Case No: ZW17C00591

IN THE FAMILY COURT AT WEST LONDON

West London Family Court,
Gloucester House, 4 Dukes Green Avenue
Feltham, TW14 0LR

Date: 05/04/2019

Before :

HIS HONOUR JUDGE WILLANS

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Between :

THE LONDON BOROUGH OF BRENT — **Applicant**

- and –

(1) The Mother
(2) A (by his Guardian Ms Della Jackson) — **Respondents**

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Ms Stephanie Hine (instructed by **Brent Legal Services**) for the **Applicant**
Ms Frances Orchover (instructed by **TV Edwards Solicitors**) for the **First Respondent**
Mr Henry Lamb (instructed by **Duncan Lewis Solicitors**) for the **Second Respondent**

Hearing dates: 2-5 April 2019

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JUDGMENT

His Honour Judge Willans

Introduction

1. My concern is child A who was born on 1 June 2010 and is approaching 9 years of age. The Local Authority seek a final care order with a plan of long term foster care. The child's mother, M, and his Guardian, G argue for the making of a supervision order with G arguing that were I minded to make a care order then there should be an active plan for rehabilitation.

2. In reaching my decision I have considered the papers contained within the final hearing bundle; the live evidence of PB (Consultant Psychologist); BK (previous social worker); FS (allocated social worker); M, and; G; and the submissions made for counsel for all parties.

3. This judgment summarises the evidence in the case and focuses on those parts most relevant to my decision making. I have though borne in mind all the evidence in reaching my decision.

Background

4. This case commenced on 30 November 2017 and is now in <u>week 70</u>. This delay is deeply regrettable not simply because it is far outside the required 26-week period but more so because of the undoubted impact upon a young boy whose life has been put on hold whilst serious decisions are made about his future.

5. I do not intend to spend significant time explaining the causes of the delay but it certainly includes (in no particular order):

   i) Delay whilst overseas kinship placement was considered with family members on both maternal and paternal sides of the family. Ultimately despite significant effort this has not led to a realistic option for A.

   ii) M's incarceration between December 2017 and March 2018 for an assault upon A's father

   iii) The death of A's father in the days preceding an intended final hearing in September 2018 (unrelated to (ii) above).

6. I took over management of this case for the final hearing referred to above. Since that date I have retained case management up to this final hearing.

7. The parents derive from the the East European States of A and B. They met in 2005, came to the UK in that year and were married in 2008 before A's birth in 2010.

8. There is longstanding child services involvement with the family as set out in the social work chronology [C7-C13] with a consistent concern around alcohol consumption with resultant neglect. In April 2011 child protection procedure commenced when A was found in the care of M in '*unsuitable filthy conditions'* following her report of the father being drunk and her presenting as drunk on

police arrival. This process terminated in November 2011 after a period of sustained engagement and insight by the parents.

9. In February 2015 A's school expressed concerns around M presenting intoxicated and A was taken into police care. Care proceedings commenced and A was returned home to his parents with his father as primary carer. These proceedings concluded in June 2015 with the making of a 12-month supervision order. BK was the social worker in these proceedings. At section H I have key documents from the proceedings including a psychiatric report on M [H1-8]; parenting assessment [H9-42] and final threshold [H45-6]. The threshold is based on concerns arising out of alcohol consumption. By October 2016 the case was closed to the Local Authority in the light of parental progress; good engagement and an absence of safeguarding concerns.

10. On 26 October 2017 police attended the family home on reports of the parents being intoxicated in the care of the child. A is reported to '*have left the family home and walked to a neighbour's pleading for help as his parents were drunk and asleep'* [G §4]. A was removed from his parents care and has remained in Local Authority care since this date. Shortly afterwards M assaulted the father [see further chronology at C58-61]. M was arrested and was remanded until sentencing in March 2018 when she was released. The chronology includes repeated issues surrounding the father's alcohol consumption over this period [see for example C59 (29.1.18); C60 (3.5.18) C92 (20.6.18) & (21.6.18)]. I also have regard to the updating chronology at [C107-9]. It is clear from the chronology the father was struggling with the idea of an international placement and was reported to have left the country in June 2018. On 8 September 2018 he was found dead at his property.

