IN THE FAMILY COURT SITTING AT BOURNEMOUTH

Case Nos: BH21C00023 and BH21C00560

Courts of Justice
Deansleigh Road
Bournemouth
BH7 7DS
Date: 6/8/2021

Before:

HIS HONOUR JUDGE DANCEY

- -

Between:

Dorset Council	**Applicant**
- and -	
M	**1st Respondent**
-and-	
F	**2nd Respondent**
-and-	
A (a competent child)	**3rd Respondent**
-and-	
B, C and D	**4th Respondents**

(by their children's guardian Leanne Wilkinson)

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Anthony Hand (instructed by **Dorset Council Legal Services**) for the **Applicant**

Justine Hayler (instructed by **Mustoe Shorter**) for the **1st Respondent**

Omar Malik (instructed by **Battens**) for the **2nd Respondent**

Jamie Porter (instructed by **Porter Dodson**) for the **3rd Respondent**

Nigel Hawkins Solicitor **(Abels)** for the **4th Respondents**

Hearing dates: 26 to 29 July 2021

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JUDGMENT

His Honour Judge Dancey:

Introduction

1) Dorset Council say that four children, A, a girl aged nearly 15, B, a girl aged 10, C a boy aged 7 and D a baby girl aged just 11 weeks, should be removed from the care of their mother, M who is 34.

2) D is subject of separate proceedings but I am hearing them together.

3) The local authority ask me to make final care orders for A, B and C. They were also asking for a final care order for D until it was discovered on the third day of the hearing as a result of DNA tests that the father of A, B and C (F) is not the father of D. So now they ask me to make an interim care order with a plan for removal while two other possible fathers are investigated.

4) The local authority's plan for D is (or was) placement for adoption. No placement application has been made yet because M has not given consent to an adoption medical. There are also outstanding kinship assessments and doubtless if the father of D puts himself forward he will need to be assessed.

5) The children have remained at home with M since she and F separated at the end of July 2020. Although the proceedings for A, B and C have been going on now for nearly 7 months, the proceedings for D are only 2 months old. Interim supervision orders are in place for A, B and C. No order has been made in respect of D.

6) The children have supervised contact with F.

7) The relationship between M and F started when M was just 15. She had a really traumatic childhood. She witnessed her father commit suicide by shooting when she was just three years old. Her mother used a variety of drugs including ketamine, cocaine and cannabis and was in an abusive relationship.

8) The relationship between M and F was violent and abusive. F would say that M was also abusive but it seems clear to me that M was a victim of domestic abuse. In the end she separated from F, got a non-molestation injunction against him and, when he breached it more than once, she told the police on each occasion and supported prosecution of F and he ended up going to prison. So she acted to protect herself and the children.

9) Both M and F also regularly used drugs during their relationship, including ketamine, cocaine and cannabis. M says she reduced her using in August 2020 and stopped in November 2020, lapsing on New Year's Eve 2020 and 28 May 2021, on each occasion using two lines of cocaine. Monthly segmented hair strand tests (HST) in February and June showed the presence of medium levels of cocaine throughout the period tested (November to May). M accepts she hasn't always been truthful about her drug use.

10) A parenting assessment of M in May 2021 was positive. There was clearly a loving bond between M and the children, with lots of warmth and affection. At that point the local authority's plan was for the children to remain at home with M under supervision orders.

11) There are concerns particularly about A's education – her attendance is only about 40% and she is at a key stage, moving into year 11. B and C's school attendance has improved considerably more recently and is not now seen as a problem.

12) Two things then happened to change the local authority's care plan.

13) First, the expert psychologist Dr Jefferis reported on 1 June. He highlighted how psychologically and emotionally damaged the children were by their experience of living with domestic abuse and drug use, especially A who had lived with it for longest.

14) Dr Jefferis does not think the children will get what they need emotionally or by way of therapeutic repair while living with their mother who he regards as vulnerable because of her own childhood trauma and life experiences and lacking insight. He also considers M to be at risk of relapse into drugs or other risky relationships and either would be a significant concern.

15) The second thing that happened was a further HST report in respect of M in July that showed cocaine present over the three months to 9 July (although reducing from medium to low in the last month). It was in response to this that M admitted using cocaine on 28 May.

16) As a result the local authority changed its care plan to one of removal with A and D being placed in Bournemouth, some 1½ hours from home and school and B and C being placed in Shaftesbury, also some 1½ hours away from both M and A and D. While it is thought A could be taxied to her existing school each day, B and C would need to change school in September (although their current headteacher thinks the change may be a good thing for them).

17) A is a competent child able to instruct her own legal representatives. So she is separately represented.

18) The mother's sister P and her partner put themselves forward early on to care for the children but withdrew when it looked like M was doing well. They have come forward again in light of the changed care plan. A viability assessment of them was negative, partly because of lack of accommodation but also concerns about a possible association between P's partner and drug users/dealers at an address P's partner used to live at. The local authority has agreed however that there should be a full special guardianship assessment of Aunt P and her partner. That will take some 14 weeks.

19) F's brother and his wife had also recently put themselves forward to care for D and they were being assessed. That I suspect will change now we know F is not D's father.

20) In light of all that, M, F and A all argue that I should not make final orders. Instead they say I should adjourn until the assessment of family members has been completed, with the children staying at home until then. It is pointed out that if I make final orders the parents will then be left without representation, and the court without a role, while the local authority pursues family assessments. The parents would also have to fight a placement application for D without automatic entitlement to legal aid.

21) They also point out that removal into foster care now will involve an unnecessary and upsetting move for the children should a family placement prove possible later. A is clear if she cannot stay with her mother she would want to go to live with Auntie P.

22) The local authority and the children's guardian (supported by Dr Jefferis) say the risks to the children are too high and, if I am not prepared to make final orders, I should make interim care orders approving removal now.

23) It is clear A, B and C want to stay at home with their mother and would be very upset if they were removed. A, in particular, says that things have improved since her parents separated. She believes her mother has made big changes and is on the right track. She asks the good question: why removal now?

24) Everyone agrees this is a particularly difficult decision. Dr Jefferis and the social worker describe it as finely balanced. The guardian has always been more circumspect about the children remaining at home and sees the case for removal as more clear cut.

Summary of my decision

25) I have decided not to make final orders for any of the children at this stage.

26) The assessment of Aunt P should be completed so that all available options are before the court.

27) I consider that in the short term the risks to the children of staying with their mother are not as great as the risks if they are removed.

28) I do not consider that the children's immediate safety means they have to be removed now.

29) In particular I am worried about the impact on the children emotionally of being separated not only from their mother but also each other and the practical consequences in terms of schooling and contact.

30) I consider that the short-term risks are manageable with a good deal of support (which I identify at the end of this judgment) and a clear understanding by M that if she doesn't work with the local authority and support services and, most importantly, carries on using drugs, then the children may have to be removed.

A's participation

31) During the evening of Thursday, 22 July I received a message from A's solicitor that A wanted to attend the hearing due to start on Monday 26 July. I was told that everyone else was opposed to this and A's solicitor had urged A not to attend. I was asked to deal with this.

