and any development from that situation would have to be justified by reference to expert advice which if not agreed by Baby X's primary carers and contact relatives, ie the paternal family, would have to return to this court for determination.

[11] Baby X is now 3 years old. She is described as a child of mixed race: Anglo-Indian/British. She presently lives at a specialist care unit, Hospital

Services B Enhanced Care Service, where she moved from Hospital Services D Head Injury Unit in May 2010. She has almost daily contact with her maternal grandmother with whom she has developed a secure attachment. She has very positive contact with her mother, father, maternal grandfather and paternal grandparents and all agree that the regularity of that contact should be preserved.

[12] She is very severely disabled as a consequence of the upper airways obstruction to which she was subjected and the cardio respiratory arrest which followed. She has a permanent brain injury. She is a very vulnerable and totally dependent child who needs carers who can promote and safeguard her physical and emotional safety in every respect: she will never be able to protect herself. She now needs the security, stability and loving environment of a primary carer rather than the expert inter disciplinary care provided by an institution, no matter how good. Research clearly indicates that for Baby X to achieve any of the outcomes desired for a child she and her carers will have to surmount additional barriers caused by the complexity of her needs, the requirement for inter-related and co-ordinated service provision and the requirement that more than most Baby X will need very stable and predictable, committed care which is stimulating, positively child centred, replete with opportunities but more than anything else intensely nurturing.

[13] Baby X has already demonstrated in her behaviours that she is unsettled by change and that change is likely to have a significant, enduring effect upon her emotional welfare. She now requires increased support to promote positive attachment behaviours and experiences. Her susceptibility to stress appears to be more pronounced. The impact of the trauma upon her is likely to have profoundly affected her capacity to deal with anxiety, fear, frustration and unpredictability. Just one example of this is the Triangle assessment opinion, which I accept, that 'Baby X needs to be held on a regular basis throughout the day, in order to support her emotional regulation and sense of safety and existence'. The impact of good primary care is well demonstrated by this extract from the Triangle assessment report:

> 'When maternal grandmother picked up Baby X we saw Baby X reach with her left hand towards maternal grandmother's face. She turned her head into her neck. And her body extended in relaxation. Baby X's sucking movements reduced. She was more relaxed facially, especially around (the) brow area. She exhibited increased eye movements. Most distinctly, her breathing became quieter, slower and less laboured. She appeared to be breathing in concert with maternal grandmother's breathing and be eased by maternal grandmother's relaxed affect.'

[14] The local authority plan for Baby X has developed over time and in response to very different expert opinions. From identifying her need for a primary carer to highlighting her acute safety needs and finally to presenting the alternative final care plans of long-term specialist care or placement with Mr JA and Mrs SA. The issues are and have been finely balanced and no criticism attaches to the local authority for their careful appraisal and re-appraisal of the options. Before the final evidence was tested in this hearing they preferred a specialist placement of full-time foster care or a small group home and after the oral evidence of the experts had been heard and I had been

invited to make observations thereon, they preferred a placement with Mr JA and Mrs SA in line with the advice of those experts.

[15] For some while now Baby X's guardian has carefully investigated and analysed the options. It was in the circumstance of an expert consensus that she opposed a plan for specialist foster/group home care and supported a placement with Mr JA and Mrs SA, albeit that she was requesting careful investigation of the latter option before this expert consensus emerged. In essence, I agree with her and for the reasons she gives which I will elaborate upon in due course.

[16] Ms A supports her parents wish to care for Baby X. Mr B and his parents have very properly highlighted all of the arguments but in their opposition they have chosen not to give evidence and to abide by the decision of the court provided their contact is secured, which by common consent it will be. In essence, although the nuances are important, their opposition is formal rather than adversarial.