11. Having left prison in March 2018 the M sought to be assessed to care for A. It is reported she has been alcohol abstinent since this date. A negative parenting assessment was completed on 31 August 2018 [See E269 (May '18) and addendum E419 (Sept '18)]. Much of the subsequent period has involved the respective assessments of maternal and paternal family members.

12. Contact has continued between M and A and I have a substantial set of contact notes in section J. The Court has returned to the expert psychiatrist seeking updating evidence [E88 (Feb '18) and E437 (Nov '18)].

Legal Principles

13. The parties agree the applicable principles as follows:

    i) A's welfare is my paramount consideration. I am assisted by assessing this through the prism of the welfare checklist [section 1(3) Children Act 1989]

    ii) The making of a public law order requires the legal threshold to have been crossed [section 31(2) Children Act 1989]. This requires a finding of '*significant harm*' at the relevant date. This is not in dispute. The parties have agreed a threshold document [A67-8] which I accept as proving the threshold requirement.

iii) The crossing of the legal threshold sanctions the making of a public law order but does not require the same. The ultimate disposal requires a qualitative assessment under which the Court considers all the evidence; carries out a holistic balancing exercise comparing the realistic options; ensures welfare is maintained as the paramount consideration whilst ensuring the outcome is respectful of private family life by testing the outcome against the principles of proportionality, reasonableness, necessity and lawfulness.

14. Specifically, relevant to the issues in this case[1]:

i) A Court can require a Local Authority to provide either an alternative care plan or evidence in respect of support that might be relevant in circumstances in which the Court is not minded to approve the Local Authorities planning (§64 - 65);

ii) Once a full care order is made the role of the Court comes to an end (§71);

iii) The courts powers extend to making an order other than that asked for by a local authority. The process of deciding what order is necessary involves a value judgment about the proportionality of the State's intervention to meet the risk against which the court decides there is a need for protection (§80). It is the obligation of the Local Authority to make the Order that the Court has determined proportionate work

iv) One starts with the court's findings of fact and moves on to the value judgments that are the welfare evaluation. That evaluation is the court's not the local authority's, the guardian's or indeed any other parties. It is the function of the court to come to that value judgment. It is simply not open to a local authority within proceedings to decline to accept the court's evaluation of risk, no matter how much it may disagree with the same. Furthermore, it is that evaluation which will inform the proportionality of the response which the court decides is necessary (§80).

v) Where the care plan remains unclear in important respects then the litigation process should be duly considered and the Court may not be satisfied with the care plan in such circumstances. In such circumstances the Court may adjourn the matter for refinement of the care plan[2]

vi) There is a powerful quasi-inquisitorial aspect to the proceedings with the Court and the Local Authority having a shared objective to achieve a result in the best interests of the child. If a case is adjourned to permit a Local Authority to reconsider its care plan then it should do so. If after such a reconsideration the Local Authority is unchanged then the Court may have to decide whether or not to make a care order[3]. Where there is

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[1] § references are to Re W (Care Proceedings: Functions of Court and Local Authority) [2013] EWCA 1227 [W v Neath Port Talbot]

[2] Re CH (Care or Interim Care Order) [1998] 1 FLR 402

[3] Re S and W (Care Proceedings) [2007] EWCA Civ 232

no realistic alternative to the care plan proposed a final care, order should be made[4].

Discussion

15. I intend to investigate the key issues in the case by reference to the evidence received. I will in each case set out my analysis and conclusions.

Alcohol

16. This issue is at the heart of the case. The parties are in agreement that alcohol is a problematic issue for M and she has made it clear her intention is to remain abstinent. It is also agreed M has been able to maintain abstinence for significant periods. It is agreed M's historic drinking has been associated with neglect of A's care. The key question is as to the confidence one can have in M's stated intention to remain abstinent in the light of the prevailing history and evidence and the likely impact upon A were the Court to place A with M only for her to fail in her intentions.