32) I made the point that A is a competent party who is entitled to be heard on the question whether she should attend and who is entitled to privilege in respect of any advice given. I listed a hearing on the afternoon of 23 July so we could consider the question of A's attendance or participation by other means.

33) I referred the parties to a decision by Peter Jackson J (as he was) in *Re K* [2011] EWHC 1082 when he held that the old presumption that it would be harmful for children to attend hearings had gone to be replaced by an open evaluation of the welfare consequences for the child of attending.

34) Neither Mr Porter nor A's solicitor, Ms Marshall, had any opportunity to speak with A before the hearing on 23 July. Mr Porter asked me to put the matter back until the start of the hearing on 26 July. He also raised the question of A's entitlement to see the case papers (having apparently been told by the Bar Council that A was entitled to see them). During final submissions on 29 July Mr Porter indicated that papers could be withheld if showing them to the client would cause psychological harm.

35) I made an alternative suggestion. I said I would be happy to see A at the start of the hearing, either as a meeting under the April 2010 guidelines for judges meeting children or, if she wished to express her views, by way of informal evidence during the hearing but without questioning by other parties. Also I would be happy to write to A at the end of the hearing to explain the outcome and, if she wished, to meet with her further to answer any questions she might have.

36) Later that evening I received a message from Mr Porter saying that A was happy with my proposal. And so I met with A and Ms Marshall by Teams before the hearing started on the Monday morning.

37) Having confirmed with A that there would be no secrets and a note of our meeting would be circulated I talked to her about the decision-making process. Our discussion did extend to expression of A's views. Appreciating what the guidelines say, that can be difficult to avoid (although I did ask her about school).

38) A told me that she was struggling with school because she was worried about this case and what might happen. She was clear that her mother had made changes, that she felt safe and settled and that she wanted to stay home with her brother and sisters. She could understand why they might have needed to be removed when her parents were together. But she could not understand why now when things were so much better. She was clear she would say if she thought she and her siblings were at risk. She felt removal would affect her mental health for the worse.

The hearing

39) Although the hearing was spread over 4 days it had to be fitted around other commitments. It was that or adjourn the hearing and the local authority and children's guardian were keen that it should be heard urgently given their case that these children needed to be removed.

40) Mr Hand represented the local authority (attending remotely as he was self-isolating). Ms Hayler represented M, Mr Malik F, Mr Porter, A and (attending remotely) Mr Hawkins for B, C and D instructed by their guardian Ms Wilkinson. I thank them all for their help.

41) On the morning of the first day I heard Dr Jefferis (remotely) and started the evidence of the allocated social worker, Rachael Deem.

42) On his way to court for the second day F was involved in a car accident and suffered concussion. He came to court but was soon dispatched to A&E and he was unable to re-join the hearing until submissions on the fourth day. F does not put himself forward as carer and his concern is about contact. I suggested, and Mr Malik agreed, that we focussed on the immediate question of removal of the children. If needs be the question of F's contact can be looked at again at another hearing.

43) On the second day Ms Deem started her evidence but with Mr Malik putting his questions on the removal issue only on the third day once he had an opportunity to take instructions from F.

44) We also started M's evidence. Dr North, psychologist had reported on M's cognitive ability. M has a whole scale IQ of 86. Notwithstanding that a

recommendation was made for an intermediary to assist M when giving her evidence and that was arranged.

45) At the start of the hearing on the third day I was told that the results of the DNA tests had been received which showed that F was not the father of D. We went on to finish M's evidence and I heard Ms Wilkinson, the children's guardian (who was not available after that day), with submissions on the fourth day. I then reserved judgment.

46) During the course of the hearing M also made clear that she would wish the court to extend the non-molestation injunction against F, which runs out on 28 August. I agreed with Mr Malik that as F had suffered a concussion injury, it would be better to postpone consideration of that to the hearing when this judgment is given.

47) I agreed to write to A to explain if my decision was that she and/or her siblings had to be removed.

Legal principles

48) The parents accept that because A, B and C were exposed to domestic abuse and drug use they suffered significant emotional harm. They accept that was unreasonable parenting. And so they also accept that the local authority has met the threshold test in section 31 of the Children Act 1989 for care or supervision orders.

49) So far as D is concerned the local authority say she is at risk of harm given the history. The parents accept that the test for an interim order under section 38 of the 1989 Act is met.

50) The question what orders the court should make requires a framework of considerations:

a) The welfare of the children overrides everything else and is the starting and finishing point in the decision-making process;

b) the welfare checklist under section 1(3) of the 1989 Act;

c) avoiding delay unless it has purpose, bearing in mind (a) that in *Re S* [2015] 1 WLR 925 (Munby P) one of the potential reasons for extending the timetable for proceedings was the need to assess family members and (b) the care and time needed for thorough and robust special guardianship assessments;

d) asking what the risks are for these children, how likely it is that they will happen, what are the likely consequences if they do, whether the risks can be managed or reduced and, in light of all that, whether removal is proportionate;

e) while giving due weight to the views of professionals and experts as well as family members, making decisions based on all the evidence;

f) deciding whether to make final or interim orders, having regard to c) above;

g) if the orders are to be interim, asking the question whether removal now is necessary for the immediate safety of the children pending final resolution, balancing the harm of removal against the harm of leaving the children where they are;

h) if the orders are to be final, a holistic analysis of the pros and cons of each of the options before the court, making care orders only if placement within the family is not in the children's interests such that care orders are necessary and proportionate.

51) M's credibility is in issue. I bear in mind that just because she may have lied about one thing does not mean she has lied about everything, because people lie for different reasons. Also, to be relied on, a lie has to be shown to be a lie in the first place and, if so, it must be a deliberate lie, motivated by a desire to avoid the truth and it must relate to a relevant issue.

52) Overarching the court's decisions are:

a) the family's rights under Article 8 of the European Convention on Human Rights to respect for private and family life, to be interfered with only so far as is necessary and proportionate;

b) acceptance that whenever possible children should be brought up by their parents or, if that is not possible, by other family members;

c) the margin or tolerance around parenting afforded by the court, bearing in mind what Hedley J said in *Re L (Care: Threshold Criteria)* [2006] EWCC 2 (Fam):

> "..society must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent. It follows too that children will inevitably have both very different experiences of parenting and very unequal consequences flowing from it. It means that some children will experience disadvantage and harm, whilst others flourish in atmospheres of loving security and emotional stability. These are the consequences of our fallible humanity and it is not the provenance of the State to spare children all the consequences of defective parenting. In any event, it simply could not be done."

d) and for my part I consider that the passage I have just quoted is relevant to both determination of the threshold criteria and consideration at the welfare stage;

e) the right of children and young people under Article 12 of the United Nations Convention on the Rights of the Child 1989 to be listened to when adults make decisions about them, including courts;

f) ultimately, the need to make best interests decisions for children who are subject of proceedings individually.

What are the risks?