[17] The key issues are described by Dr Bentovim, consultant psychiatrist, in a report of 23 November 2010 and by Dr Craissati, chartered forensic clinical psychologist, in a report of 19 November 2010. Dr Bentovim said:

> 'In my view the issue concerning the capacity of Mr JA and Mrs SA to provide the quality of care that Baby X requires is not in their skills to respond to her day to day needs, not in their capacity to maintain boundaries with their daughter, but in the developing relationship with the complex set of professionals who may have a particular role in terms of protection, provision of services, financial support, supervision training of other staff. There is a potential for disagreements and conflicts which in turn could have a destabilising effect on provision of Baby X's care. The major need here is to look at factors associated with a positive outcome in such a high risk situation, the capacity of the parents to work together constructively with the local authority is an absolutely key role. My concern is that that process has not been achieved satisfactorily and misunderstandings, conflicts and differences continue.'

[18] He continues:

> 'Other areas of potential conflict if Baby X was in the maternal grandparents care are whether issues of contact with paternal grandparents can be satisfactorily maintained. The paternal grandparents have made a significant commitment within their capacities and the regular contact with all members of the family who have a caring, loving and capacity to provide affection, warmth and consistency for Baby X is in her interests. Given the significant suspicion and unhappiness of the relationships between the grandparents, any issues of contact and arrangements would need to be made via a third party. The scope for conflict and disagreement is considerable unless there was a very significant shift in position.'

[19] Dr Craissati is of the opinion that the question of Baby X's safety is not dependent on Mr JA and Mrs SA's attitude towards the culpability of their daughter. Absent significant change in respect of Ms A herself the risk remains. She says that:

> 'insight or acceptance does not necessarily result in compliance and reduced risk … the assessment of likely compliance is based on factors other than an acceptance of (the) Findings of Fact.'

[20] Dr Bass, consultant psychiatrist, identified the two issues in this way:

> 'Their inability to acknowledge that Ms A has caused harm to Baby X (although this appears to have been modified in the last few months)'

and

> 'The continued tension between the grandparents and the local authority. This may impact in a negative way on the subsequent care of Baby X.'

[21] In analysing the two key issues I remind myself of three matters:

(a) the fact that it has already been decided that the risk of harm against which the court is seeking to safeguard Baby X's welfare is in the context of a smothering which the mother did not intend would cause the death of her child;
(b) the prevailing and conventional social care expert evidence which was, until psychiatric and psychological assistance was commissioned by the court, that the physical and emotional danger implicit in the facts found by the court could not be addressed without an acknowledgement of culpability by the mother and/or by the maternal grandparents with respect to their daughter. This was most clearly encapsulated by the independent social worker Ms Carrie Waldron who said that 'their failure to understand the level of risk does compromise their ability to maintain a safe context of care'; and
(c) Mr JA and Mrs SA are innocent of all involvement in the circumstances that led to their granddaughter being harmed. Furthermore, no one has articulated a case that the significant problems from which Ms A suffers are of a nature or extent that as carers their capabilities should be questioned. Quite the contrary, their parenting skills are regarded as being of a high order.

[22] The three experts commissioned to analyse the key issues were heard in oral evidence by the court. Not for the first time this court was very greatly assisted by hearing their evidence concurrently. A device unfortunately and colloquially known as 'hot tubbing' was used with the agreement of all parties. This process has been tested in America and Australia but not in this jurisdiction. Out of the experts' reports and discussions the court derived an

agenda of topics which were relevant to the key issues and to which counsel were asked to contribute. The witnesses were sworn together and the court asked each witness the same questions under each topic, taking a topic at a time. The experts were encouraged to add or explain their own or another's evidence so that a healthy discussion ensued, chaired by the court. Each advocate was permitted to examine or cross-examine and where appropriate re-examine each witness after the court has elicited evidence on a topic.

[23] The resulting coherence of evidence and attention to the key issues rather than adversarial point scoring is marked. The evidence of experts who might have been expected to fill 2 days of court time was completed within 4 hours. The evidence can conveniently be described under themes into which I have interpolated some of the written evidence which was not disputed in cross-examination.

Parenting skills

[24] As to this factor, there was no disagreement with the prevailing social care evidence that Mr JA and Mrs SA have the parenting skills to manage Baby X's day-to-day care and special needs. They have the practical and emotional capabilities to safeguard her welfare.