17. The history is concerning. I have identified three episodes which came to the attention of the Local Authority in 2011; 2015, and 2017 and which led to A being placed into the care of the Local Authority. In addition to this M was candid in her evidence that her husband would binge on a bi-annual basis and she would join in to some extent (certainly in the period up to 2015). During such period's post-2010 A would be placed at risk. There is also evidence of binge drinking in June 2015 whilst visiting family in Europe.

18. The concerns are exacerbated by reference to the inability of M to moderate her behaviour or condition her behaviour in the knowledge that A had been previously removed as a result of such behaviour. This speaks as to either the level of urge or drive that led her to drink or a prioritisation of her needs over those of A.

19. A further factor of concern is the level of confidence bestowed in the M only for the same to be dashed by future actions. The chronology records a high level of engagement and insight post-crisis leading to the cessation of child protection procedures. In addition, there are significant periods of abstinence (in particular see period from around June 2015 to October 2017) only for M to return to drink.

20. There is a question as to whether M is alcoholic dependent (AD) or not. The Court appointed expert did not draw this conclusion in 2015 whereas an expert appointed in the criminal proceedings made the diagnosis of AD. On returning to the matter in November 2018 the Court expert expressed the view that M's presentation was consistent with AD. I am not persuaded a great deal turns on the dispute given M's stated intention to remain abstinent and given the Court appointed experts focus on abstinence. My understanding is that AD is indicative of an inability to have a 'healthy relationship' with alcohol, i.e. inconsistent with social drinking. In such circumstances any relationship with

[4] Re R (Care proceedings: Adjournment) [1998] 2 FLR 390

alcohol is prone to a deterioration into further dependence. I intend to approach this case by assessing M's stated intention to remain abstinent.

21. As noted above there is significant evidence of engagement on the part of the M together with indications as to insight and commitment to change. Such evidence can be found in the historical chronology and the papers contained within the previous proceedings. A clear example of the same is seen in the Addaction Report (May '15) [H43].

22. A similar pattern of evidence can be found within the current proceedings. There is consistent alcohol testing evidence, including SCRAM bracelet, demonstrating either abstinence or the absence of problematic drinking for the period March 2018 – March 2019. M gave evidence of abstinence throughout this period and was not challenged in such regard. I accept this evidence. In addition to this I have evidence [F67] from the Westminster Drugs Project (WDP) in respect of M's engagement between April – July 2018 in which it is said by the author that:

> *Over the time [M] and I worked together it became evident [M] gained a deep understanding in to the function alcohol played in her life…Through the implementation of counselling skills during our sessions [M] was able to look at, identify and work on destructive behaviour patterns, triggers, high-risk situations and out dated coping mechanisms. Once identified [M] was able to incorporate new more appropriate, practical and healthier ways to manage her life and her emotions…[M] has put relapse management strategies in place she can employ in any given situation. In my professional view [M] has taken both her recovery and treatment here with WDP seriously…During her time with WDP [M] has gone above and beyond what has been asked and expected from her…I am extremely encouraged by the way JS has and continues to embrace her sobriety and new life. It is with this I feel the likelihood of JS to slipping back in to destructive behaviour patterns and subsequent relapse negligible.*

23. I have had regard to the expert evidence in this regard. The expert provided an addendum in which she was asked as to questions of relapse [E444]. She identified both positive and negative prognostic indicators. I note these and also her reference to there being evidence of alcoholic co-dependence between M and her husband and reduction in risk associated with their relationship given his untimely death. She concludes:

> *[M] has the ability to achieve abstinence but the challenge is maintaining it. Abstinence of a year is indicative of change and I would suggest this is taken from time of release from prison. However, the maintenance stage lasts 5 years before an individual is in advanced recovery. The maintenance stage of abstinence requires ongoing plans, goals and consolidation, which [M] can address through continued attendance at AA, employment and development of a support network.*