53) The parents have agreed the concerns set out by the local authority in the threshold criteria. Broadly the concerns are

a) domestic abuse between the parents during their relationship;

b) failure to put the children's needs first, including poor school attendance and F breaching the non-molestation injunction in December 2020, scaring the children;

c) drugs and alcohol misuse;

d) poor mental health – both parents having a history of low mood and depression;

e) failure to effect meaningful change;

f) criminal offending by F, including offences against the person and drug and driving offences, while M has two cautions for battery in 2013 and 2014.

54) So far as D is concerned the local authority say that because of this history of concerns, she would be likely to suffer significant harm.

Domestic abuse

55) The history of the relationship between M and F is very worrying. Starting with the chronology we can see between 2007 and 2012 three incidents of A and/or B witnessing violence. In 2013 there was a separation of over a year when F went to prison for 6 months and then went to live with his mother for a while. It seems M couldn't cope and she sent the children to live with F and his mother for a while.

56) In 2014 there were child protection plans for the first time. By 2016 there had been no progress so we see the first PLO process (the last step before care proceedings). Then the situation must have improved because the child protection plans were removed.

57) In 2017 there was another separation, again for more than a year. During this time A fell out with M and went to live with F, not wanting to speak to M.

58) Child protection plans were made again in 2017 and a PLO meeting took place but went no further as the situation improved again.

59) On one occasion F threatened to put fuel through the mother's letterbox and burn the family home down. On another occasion the school reported F driving a car at the mother in Owen's presence.

60) On 30 July 2020 F strangled M and threatened to kill her. At this point M says she separated from F. She obtained a non-molestation order in August 2020.

61) F breached the non-molestation order. To her credit M reported and pursued each breach in December 2020. F received a suspended sentence which he breached. He served some time in prison since when he has not breached again.

62) The local authority remain worried that the parents might get back together. They have separated and come back together in the past. A family member has reported seeing them together but was not prepared to back this up with a statement. M is clear (as is F) that their relationship is at an end. The local authority accept there is no credible evidence that the parents have resumed a relationship currently.

63) Since separating from F M has worked with the Domestic Abuse Intervention Team and done the Freedom Project. The domestic abuse worker, Dawn Knight, reports good engagement and level of understanding and the ability to reflect on some of F's behaviours.

64) I bear in mind that the children have grown up, as did M, exposed to conflict, violence, periods of separation and changing carers. This has been their lived experience and it has undoubtedly been emotionally harmful for them. It is

obvious that if M were to reunite with F, or form another abusive relationship, the emotional harm to the children would continue.

65) Since separating from F, has had two brief sexual interludes when drunk with two males within a week or two, one of which resulted in M's pregnancy with D. She was not in a relationship with either of them, although she did know them. While still pregnant with D she also started a relationship with another man which she quickly broke off when she realised he had a criminal past. She is not currently in a relationship.

Drug and alcohol misuse

66) M has used drugs since 14, starting with cannabis. She did not start using cocaine until she was 27. During their relationship the parents used cocaine, ketamine and cannabis. In her statement M said she was using 1.5gs of cocaine daily. She told me this was all supplied by F and in fact that was the amount they shared. She also said that wasn't every day, perhaps 2 or 3 days a week, despite seeming to understand what daily meant.

67) M says she cut down on her drug use from August 2020 and stopped using in November 2020, save that she used cocaine on New Year's Eve 2020 and on 28 May 2021.

68) Hair strand test (HST) results show the presence of cocaine in M throughout the period from June 2020 until 9 July 2021, although reducing from medium levels to low in the last month tested. The testers have said that the readings are more consistent with regular use that the occasional use reported by M.

69) M had signed a working agreement which included not drinking alcohol or using 'any form of illegal intoxicant' while in the presence of the children or while having caring responsibilities for them. If situations arose in which she was likely to use she had to arrange alternative care for the children.

70) M says she did not use in the presence of the children, although she has to accept she did have caring responsibilities.

71) M says that on 28 May 2021 she was upset that A had self-harmed and she had a headache. She could not talk to F as she normally would when they were together. She had kept a couple of lines of cocaine in a locked box in a drawer with codeine and paracetamol and found it when she went to get something for her headache. Stupidly and to her eternal regret, she told me, she used the two lines of cocaine.

72) M says she went to call Ms Deem to let her know about the lapse but realised she was on holiday. In the event Ms Deem took the HST results of 9 June to M on 11 June and M admitted the lapse on 28 May. I am satisfied this was the first time she told anybody about it.

73) At Annex A I have drawn together the findings from the various HST reports. There is an overlap of tests (by the same tester) between November 2020 and January 2021. The February tests showed 2.8ngs/mg and 1.5ngs/mgs of cocaine detected while over more or less the same period the June tests showed 6.8ngs/mg and 4.3ngs/mg. For reasons that are not explained nobody thought to query this with the tester.

74) What the tests do show is consistent levels of cocaine between June 2020 and June 2021 at medium levels falling to low from 9 June 2021. If M is right and

she only used cocaine on 31.12.20 and 28.5.21 I would not expect to see an increased reading (6.6ngs/mg) for the period 10.4.21-10.5.21. I am aware that that cocaine can still be detected in hair samples for 3 to 4 months after last use (latent use).

75) M's evidence about drug use was not satisfactory. She gave me different explanations. She has not been truthful with professionals outside court either.

76) Taking the readings with the history of what M has said I make the following findings:

a) M has not been truthful with professionals outside court;

b) M accepts this but is unable to give a good reason other than she was worried about the children being taken away;

c) she hasn't been truthful with the court in her evidence about her drug use either;

d) the test results show it is more likely that M has used cocaine on a more regular basis than she has admitted;

e) however I do not find that M deliberately dyed her hair before the latest sample in order to affect the test result (despite her being at the hearing when she was told not to).

77) Having said that:

a) There is no direct evidence that drug use has caused any dip in parenting. Nobody reports seeing M apparently under the influence of drugs. There is no sign of neglect typically associated with regular drug use.

b) The local authority and the guardian rely on the assumption that using cocaine must at least make a parent unavailable for children. In particular the guardian is concerned about the safety of D given her vulnerability as a totally dependent infant. Ms Wilkinson went as far as saying there is a risk of fatality if for example M were to fall asleep on D. Dr Jefferis talked about M being less available than she should be, with dangerous people entering the children's orbit.

c) M says that she does not have any more non-prescription drugs in the house. What she had was kept in a locked box in a drawer, away from the children. She says she did not use in front of them. I have no reason to disbelieve any of this.

d) M has engaged with REACH. Her REACH worker Donna Bentley is now working with M face to face, having done so remotely during lockdown. Ms Bentley describes in an email seeing a difference in the depths M has worked at, with genuine progress, working hard looking at alternative coping skills and mechanisms, asking if she hasn't understood something.

e) REACH tests on 14.6.21, 22.6.21, 12.7.21 (unannounced) and 19.7.21 were negative for all drugs.

M's mental health

78) Dr Jefferis assessed M by telephone over two calls lasting 1½ hours and 1 hour in April with a short follow up to discuss assessment of the children. Ms Hayler challenged the adequacy of an assessment by telephone. Dr Jefferis was not at

that point conducting face to face assessments because of lockdown restrictions. He agreed video assessment would have been better, but M could not join by video. Although he accepted he could not see M to gauge her reactions he said he could sense her mood, for example, at times she was tearful.