Physical and emotional safety

[25] The experts analysis of this factor, ie their assessment of the risk of harm is in part dependent on a developing understanding on the part of Mr JA and Mrs SA who now say that they 'acknowledge the findings and the risk Ms A poses' and 'we are fully aware of the risk posed to Baby X by her mother'. That is not the same as them saying that they agree with the findings but it is a helpful development in their understanding.

[26] Dr Bentovim described them as being at the beginning of their understanding, ie still a way to climb. His clear evidence was that risk is dependent on the issue which led to harm which is the extreme ambivalence of Ms A towards her own daughter. If Mr JA and Mrs SA were to break their contract with the court, ie to go backwards in their perception and understanding by trusting their daughter without objective good reason that would present a physical risk. The best protection is in the fullest understanding. He agreed with Dr Craissati that acknowledgement is not the key issue in a case where, sadly, Baby X's capabilities are such that she will thrive off their emotional warmth and attachments but be oblivious to their understanding and language save and unless that overspills into disagreements and tensions which directly affect her care.

[27] Both Dr Bass and Dr Bentovim would want to see the protective force of a care agency as an external control to the intellectual and emotional understanding of the paternal grandparents and any shift in their trust in Ms A.

[28] Dr Craissati wanted clarification of the present position of their understanding to which I have referred, but was very clear and helpful in articulating the point that in any event the risk remains – that is inherent in the facts (and by implication the perpetrator). She stated that the acknowledgement question is frequently used by professionals for understandable and common sense reasons but addressing a risk is dependent on intellectual and emotional understanding which is a process which comes with time. She said that it is inevitable that Mr JA and Mrs SA are on the

foothills of that process. She felt that a healthy ambivalence by Mr JA and Mrs SA towards their own daughter would be more protective than any pressure upon them to accept culpability on her part. In essence, she said, research has shown that acknowledgement can be a red herring: words are used that do not alter risky behaviours. There is a need to re-visit understanding and trust from time to time to prevent complacency and that is the function of the local authority.

[29] Dr Bass agreed in principle but emphasised the need for vigilance in relation to contact for the perpetrator in a kinship placement. He re-iterated the need for an alliance with Mr JA and Mrs SA. If animosity is engendered with professional agencies or for that matter the paternal family that will not only directly harm Baby X it will damage the protective alliance.

[30] The experts advised 'real collaboration in the face of real ambivalence'. They agreed there was no likelihood of Mr JA and Mrs SA inviting the mother into their house or offering unsupervised contact. They also were of the opinion that Mr JA and Mrs SA will not breach boundaries with their daughter and place Baby X at risk. That is important because the trigger for Ms A's actions remains unknown. Dr Bass reminded the court not only is the aetiology unknown, her motives are difficult to discern and the therapy she would need to become less of a risk and more protective of her child is as yet untried and untested. Her background as reported by her can be given little credence and such objective evidence as there is about her and her care as a child does not give rise to significant concern in respect of Mr JA and Mrs SA's capability to care for and protect Baby X.

[31] In summary, therefore, having heard and accepted the broad experts' consensus I agree with the guardian that Mr JA and Mrs SA are capable of providing for Baby X's physical and emotional safety.

Relationships with the local authority and the paternal family

[32] Dr Craissati highlighted the question whether the more important key issue in this case was the capability of Mr JA and Mrs SA to form relationships for the benefit of Baby X. Collaboration is necessary not just with the local authority but also with the paternal family who are part of Baby X's protective and emotional environment.

[33] There is evidence before the court of Mr JA and Mrs SA being resistant to advice and instructions given by the local authority. One classic example, now resolved, is their inability to come to a contact agreement with the local authority relating to their daughter because there were errors in the narrative even though the principles should have been readily capable of acceptance and have indeed formed the basis of an agreement now entered into. Dr Bentovim was able to helpfully identify the conflict engendered in them by being both an advocate for Baby X and not agreeing that her interests have always been correctly provided for by the teams who must work together. He remains doubtful that these conflicts will always work out unless Mr JA and Mrs SA feel they have link workers to whom they can go for help. Again, however, the process is developing and there appears to be an understanding that conflict will harm Baby X.