24. Reflecting on the live evidence I consider it fair to observe that the evidence of the social workers relied on the history and the failure to maintain abstinence, despite promising signs, as the basis for the pessimistic conclusions drawn. In the case of BK, it was plain he had lost confidence in M given his earlier faith in her (as at 2015-16) subsequently undermined by her conduct in 2017. At one point he told me he was '*convinced she would not be able to do it*' and consequently did not consider support services that might allow A to be returned to M. FS was equally influenced by these background features. I formed the clear impression that there was in the circumstances little M could do to persuade either witness as to her capacity to remain abstinent. I felt they were each entitled to be highly cautious in approaching her position given the history but the evidence of the developing circumstances required a deeper and more sophisticated analysis of risk than simple reliance on history. This was lacking.

25. M gave clear and compelling evidence as to her progress in such regard. She is entitled to rely upon the good engagement and the evidence of abstinence but must accept this has been seen before and has ultimately followed by relapse. It is clear she is an articulate and intelligent individual who is interested in the underlying issues that surround her drinking. Having heard the evidence, I consider there really is little more she could have done in favour of her position short of rewriting history. Importantly she made three points as to what has now changed. I consider on the facts of the case it is relevant to ask what has changed. She told me (a) the attack on her husband had brought home to her the impact alcohol had upon her and the possibilities for the future were she to continue to drink; (b) her husband's death had ended a co-dependent relationship which had been central to points of crisis and relapse, and; (c) her imprisonment had been a deeply shocking and cathartic experience. Each of these factors are significant in nature and have the potential to impact on M. The second point is recognised by the expert as a 'positive' factor. Having heard her live evidence, I found M's evidence both credible and genuine. I accept she has been deeply affected by these recent events and I also agree the ending of her marriage is a factor worthy of real consideration. This makes the current position different to what came before and it would in my judgment be short-sighted not to at least reflect upon this feature when assessing risk.

26. I also heard from her evidence as to progress she has made in stress management. It was clear to me this reading has had a significant impact on M and she was able to explain her learning in a manner which left me in no doubt she had applied her mind conscientiously to the topic. It is striking that the death of the husband did not lead to a relapse on the part of M. It is further striking that the stresses of these ongoing proceeding with the associated uncertainty as to placement of A did not lead to relapse. In my judgment the levels of stress arising over the recent period are likely to be set at a comparatively high level and yet M has retained abstinence. In my judgment this speaks volumes as to her development of stress management; her support networks and her commitment and motivation to maintain change.

27. G made clear she considered this a one issue case concerning alcohol. She accepted her earlier conclusions in 2015 were reached having regard to circumstances similar to those now present (i.e. engagement and a period of abstinence). She also accepted that a further relapse with A in M's care would be devastating for the child. Last, she agreed she had as at September 2018 reached the conclusion that A's welfare was not consistent with him returning to the care of M. However, she told me the death of the father was a fundamental change in circumstances that justified reconsideration of M's case. She told me she had spoken about this with the social work team and had been informed there would be a reconsideration. She felt on the evidence this simply had not taken place.

28. This was fundamental having regard to the longstanding nature of the parent's relationship; the influence this had on drinking patterns and the concern in the mind of the G that notwithstanding separation there was too high a chance of the relationship resuming with consequential further risk. This all changed on the death of the father. She also accepted the events of December 2018 had a

significant impact on M and in her meetings with M it was clear this had profoundly altered her thought patterns towards alcohol.

General Parenting

29. The relevance of this issue developed in the course of the hearing. My sense at outset was that alcohol was the single issue in the case. I appreciate this is the view of G. Th evidence from both the parenting assessor and BK appeared to suggest that M can provide a good level of care to A when not drinking. BK spoke of A '*thriving*' in M's care when she was sober. The parenting assessment [E289 8.20] concludes:

> *I have no doubt that [M] loves her son, she enjoys a close bond with him, and when she is not consuming alcohol, she is able to meet all of [A's] needs to a very good standard.*

30. Understandably and correctly the focus was on the impact alcohol had on the maintenance of such care during periods of alcoholic abuse.