79) As Dr North pointed out in an assessment of M's cognitive abilities, she may have problems with verbally presented material and expressing herself verbally. Given this was the only method of communication using telephone assessment, Ms Hayler questioned how that, and the fact that M was heavily pregnant, had been taken into account. Dr Jefferis said he took into account M's pregnancy by not pressing her too heavily in questioning. He felt he was able to gauge whether M was understanding and making adjustments. He did not think these issues impacted on the assessment.

80) Dr Jefferis says M's traumatic childhood has impacted on her despite her self-reporting no real problems. It was obvious when giving evidence that M was much affected by what had happened. She wants to know why her father committed suicide and why he would take her at the age of 3 with him for a walk when he did it. Of course, she cannot get answers to these questions and she says her counsellor has told her to just try and move past this.

81) Dr Jefferis says that M does not have a diagnosed mental health disorder. However, in his report he identified the following areas of concern:

a) M had low mood and anxiety at times when her relationship with F had been particularly difficult or during periods of separation linked to difficulty coping with the children. Dr Jefferis thought M would remain vulnerable to this.

b) She is a psychologically damaged fragile and vulnerable individual.

c) Despite this M under-rates her own symptoms and does not consider herself to have any significant psychological problems, which she clearly does.

d) M has a 'blind spot' about repeating abusive behaviours from her own childhood in her own parenting.

e) And so she minimises concerns around domestic abuse and drink and drugs (a dysfunctional coping strategy) and their impact on the children as well as the extent of the children's own psychological and emotional difficulties.

f) She finds it difficult to talk about the trauma she has suffered in her life and doesn't want things stirred up for the children either, preferring to 'brush it under the carpet'.

g) Her ability to recognise the significance of A's school attendance has yet to be demonstrated, although there are some hopeful signs.

h) M's parenting capacity has yet to be established.

i) By using drugs and failing to protect the children from the effects of an abusive relationship, M has failed to put the children's needs first.

j) Although M has separated from F, her ability to remain separated from him remains an unknown.

k) She blames others for what has happened, particularly F, without acknowledging her own responsibility.

School attendance

82) A's school attendance remains poor at around 40%. B and C's attendance has improved greatly. However, we can see that A's school attendance was poor when she was just 6. As Mr Hand says, that is more likely to do with parental attitude than teenage issues.

83) I accept that M has done her best to encourage A to attend school. A is clearly struggling with issues at school (bullying) and she is worried about the outcome of these proceedings.

84) M has supported C with ELSA at school and has also asked for it for B. She has attended nurture classes with B every week and C has now joined in too.

Impact on the children

85) I am going to look here at the children, how they present and Dr Jefferis' assessment of them.

A

86) Dr Jefferis saw A for 2 hours by video call when she was at school. She was calm and co-operative and engaged well. There were no signs of mental health disorder. She was aware of domestic violence and drug use but thought things had got much better since her father had left home. She thought her mother was much better and she was not worried about these things happening again unless her father came back. She liked seeing him but was not in a hurry to have unsupervised contact.

87) A talked positively about her paternal grandmother and Aunt P as people she could talk to.

88) She seemed able to talk about times she lived with her father, including when she was about 11 or 12 because she and M were not getting on.

89) A was clear, although there had been violence between her parents, there was no physical abuse or chastisement of the children.

90) A talked about having good friends who she would see outside school, including one particular close friend who lives nearby. A talked about being close to her siblings.

91) Psychometric assessment showed that A has some anxiety and problems sleeping. Her main anxiety was about the court proceedings and being taken away from M. she thought herself sensitive to any form of betrayal. She has some difficulty feeling comfortable with others and tolerating difference.

92) A's literary skills and verbal comprehension (equivalent age 11) are below her ability level (which is in the average range), unsurprisingly given her experience and missed schooling. At school A doesn't stand out as a child with difficulties (when she attends), although she can be emotionally fragile.

93) Dr Jefferis thought A to be the most overtly damaged of the children, probably reflecting longer exposure to the toxic family environment. She is troubled by anxiety, low mood and severe insomnia. He thought school attendance problems were likely to be linked to insecure attachment with M in addition to low mood, tiredness and anxiety, rather than problems at school.

94) A was more open than the other children in acknowledging the extent of problems in the family. It was likely, thought Dr Jefferis, that she had taken on a caring responsibility for her younger siblings and felt protective towards her mother with whom her relationship was complicated.

95) Dr Jefferis considered that A is at high risk of going on to have psychological problems across her life including emotional disorders such as depression, problems forming healthy and satisfying relationship and chronic educational and occupational underachievement. She was clearly, thought Dr Jefferis, in need of therapeutic support and he hoped a referral to CAMHS would be accepted (as it has been). In evidence Dr Jefferis agreed that A was settled in M's care and could be supported with CAMHS if she remains there, although thought she would be better placed with that and school attendance if in a foster placement. He thought M is selective and a therapist may have some concern whether M is able to support A with in depth therapy.

96) A is a likeable girl, well regarded by professionals and able to demonstrate maturity in respect of her ambitions – ambitions that were unlikely to materialise unless something happens about her schooling.

<u>B</u>

97) Dr Jefferis saw B for 1½ hours by video call when she was at school. Baby D had been born that morning and B was excited. She had chosen the baby's name.

98) Although B engaged in the assessment she was superficial in her responses. She thought the problems were just '*mum and dad arguing*' and rather minimised the importance of this and said it didn't have any effect on the children. She too thought M was happier since F moved out. Dr Jefferis said that B adopted a defensively avoidant style. She didn't see any problems and had no concerns. This, thought Dr Jefferis, could be an adaptive strategy which children adopt when faced with dysfunctional family life. There was some rocking back and forth noted both by Dr Jefferis and in school which might, with her lack of attentiveness, be caused by unprocessed feelings of fear about adverse family events, typical of defensively avoidant children exposed to maltreatment. She also tended to 'catastrophise' – imagining disaster and danger.

99) Like the other children Dr Jefferis felt there were insecurities in B's attachment with M and she doesn't have a close attachment figure. This is because she has not been able to see her parents as a reliable source of comfort or safety.

100) B acknowledged that her school attendance had been poor in the past (although it has improved) saying she '*didn't want to do learning*'. Like A, she was behind in her reading level and is underachieving. At school she can be grumpy, rude and volatile at times and at others bright, alert and good-humoured.

101) Also like A, Dr Jefferis thought B is at significant risk of psychological problems during her life – again around depression, relationships and underachievement. Her defensive avoidance is likely to develop into a pattern of constrained and problematic emotional functioning with problems managing her emotions and forming superficial and unsatisfactory relationships.

102) On the positive side B comes across as likeable, confident and chatty. She interacts well with C.

<u>C</u>

103) Dr Jefferis also saw C for 1½ hours by video when he was at school. While pleased, he seemed rather less excited than B by the birth of D 5 days earlier, not least because it meant 3 sisters and no brothers.

104) Like B, C showed a significant degree of defensive avoidance. There was sometimes a tendency towards fantasy, with little connection between children and parents, although some pictures of pleasant domestic life suggested it wasn't always bad.