[34] Dr Craissati emphasises that there is a personality style (one I have described in the preamble to this judgment) which is questioning rather than unco-operative and oppositional. Mr JA and Mrs SA are educated risk

assessors who need to be able to rationally discuss the issues which arise. That is in contrast to a parent whose psychopathology engenders conflict. Having said this, children with the level of disability which Baby X possesses need highly structured professional co-operation. Dr Bass said he would feel more sanguine if Mr JA and Mrs SA displayed more openly their understanding of the complexity of the provision which will be needed for Baby X.

[35] Dr Craissati summarised the hesitance of the experts by saying that on balance she would be surprised if the professional relationships did not resolve after this hearing and Dr Bentovim, in agreeing, predicted that there would be a parallel relaxation in the anxiety of the local authority.

[36] All three experts agreed that Mr JA and Mrs SA would preserve and work with the protected contact for the paternal family.

[37] The guardian agrees and points out that placement outside the family would provide an equivalent if not greater opportunity for conflict which would be harmful for Baby X. She believes the mediation opportunity which is engaged will also be helpful.

[38] On balance and it is a very fine balance I have come to the conclusion that Mr JA and Mrs SA are capable of working with professionals for the benefit of Baby X. They must be clear that a significant breach of the necessary alliance between them and the professionals involved in Baby X's complex needs will cause significant harm to Baby X from which she would as likely as not never recover. A great deal of trust is being placed in them and they must never forget that.

[39] In resolving the two key issues on the evidence in favour of Mr JA and Mrs SA, it is still necessary to work out the merits and de-merits of the two options for Baby X's long-term care.

[40] Baby X needs primary attachment figures and would be harmed by any care regime which included change and inconsistency. Her caring adults should be the same people not a sequence of well-trained professionals. Whereas Mr JA and Mrs SA can provide Baby X with that consistency and care, a professional placement would be subject to the vagaries of impermanence. The local authority might be lucky in identifying people who remain consistent in Baby X's life and who have the skills of Mr JA and Mrs SA and a co-operative attitude to inter-disciplinary care. They might not.

[41] It is not just that the alternative to Mr JA and Mrs SA has to be at least as good, it is, as the guardian has set out in some detail, that Baby X already has primary attachments to her family of origin. She already feels safe and experiences consistent and beneficial care in their company. She is extremely sensitive to change not least because the quality of human responses to her provide her key motivation.

[42] The agreed evidence of Dr Bass and Dr Bentovim is that a change of the magnitude proposed by a foster care placement could be very detrimental to her. If the key issues are resolved in Mr JA and Mrs SA's favour then the benefits of a kinship placement overwhelm its detriments and the theoretical benefits of foster care or specialist care.

[43] In all the circumstances, I agree with the guardian that it is proportionate, necessary and in the best interests of Baby X for a care order to be made and I approve the local authority's plan to place Baby X with Mr JA and Mrs SA, her maternal grandparents.

[44] I have suggested that a detailed contact plan is agreed between the parties so that there can be no misunderstanding about the relationships that need to be preserved for Baby X's benefit.

[45] I shall direct that this judgment and certain identified documents be provided to the placement panel which is asked to recommend the placement to the agency decision-maker and to any complex needs panel which may hereafter consider Baby X's needs.

[46] Although I have identified the paternal representatives for my thanks in the circumstance that the father and his parents felt unable to be present for the final hearing, I wish to extend my thanks to all of the advocates, legal teams and professionals who have contributed to this case. The impeccable standards of probity, case management co-operation and professional skill and experience have been notable. I am particularly grateful to all counsel and to the guardian.

Order accordingly.

Solicitors: *A local authority solicitor*
B & Co for the first respondent
R for the second respondent
H for the third respondent

PHILIPPA JOHNSON
Law Reporter