31. Yet the evidence of FS raised concern as to M's parenting capacity in the light of A's perceived needs requiring better than 'good enough parenting'. She felt that whereas M displayed the capacity to manage A's minor issues, she would and did struggle when he was more challenging.

32. I do not accept this aspect of the evidence. I cannot ignore the contradictory evidence and particularly that of the parenting assessor who was instructed to investigate these issues and was not called to give evidence. Secondly, I bear in mind FS's evidence was based on a reading of the papers and not on independent observations. Thirdly, I did not find the specific examples which were said to illuminate this concern illuminating. The evidence including contact notes illustrates examples of occasions on which M was advised as to her parenting but they also demonstrate M following through on this advice (e.g. the scooter). Three specific points noted from contact (the pancake; A lying on M, and; an incident with some moss) in my judgment told me very little about this subject.

33. I will return to A's specific needs arising out of his medical condition below. However, in considering a need for more than good enough parenting I will continue to remind myself that all children have individual needs and demands for different levels of parenting and that the parenting each child requires sits on a spectrum at such a point as is good enough for that child. There is a level of artificiality in raising the bar by reference to this terminology as there is not a fixed point at which good enough parenting exists against which all parenting can be judged.

A's Needs

34. I received key evidence from PB. I did not understand this evidence to be controversial. I have considered his report. In live evidence he told me that any carer for A would benefit by receiving parenting course support. He confirmed A's ADHD symptoms (plus possible Asperger's) are likely to be a combination of genetics and environmental circumstances. He noted recent medication was working by focusing A's attention. He viewed A's challenging behaviour as a form of anxiety reduction (thus reducing stress whilst elevating behavioural

symptoms). He felt joint parent-child counselling would be important having regard to the likelihood that A is grieving his father. He felt A would become more challenging as he grew older and that his carer would need continuing advice and guidance. He was highly complementary as to A's school.

35. My understanding was that he could not break down the behaviour as being attributed to certain degrees to nurture and nature but he was clear it was likely each played a role. He drew particular attention to A's emotional immaturity despite him being of average intelligence and bright in certain areas. His evidence was of a need to create the best situation for A to enter adolescence. The current medication was enabling an opportunity to make progress in advance of this developmental stage. It was likely to be a combination of the medication and the positive care which had improved matters. A needs the constant reinforcement of appropriate boundaries. The witness provided a very helpful toolkit at the end of his report with respect to working with A. He felt A would be a challenge to any placement.

36. The expert made clear A needed consistent and predictable parenting which could set boundaries and reinforce the same. In combination with medication such parenting would be the most likely to maximise A's development. Whatever the situation A would pose challenges and the carer would need support and guidance and would benefit from parenting work. Just as nurture and nature could lead to a concerning situation so medication and good care could improve the situation. Absent such an approach the future might be bleak for A. He was concerned as to A blaming himself for what had happened and viewed some support as being required (therapy/counselling).

M's Honesty/Ability to work with Professionals

37. I will deal with this point in relatively short-order. During the evidence attention was drawn to a feature of the evidence relating to the 2015 removal. Contemporaneously, M had 'blamed' this on difficulties in coping with A's care needs. She reported this explanation to at least three professionals. More recently, she has changed her position and stated it arose out of similar circumstances to those arising in 2011 and 2017, namely the father's drinking patterns and the impact on her of the same. She told me she had lied to the professionals at the time to obtain A's return to the family home. The Local Authority unsurprisingly question M's honesty and indeed to what extent she can now be believed.