105) Dr Jefferis thought that C had not experienced the type of secure attachments and consistently affectionate family relationships within which children are able to process and manage challenging emotions. His avoidance and use of fantasy are defences against painful emotions. He did not know why professionals were involved. He accepted there had been arguments but thought there were no other areas of concern. He too thought things got better after his father moved out. There was nothing he wanted to change at home now.

106) C was slightly behind with reading. A few hours before the assessment C had punched another boy at school. This was a reverting back to violence in him which had not been witnessed for some time. C didn't say anything about this when doing the 'Bag of Feelings' and the answering the question whether he had any worry, sadness or anger.

107) As with his siblings, Dr Jefferis thought C was at risk of psychological problems across his life including depression, aggression, regulation of emotions, unhealthy relationships and underachievement. That said, he too is a likeable boy whose school attendance and behaviour has improved.

Observation of the family

108) Dr Jefferis saw M with B and C at a children's centre. Unfortunately, A went off to be sick at the start and had to go home. There was good play and supervision with good co-operation and a positive atmosphere throughout. The children were good-humoured and there were no behavioural problems. M was attentive and set appropriate limits.

109) F did not engage in assessment with Dr Jefferis, however Dr Jefferis saw him with B and C in contact. They greeted their father enthusiastically. They chatted and there was affectionate physical interaction with appropriate praise (particularly of C). Sometimes B sought the supervisor's attention rather than her father's.

110) Dr Jefferis agreed that contact notes showed generally positive contact between F and the children.

Dr Jefferis' evidence and recommendations

111) Dr Jefferis thought the family would need a high level of monitoring and support for some time to come. While M's future ability to meet the children's needs seemed uncertain, Dr Jefferis did not expressly say in his report that it could not be done. He seemed to appreciate that there were some positives. While being cautious he did not recommend at that point removal of the children from M's care.

112) Since that report of course we have had the further drug test results.

113) In evidence Dr Jefferis, while accepting the decision remained finely balanced, gave his opinion that the children should be removed. It was clearly a matter of significant concern for him that M had lapsed into further drug use, particularly during pregnancy. What he described as the 'parallel tracks' in her mind – one affected by her disturbed upbringing, the other on the surface functioning quite well and not recognising underlying problems – made it difficult to predict what will happen around drug use and abusive relationships. The children could be exposed again to erratic parenting.

114) Dr Jefferis thought M's dissociation from her problems and minimisation made it very difficult to trust what she says. It also makes it difficult to identify therapeutic services which could even be offered let alone engaged with by M. She would have to take part in an emotional management course as a preparation before engaging in therapy. The problem with engaging the Community Mental Health Team (CMHT) would be the lack of any diagnosable symptoms. Her GP may be able to refer her on the basis that there is a real puzzle that needs solving. But if she goes because she has been told to (eg by the court) and maintains there is no real problem, there is unlikely to be any real benefit for her.

115) Asked what the risks for the children would be if they remained with their mother in the short term, Dr Jefferis thought that A's emotional needs would be only partially met while B and C would continue to be avoidant. He did not anticipate any catastrophes over the next few months. He thought however that changes need to be made sooner rather than later. On balance he thought A should be removed now, there being no benefit to her in delaying the decision. And if A was removed there was a greater case, he thought, for D to be removed.

116) In the longer term, Dr Jefferis thought that, unless there are significant changes in M's functioning regarding drug use and some engagement with therapeutic services, the risk is that B and C's defensive avoidant pattern would become part of their personalities, preventing them from doing any therapeutic work. A, he thought, would go downhill and become a significantly more troubled adolescent, dropping out of school.

117) Dr Jefferis thought that if M's drug use relates to her childhood difficulties then she does need to address those difficulties first. If she starts unpacking psychological issues she may go downhill before things get better.

118) Ms Hayler put to Dr Jefferis that there were few (perhaps three recorded) instances of low mood and M had not had treatment for her childhood issues, suggesting she had been able to manage. Dr Jefferis said he could hardly disagree more. In the past her low mood had been about inability to cope without F. She had been in a dysfunctional relationship since 15 with violence, volatility and drugs. The children had been exposed to all kinds of problems. Dr Jefferis disagreed that was someone who had coped well; on the contrary it showed the consequences of her difficulties being played out through the dysfunctional aspects of the relationship.

119) Although Dr Jefferis thought M's engagement with REACH (and the 4 negative drug tests they did) was a good sign it was not enough, he thought, to draw any firm conclusions on.

120) Mr Porter asked Dr Jefferis his view about the prospects of getting A, as an opinionated teenager, from the foster placement into a taxi at 7.15 each morning

for the 1½ hour journey to school. Dr Jefferis thought the prospects of getting A to school were better from a foster placement. It was, he thought, to do with insecure attachment with M. He agreed the prospects of getting her to school might be better if she were living with Aunt P. A's emotional intelligence does not match her intellectual ability and she has limited insight about school attendance. Rather like her mother, A is unable to appraise the extent of her problems, said Dr Jefferis.

121) I was particularly interested to know what Dr Jefferis thought about risk of harm to the children in the event of removal from their mother's care, especially A. I wondered in particular what the risks were of A going missing and being exposed to risks of CSE, drug use, including County Lines, and so on.

122) Dr Jefferis put the chances of A going missing at around 10%. It would certainly be a damaging experience for A and would damage her trust of professionals. But if she did run away it would be to her mother or aunt rather than into riskier situations, he thought. A does not have a conduct disorder which might pre-dispose her to such risks. Rather A's problems are internalised anxieties. There might be some rebellion but she was unlikely to go down that route. The bigger risk, he said, was that foster care just wouldn't work and A would be very unhappy and not go to school or, perhaps, co-operate with CAMHS.

The social work evidence

123) Ms Deem has clearly approached this case with a view to trying to keep the children with their mother. She co-authored the parenting assessment report in May with Dawn Knight, family worker. She was involved with the family a few years ago but there was then an intervening allocated social worker before Ms Deem resumed as allocated social worker in October 2020.

124) Dawn Knight reported:

a) having been in what looked like a controlling relationship with F, M was now saying she was doing things her own way which was very different to what she was used to;

b) M had demonstrated good understanding of the children's basic care needs;

c) she had put into effect behavioural management strategies, especially with C who was now respecting M's decisions;

d) M understood the need for a healthy balanced diet and had demonstrated she could provide healthy meals;

e) M presented as a warm and loving mother, attentive to the children's needs.

125) Ms Deem also reported:

a) the children's physical, medical and dental needs were being met by M;

b) she had demonstrated commitment to protecting the children from harm by reporting breaches of the non-molestation injunction;

c) she was meeting the children's emotional needs, giving them a sense of being individually valued with warm and loving interactions being observed – there was no doubt M loved the children unconditionally;

d) C had benefited particularly from his learning being promoted, with cognitive stimulation at home;

e) M was finding it more difficult to assist A with her school work and attendance;

f) M was beginning to understand the impact on the children of witnessing parental conflict and a toxic relationship – she was adamant she would not allow this to happen again;

g) over the more than 6 months that the children had been in M's sole care she had been focussed on ensuring the children are provided with routine and boundaries and listening to advice from professionals, contrasting the past situation;

h) Aunt P and paternal family members were a positive support for M;

i) the house (a 2 bedroom property which had been the family home for 12 years) was over-crowded and there were some rent arrears.