38. Having heard the evidence, I accept M's account. I note the G takes the same position but I have reached my judgment independently. I do so having regard to the following matters:

- I approach the case having regard to the *Lucas Direction* which directs me to take a sophisticated approach to witnesses who have lied and to have regard to the circumstances surrounding that lie when evaluating the credibility of that witness otherwise. The account given by M of a context in which she was seeking to obtain M's return and placed blame on herself (where it was bound to reside to a degree on the available

evidence) exculpating the father (against who there was no evidence) has the ring of truth about it;

- I have asked myself what the M really gets from admitting lying at this stage. Whilst it moves her away from stress related drinking arising out of care needs it then leaves her open to the challenge (as she has faced) of not being credible;

- I accept the inherent logic that nothing extra is shown by the fact the same lie was told to a number of professionals. It might be different if this was a situation in which a multitude of lies had been told. Instead I am concerned with one lie that was then repeated;

- Furthermore, the explanation fits better with the evidence (of patterns of M and father falling into excess alcohol usage at the same time followed by M abstinent and good care) than with the lie (M alone falling into alcohol misuse with F abstinent and caring). Taking a broad overview, the current account fits the unchallenged evidence more comfortably than the historic account.

39. Of course, this still means M lied and this does raise issues of transparency. Yet this must be viewed having regard to the passage of time; the limited extent of the lie; the absence of any suggested pattern of lying, and; the broad engagement with professionals as developed above.

40. Finally, it was suggested M might not be showing insight but rather demonstrating disguised compliance. I do not favour that suggestion. This is not my assessment of M and does not fit with the agreement that M is genuinely motivated to abstain and fails out of a lack of capacity rather than because she truly had no intention to abstain.

Welfare Assessment

41. *Wishes and feelings:* The evidence points to a positive relationship between A and M. The G contention for extensive contact even if a care order is made underlines the quality of the relationship. It is appropriate to infer A is likely to have a wish to be with his mother. However, it has been difficult to properly ascertain his wishes and feelings given his presentation and in any event his age and understanding would to an extent limit the weight that should be attached to such wishes in any event. I am though not particularly influenced by his stated wish to '*live with [x]*' during his meeting with G. This was in the context of him being prepared for a move into her care for a respite period and this may be behind the words used.

44. *Needs:* There is a significant premium on A being able to remain in his current school. Whilst it is correct he poses a challenge to those involved in his education it is clear (see PB) that this school are working well with A and he is receiving a high level of support. All parties agree with this finding and the Local Authority are focused on retaining the place. A's educational progress is likely to be closely corelated to the care he receiving from his primary care giver given the need for robust boundaries to be set to enable him to focus and manage

his behaviours. As such this is a case in which ensuring emotional needs are met is likely to ensure other needs are met to the best level possible.

45. I accept the evidence of PB without question. My understanding is all parties agree A needs good quality, consistent and predictable care. Given the challenges he poses and the likelihood of the same continuing A's emotional needs require a committed carer who is willing to seek and take guidance to manage his behaviour. His emotional needs demand a carer who can set in place boundaries which will allow A to regulate himself and make progress as he heads towards adolescence. At the same time, he is immature and retains the need for emotional warmth so long as this does not reinforce his immaturity.

46. *Change in circumstances:* My sense is that A does not react well to change. The evidence from PB would tell me that were this to cause stress then A would seek to sooth this stress by acting out in the manner viewed by others as being behaviourally problematic. Furthermore, change must be limited to allow A the opportunity to formulate the boundaries I have identified above. It is likely repeated changes would come with repeated styles of caring and this would pose a real problem in setting consistent and understood boundaries.

47. The evidence is clear that A's welfare would be significantly harmed if the next change was then undermined by the environmental circumstances surrounding the placement. I agree a move to M followed by relapse would be devastating for A. I had understood the Local Authority was particularly promoting a placement with a particular foster care given A's understood bond to her. It was therefore disappointing to discover (and only as a result of cross examination) that this was not a settled position.

48. *Personal characteristics:* I have referred to A's characteristics elsewhere within this judgment. The key characteristic relates to his medical condition. I have made little reference to his cultural heritage. The historic planning would have respected this by way of a kinship placement. The current planning is unlikely to meet his identity needs fully however it is clear he would retain significant contact with M and I judge this would amount to an important positive factor for A.

49. *Risk of harm:* I agree the risk of harm in this case is of neglect arising out of alcohol misuse. Given the history this risk arises at both an emotional and physical level. I have accepted the threshold document and consider it would be most unwise not to have regard to at least the potential for the risk to arise in the future. The question in this judgment which has to be answered is what is the level of risk and what are the implications for A's care. I do not consider any risk arises out of parenting issues.

50. *Capacity:* I accept the parenting assessment and the evidence generally as to M having sufficient skills, capacity and motivation to meet A's needs on a daily basis. The issue relates to her capacity to abstain from problematic alcohol use. I bear in mind that A presents (and is likely to continue to present) with problematic and challenging behaviour. The evidence suggests that any carer will find A's care challenging and will require support and guidance to meet his needs. This is not a concern specific to M (see evidence of PB).

51. *Range of Orders:* having heard the evidence and submissions the positions have developed to the point at which both G and M argue for a 12-month supervision order with a likely initial period of continued section 20 care. I certainly can make a supervision order given the legal threshold has been crossed so long as this meets the test of proportionality. The Local Authority argue for a care order with a plan of long term foster care. This is an available outcome subject to the same caveat.

52. I directed the Local Authority (pursuant to Re W principles) to provide evidence as to the supports that might be available were I to prefer M's position. I acknowledge they have produced such a document but I am concerned they have not done so in the spirit required by the authority, and more importantly by my direction. During evidence, I was told the identified parenting course (which had been identified pursuant to my direction) would be insufficient; that whilst there would be available additional courses that could supplement the identified course the same had not been identified. Plainly this approach failed the entire purpose of the direction and left me having to consider the gap left by the failure of the Local Authority to provide the evidence directed by the Court.

53. I was very concerned as to this lapse in appropriate assistance to the Court. Sadly, it was not an isolated incident. I have referred to the troubling circumstances in which an understood plan of action (placement with X) was only signalled as not being necessarily the plan of the Local Authority when FS was cross examined. Had she not been asked the question in cross examination (and there was no reason the question should have been asked on the facts as understood) I would have concluded this case on a false understanding of the care plan. It is concerning I would have been asked to approve a care plan which was not the care plan of the Local Authority. I was troubled that a team Manager did not attend Court to assist the social worker in circumstances in which it was plain such assistance was required.

54. *Holistic Assessment:* The options are long term foster care or placement with M. I acknowledge and broadly accept the relevant assessment of long term foster care undertaken by FS at [C140]. Importantly this option enhances the potential for A to retain a relationship with M. Secondly, it importantly removes the risk of the central feature in this case – A being impacted upon by alcohol abuse. In respect of the negatives I agree the point made as to statutory intrusion and I remind myself of Lady Black's observation in the case of Re V (albeit there in considering the distinction between long term foster care and adoption). The chief negative of such a placement is the significant restriction on family life and particularly in circumstances in which the risk is a predicted risk.

55. I do not endorse the contrary assessment of placement with M with the same enthusiasm. It seems to me the positives are somewhat understated. On my assessment there are important points to be considered as to the evidenced capacity of M to meet A's care when sober; there is the cultural and identity issues that will be enhanced by such a placement; there is the emotional benefits to A if the placement remains secure. Most important is the identified point – that this is A's mother and there is a warm and loving connection between them and this is a valuable relationship for A. I consider the identified negatives are valid but are to an extent questionable dependent on the evidential evaluation.

There is a lively debate as insight and I have made observations already as to parenting capacity, and transparency. Yet the key point is the history and the risk of relapse with all this will bring.

Conclusions

56. I do not approve the plan for long term foster care. I prefer the outcome under which A returns to M's care under a supervision order. I have reached this conclusion as:

- I agree the death of the father was a matter of real significance demanding of appropriate calibration within a revised assessment. I agree with G. My assessment of the history is deeply concerning but it is quite clear there was in existence a somewhat co-dependent relationship between M and the father that spiralled out of control on a number of occasions. The expert comments that the risks associated with their relationship have now diminished and refers to there being the appearance of some co-dependence in their relationship.