126) Importantly, Ms Deem considered M's ability and motivation to change. She reported:

a) M was demonstrating that she had the skills and knowledge to care, protect, nurture, stimulate and provide boundaries and where she did not, she had acted on advice from the family worker;

b) she was beginning to show understanding and acceptance of the impact of her role in the harm experienced by the children (having previously blamed F);

c) she had an understanding of the children's responses to harm and could see A and B needed support to repair their emotional responses, giving the children permission to access this support;

d) there was attunement with the children;

e) she demonstrated meaningful intention to change, working with professionals transparently;

f) there was no longer any evidence of the maladaptive behaviours which had compromised parenting (eg drug and alcohol use) – HST tests had shown that drug use had reduced/stopped and M was not in a relationship with F or anybody else;

g) M was addressing her own trauma and had a consistent narrative about it;

h) practical issues were partially being addressed – M did not want to move from her property, even though it was over-crowded, because of the supportive neighbourhood and local friends; schooling had improved for B and C although remained an issue for A;

i) M appeared to be keeping to the working agreement;

j) she had engaged with the parenting assessment and weekly visits from the family worker and Ms Deem,

k) she had demonstrated good knowledge around domestic abuse work;

l) she was attending nurture sessions at school with B and C;

m) she had re-engaged with REACH to address substance misuse.

127) Having set out the concerning background of concerns, with little or no change over the years, Ms Deem concluded that, given the children's wish to stay where they were, that M was demonstrating she could meet their needs and that processes in place were beginning to have the necessary impact, the children should remain in their mother's care under supervision orders.

128) It was clear from Ms Deem's evidence that, from that promising assessment, the situation had shifted so that the balance was in favour of removal now. It was also evident that it was not for Ms Deem at all an easy decision to reach, although she was clear it was her individual professional opinion as well as that of her team.

129) Ms Deem's parenting assessment having focussed on the positives, her final statement shifted to focus mostly on the negatives. Ms Deem addressed the potential impact on the children of removal, recognising it was a very difficult balance. The benefits would be removal from the risks associated with drug use to care provided by suitably assessed, trained and professionally supported foster carers. Although foster placement would eradicate risks within the family home Ms Deem wrote:

> "*I would inevitably hold significant concerns as to the impacts upon the children's emotional and behavioural presentations as a result of being removed from their mother's care*."

130) In her holistic analysis of the two options Ms Deem identified uncertainty about whether the children could be placed together, risks associated with going missing exacerbating risks of exploitation, growing up away from the family and the stigma of becoming children in care.

131) However, Ms Deem recognised that removal would not 'eradicate risk entirely'. The local authority wanted to find a foster placement as close as possible to the children's current area to preserve local networks and social connections, including attending current schools. It was clear removal would be against the children's wishes highlighting the trauma and emotional harm that would result from removal.

132) Ms Deem identified the risks of remaining as being lapse back to drug use and resumption of relationship with F or another risky male. She also referred to the risks identified by Dr Jefferis in his report and her knowledge of the family's functioning. However, she wrote, it would enable the family to stay together and for significant relationships to be maintained and avoid the trauma of imposed removal.

133) Ms Deem also set out the view of the Quality Assurance Reviewing Officer, Sally Nield (who had chaired child protection conferences):

> "*It is really disappointing to hear that [M] has returned a positive drugs test for cocaine – she was very convincing at the last review that this was behind her and she knows how much is at stake. We have both been concerned by the prospect of the older children going into care and being separated and you have worked hard to try and prevent this – alongside this we have been realistic that the parents have not been able to sustain changes as evidenced in the extensive chronology. Although there is no proof, I think it likely that [F] has found a way back into [M's] life, is likely to be breaching the order against him and possibly supplying her with*

cocaine to perpetuate her dependency on him. The risk of further DA between [sic] is high if this hypothesis is correct.

If we think the way forward is to ask for an ICO then we need to be sure we can offer the children a better alternative which improves their life chances. In an ideal world we would place [A, B and C] together locally but realistically this type of placement is rare but shouldn't stop us from trying. Second best would be to place the younger two together and [A] close by so they have very regular contact. We have to be realistic that the fall out from this will be great as the children will think "'why now'? as it's probably the best it has been for them for a long while. They will need a lot of support and nurturing, and in [A's] case therapeutic input. I agree with you that the plan for the baby is a more straight forward [sic] and adoption is the likely the [sic] way forward.

An incredibly hard decision."

134) With the last sentence I can only agree.

135) Ms Deem did not resile from the positives in her parenting agreement. She agreed that there had been no further significant concerns about parenting save for the ongoing drug use. D is meeting her developmental milestones and the health visitor is happy with the care she is getting.

136) Ms Deem confirmed that when she saw M on 11 June with the HST results she had asked her to be honest so she could work with her. M complains that, having said that, the local authority have just worked to remove the children and have not worked with her at all. From M's' point of view, I can see some force in that.

137) A had had two sessions with CAMHS. She had not wanted to share the confidential report from those sessions with anyone. Ms Deem agreed M had supported those sessions, taking A to one session at school (the other was remote from home). If A remained at her current school she would remain open to Dorset CAMHS.

138) Ms Deem agreed that M's non-professional network provided good support to M. There had been a family group conference in 2018 but not since for reasons that are not clear.

139) The children all went to stay with Auntie P when D was born so that the lounge in the family home could be decorated. It was over-crowded (they too have a 2 bed property) and A did not manage well at all.

140) Concerning the plans for separate placements, Ms Deem said that, before D was born, A felt she could be placed on her own but, since D's birth, A would want, if she had to be removed, to be placed with her. She thought that would give A emotional reassurance. A would not be allowed to look after D. Ms Deem accepted that A would 'absolutely struggle' if D were removed to an adoptive placement.

141) There has been concern in recent weeks about B running away from school and her presentation and C wetting. M associates this with Ms Deem showing the children some photographs of the proposed foster placements to familiarise them. This, says M, has heightened their anxieties. Ms Deem said that B's recent problems at school are to do with issues within her friendship group.

142) Asked by Mr Hawkins what had changed to alter the care plans from remaining to removal, Ms Deem referred to the risks for the children, especially D, posed by M using cocaine 2 weeks into her life. The children need their mother to be able to respond which she may not be able to do if using drugs. It would, said Ms Deem, be very difficult to manage those risks. They had already been visiting frequently supported by a family support worker hoping that M would work with them honestly. As Ms Deem pointed out, social workers cannot be in the home all the time to protect against risk. Any after the event testing would not protect at the time of use.

143) Ms Deem agreed with Dr Jefferis that the risks of A going missing were low – she is not going missing at the moment or coming home late. She sticks to boundaries. She denies using drugs and being in relationships and has aspirations to do well in her life.