  In this context the supervening event of the father's death is a material feature whether or not this flowed from decision making on the part of M. It changes the environmental conditions in a case in which the very environmental decisions were argued to be the cause of relapse. I accept this is a controversial argument but it cannot simply be ignored.

  Consequently, M's care had to be reconsidered. Sadly, I can find no real evidence this has been done by the Local Authority. Whilst there is some simplistic attraction in saying this has all happened before, this falls away <u>or may</u> fall away if a significant foundation for the argument has changed.

  I also accept the fact of the stabbing and the imprisonment has the potential to necessitate a re-evaluation although I put those into a different category to the death of the father.

- In this context the period of abstinence and the level of engagement takes on a different flavour. It does not remove the concern but it weakens the argument that M has previously abstained for 20 months only to relapse.

- Added to this is the evidence of M which I found credible and impressive. I did not find her evidence to be self-serving or 'disguised compliance'. I formed the view she has done her best and intends to continue in this manner. Were the father on the scene I would have to factor in the potential for life to get in the way of good intentions. This is no longer the situation. On the evidence I find the parents relationship has been the prevailing force behind periods of poor care. This is no longer continuing and there is no evidence to suggest M is vulnerable to repeat relationships of similar character.

- This has led me not to remove any concern as to risk but to view the level of risk at a lower level than feared by the Local Authority. In fact, my sense of the Local Authority's evidence was not of a high risk but more of simple

uncertainty given the history and an overly risk adverse response to such circumstances. In the absence of a proper re-evaluation it is difficult for me to form a clearer understanding of their assessment of actual risk level.

- I accept the commitment expressed by M as to continued engagement with support services and her efforts to date justify confidence. My sense was of an individual who is engaging because it makes her feel better and clearer in her understanding rather than of an individual who is engaging because that is what is required.

- Faced by this analysis I simply cannot justify the interference suggested by the proposed care order. On my assessment M can provide good care for A when sober and on the evidence, there are significant grounds to be confidence she will remain sober. There remains a risk but it is at such a level as not to justify the proposed intervention. Were I to prefer a care order in such circumstances it would be difficult to foresee the circumstances in which A could return to M's care (as risk would likely remain into the foreseeable future).

57. I do though find there is a need for a supervision order. It is necessary and reasonable given my assessment of the history of the case. It is consistent with A's welfare needs and is a proportionate outcome supported by both G and M. An order for 12 months is required.

58. As to the process of transition I would note the following:

    - The parenting course is agreed and will commence at the end of April for 10 weeks. M will benefit from this and wishes to take part.

    - On the evidence I am not persuaded there is a need for an additional course although I would encourage M to be open to further work suggested by the Local Authority (whether immediately or in the future)

    - There is a need for therapy for A and for work between M and A. I appreciate this may be via CAMHS but other options should at least be considered. I endorse the suggestion of Thera play or similar having heard about A's presentation. The timeline for this is separate to the timeline for return home.

    - Contact needs to be structured to assist with the fluid return home of A at the agreed time. My sense if that a period of about 2 months would be sufficient although I can see the sense in a finalisation at around 3 months when the course completes and the school summer break commences. This contact should develop into the community and should permit for unsupervised care save for the short term during which transition is progressed at A's speed. I understand these points are accepted. At some point within this period A should at first be coming home for a short period (first overnight and then for a weekend) before a full transition.

- I have been told M has agreed to a period of s20 accommodation. I approve of her decision making in this regard as it would be challenging for A to suddenly return home without appropriate preparation. There is also I sense an issue of M obtaining a larger property for his return.

- There is a need for a written agreement setting out standard principles.

- There has been talk of further alcohol testing. This is not a matter for me given my findings however I can see why the parties might agree a structure for testing. This might be unannounced breath testing or scheduled HST. Whilst I can see the benefit of SCRAM bracelet use on an evidential basis I do not consider the same necessary.

His Honour Judge Willans