144) For B and C, M will be their biggest role model if they remain in her care. They are not open to discussing experiences and Ms Deem was worried how to continue to work with them and keep them safe. She told me she felt she and M were poles apart in thinking about what the children's experiences were. There was she thought a small part in M which realised the children need help. She agreed M had been saying to A she needed to go to school.

145) The guardian is concerned about placement of A and D together (not least because of the potential impact of A or removal of D in due course). Ms Deem said she was open to reconsidering the care plans with the guardian's concern in mind.

M's evidence

146) M told me A is being bullied by children at school saying they hope she is put in care. She said she had spoken to the school about this. She had been reassuring the children they need their education as a way forward in life, something she had herself missed out on. ELSA was helping C a lot and she has asked for it for B too. They both love the nurture class every Friday. D comes too. M told me she has attended all of them except when D was born.

147) She also says she gives reassurance to A about CAMHS. She believes it is needed as it was something she didn't get when she was younger. She knows the children have been impacted by their experience and need help and support, she said.

148) M told me about her own counselling. She said it has helped her but it can't answer all her questions, so she just has to stay strong and keep going.

149) She told me how much stronger she feels having separated from F and got and enforced a non-molestation injunction. She would be happy to do more work around domestic abuse.

150) I have already set out what M says about drug use and my findings. In reaching that finding I had all the evidence I have heard in mind. Pinning M down about her drug use before and shortly after separation was difficult and probably the low point of her evidence. She did not respond well to what she saw as pressurised questioning. She played down her drug use. She seemed reluctant to accept that she hadn't been truthful. When she had to accept she had lied she couldn't explain why.

151) M talked positively about her relationship with Donna Bentley at REACH, saying it was easier now she could work with her face to face. M said she would be happy to do weekly drug tests, daily if necessary.

152) M talked more positively about the support she gets, especially from F's step-mother who also supported her in court. She comes in every morning for a few hours to help get the children up and ready and then help with cleaning. M said her sister had also supported her throughout.

153) M proudly showed me family photographs and a variety of certificates awarded to B and C.

154) By the time M came to resume her evidence on the third day of the hearing the DNA tests regarding D's paternity had been received showing that F was not her father. It was clear from M's evidence that she knew he was not the father. She had no explanation for failing to clarify that sooner. It seems to be another example of M not working openly and honestly.

155) M told me that since she had been on her own the only thing that had damaged the children was the social worker showing the children photos of the intended placements. This is a further example of her tendency to blame others.

156) At points M's evidence was along the lines that she had an abusive childhood and what did anybody expect. I had to reassure her that everyone had sympathy with her about her childhood experience which was most definitely not her fault. But I stressed that the focus was on the impact that had on her parenting and the children. She seemed to understand that.

157) M was adamant that she has not had any communication with F. She says she last saw him when he came to the house at Christmas time and broke the order.

The guardian's evidence

158) In her first analysis, dated 8 February 2021, Ms Wilkinson was clearly concerned that the plan for the children to remain at home did not reduce the seriousness of the substantial risks for the children. She saw little change in the parents. She felt the local authority should have issued proceedings much sooner. The children had been exposed to substantial risks for many years. A described F as "*horrid*" and how she had been 3/10 happy when he was living with them but 9/10 happy now. The children were clearly close.

159) However the guardian noted the lack of a placement for the children together and was prepared to go along with the interim plan for the children to remain at home, while cautioning the need for removal even if it meant separation of the children in the event the children were exposed to further harm.

160) In the first of her two final reports, dated 17 June 2021 and made in the proceedings relating to A, B and C, Ms Wilkinson pointed out how it had been made clear to M how worrying the history was and how close she was to losing her children. In that context the latest HST results were, she said, "*incredibly disappointing*". Although there were positives Ms Wilkinson considered the risks of leaving the children in M's care were too great. She pointed out that if any of the children had come across the cocaine it could have resulted in a fatal accident.

161) Ms Wilkinson made the following points:

a) she referred to the amount of work M has to do to address the substantial and significant history and she could not support the children remaining in M's care while that happened;

b) M does not have the support system in place to manage stress and may again use drugs as a coping strategy;

c) the risk is increased by her failure to work openly and honestly with professionals;

d) the children need stability, consistency and a safe home environment and reparative care to help them overcome the emotional trauma they have experienced, especially A;

e) the local authority should explore options that will keep the children together as separation from their mother would cause them emotional harm and this would be made worse by separation from each other;

f) if, as seemed to the guardian likely, D was eventually placed for adoption, the children would need nurturing and attuned parenting to help them process this information;

g) A had written a letter to me in which she had described her mum as "*such an amazing parent*" who had "*really got better*", saying that she wanted them to stay with M and if they were to be put into care "*it would completely disturb all of us children's life especially mine. I'm very settled living with mum and I work near my home address part time & go to school here*";

h) A was protective of her mother and was trying to talk about her in the best possible light;

i) A did not feel that she or her siblings were at risk and saw the recent drug use as a 'blip';

j) A talked about how she felt able to engage in therapeutic work, about how some days she can't get out of bed, doesn't want to see anyone and is an emotional wreck;

k) A said she was trying not to self-harm again but she overthinks every situation and feels she has no escape;

l) in the past A would have understood why she would have been removed but was struggling to understand why now (the same question she asked when she met me);

m) the emotional impact A would experience from removal could not be underestimated – she said it would be "*massively damaging to her mental health*";

n) A's emotional presentation is of significant concern and it is imperative she gets the emotional support she needs without delay.

162) While the local authority had by then changed its care plan to removal of A, B and C it was still proposing an interim supervision order for D. Ms Wilkinson was not able to support this and was clear that D, who was vulnerable due to her age to the risks of continued cocaine use, needed to be removed as well.

163) By the time of her second final report, dated 21 July 2021, made in D's proceedings, the local authority were seeking removal of all four children (under final care orders for A, B and C and an interim order for D).

164) Ms Wilkinson made these points concerning D's welfare:

a) M had by her actions placed the children at immediate and long-term risk of significant harm;

b) these proceedings had not resulted in change and longstanding concerns had not been addressed, notwithstanding that we were at 26 weeks in the older children's timetable;

c) the level of work needed was not within D's timescales;

d) there was no guarantee that therapeutic work would result in change for M and it would be emotionally challenging for her;

e) leaving D with M would result in her being at significant risk of harm;

f) the test results showed medium cocaine use throughout the proceedings with little understanding about the impact on the children;

g) M's lack of honesty made it difficult to protect D in her care;

h) D is at a critical stage of her development and needs a stable home environment;

i) if she doesn't get this it may impact on her ability to form appropriate and safe attachments;

j) M's poor mental health is likely to impact on D who needs attuned parenting;

k) at that point there were no alternative carers for D;

l) the local authority needed to apply for a placement order.

165) In evidence Ms Wilkinson said:

a) as to immediate risks to D, she could be subjected to fatal accident if M was incapacitated by drug use;

b) regular testing would not safeguard that risk.

c) M's evidence given that day had increased the risk "*massively*";

d) it was clear she could not work openly and honestly with professionals and it would be incredibly difficult to put a day to day plan in place keeping the children safe in the interim;

e) the older three children need the closure of final orders and reparative care, for which they could not wait any longer;

f) they could not wait for decisions which might not be positive (moving to Aunt P);

g) A has a very small window of opportunity;

h) there is the risk of further harm to her of the responsibility of looking after her siblings if M is using;

i) A could remove herself from the situation if needs be;

j) in the long-term it was not in A's interests to be placed with D, given the likely plan for D;

k) she agreed with Dr Jefferis it was unlikely A would go missing – that was not her character;

l) although A would present with emotional difficulties that would be reduced if she was supported by the foster carer, social worker and, importantly, her mother;

m) the risks to the children of being removed were not as great as the risks of staying with M, although she accepted there were unlikely to be disasters in the short term, at least so far as the older children are concerned;

n) she had been persuaded by the social worker, who knew the family well, that it would be safe to leave the children with M notwithstanding the December and February drug tests – at that time M seemed to be taking the concerns seriously;

o) she accepted she had not undertaken a holistic analysis of the pros and cons of each option in her reports;

p) there are positives which were in particular reflected in the parenting assessment;

q) there is a reciprocal close and loving relationship between M and the children and the children are all polite, friendly and engaging;

r) B and C are making good progress at school with good school reports (which I have seen);

s) M is supporting A with CAMHS and giving her reassurance;

t) she did not believe M could meet the children's needs when she used cocaine on the evening of 28 May;

u) she accepted there was no direct evidence of dip in parenting associated with drug use or any effect on M's condition, for example the next morning (I note 28 May was a Friday);

v) her drug use is a coping mechanism and that requires therapy – the emails from REACH were positive but only a starting point;

w) if M kept cocaine in a locked box, that might reduce the risk but it did not make it appropriate;

x) she is still minimising her role in the harm caused to the children;

y) there was a small window within which to complete reparative/ compensatory care and the children need that now;

z) if the latest drug test had been negative she would have said the case for removal/remaining was finely balanced – given the positive test, for her it was very clear cut that the children could not stay in her care.

The parties' submissions

Local Authority

166) Mr Hand started his submissions with a survey of the history, considering the positives in the parenting assessment but then Dr Jefferis' report, the June/July positive drug tests and M's evidence in court, which gave insight into her attitude and the problems.

167) The parenting assessor's task was not to undertake a psychological assessment. Looking at Dr Jefferis' evidence it was clear, Mr Hand submits, that the risks he describes are fundamental and come down to the fact that M is psychologically damaged and unable to prioritise the children's needs. Despite saying she would never use drugs when pregnant M did just that on New Year's Eve (and more often than that).

168) M has not been straightforward about her drug use or D's parentage. She has, submits Mr Hand, been fundamentally dishonest. In terms of managing risk that creates a huge problem for the local authority.

169) The fundamental problem, Mr Hand says, is not her drug use per se but how she handles the psychological problems resulting from her childhood, which Mr Hand is at pains to point out are not her fault.

170) While acknowledging the decision was a balance Mr Hand submits that the case for removal is made for all four children, particularly for D for whom the risks are greater.

171) The assessment of Aunt P can, says Mr Hand, be done under the LAC review system and is not a good reason to adjourn in respect of A, B and C.

The parents

172) Ms Hayler submits that the decision is finely balanced. It could not be said the assessment of Aunt P was likely to negative. The local authority supported the children going to her when D was born. The children see her as a second mum. A is clear if she can't stay with M she would wish to be with Aunt P.

173) This, submits Ms Hayler, is an integral part of the court's oversight which should not be left to a care review process within which the parents would be unrepresented.

174) Ms Hayler submits that the identified risks associated with mental health, domestic abuse and drugs were largely past risks. There was a clear difference now M had separated from F. Before that the risks had been high. Risks around domestic abuse had, through M's protective actions, reduced to low. As to vulnerability to risky relationships, Ms Hayler cautioned against judging M's sexual experiences in a different way to how we would judge a man engaging in two casual occasions of sex. And as soon as M realised the man with whom she started a relationship was unsuitable she acted protectively by ending the relationship.

175) Regarding M's mental health, Ms Hayler asks me to be cautious about Dr Jefferis' assessment, conducted over two telephone calls. He found no diagnosable condition and was unable to identify what therapy M might need. M knows what an awful childhood she had and is seeking counselling. She may never get an answer to the very difficult questions about her father's suicide.

176) M, says Ms Hayler, has found family in F's family. She is well supported. She accepts the children need help with their emotions and that is reflected not just in

what she says but in her actions – supporting B and C with ELSA and nurture classes and A with CAMHS. And as to CAMHS, Ms Hayler points out that they will not normally start therapy until a child is in a safe and stable environment.

177) Ms Hayler invites me to take a cautious approach to the drug test results given the overlapping and inconsistent readings. What we can see is progression from poly-substance use when with F to single use of cocaine, with a pattern of decreasing readings. We know that cocaine stays in the system longer than other drugs.

178) When Ms Deem called on 11 June, M admitted using straightaway. There was no prevarication. It was a pity the social worker said she could work with M on this if she was honest and then promptly changed the care plan.

179) M has fully engaged with REACH who have done negative tests. There has been positive change. Any future risk around drugs can be managed through regular drug testing and ongoing engagement with REACH. Most importantly, submits Ms Hayler, no corresponding dip in parenting has been reported. In fact, the evidence is of improvements at school and at home. D is meeting all her developmental milestones and the relationships between M and the children are positive.

180) It is important, says Ms Hayler, that the children's voices are heard. They are clearly saying they want to stay where they are. Their voices cannot simply be disregarded on the basis that they are being loyal to their mother.

181) Would CAMHS be interrupted if A moves away from home, asks Ms Hayler? There may need to be a settling in period before they can work with her. She may not be able to stay at the same school, involving transition to a different team.

182) There is a high risk A may self-harm. The view that A is unlikely to be exposed to the serious risks of going missing is based on A as she is, settled at home with her mother. That may not translate into her being placed against her will some distance away from her mother and siblings.

183) There can be significant support around M and the children with them remaining in her care – family support worker, social worker visits, a family group conference (with a question why there hasn't been one already), F's step-mother, Aunt P, REACH and drug-testing and family liaison worker at school.

184) The risks, submits Ms Hayler, are manageable with such support.

185) Mr Malik said F was not surprised or indeed disappointed by the DNA results. There was no risk of him 'kicking off' on finding out he was not the father and that should not be seen as a risk.

186) Mr Malik then focussed on the practical consequences of removal. Ms Nield had said that the local authority needed to be sure they could offer the children a better alternative. The options she set out are in fact unachievable. The children would be neither together nor local.

187) Dr Jefferis said there would be no catastrophes if the children remained with their mother in the short term. Mr Malik questions whether we can say the same if they are removed. What would be the consequences?:

a) the children could not be told their foster placements were their long-term home because of the outstanding assessment of Aunt P;

b) this would create an unstable situation for them and may impact on A and her therapy;

c) B and C would have to change school – what then if the assessment of Aunt P was positive and they had to change back?;

d) for A there would be 3 hour round trips by taxi to school every day (assuming she could be got into a taxi at 7.15am each day) as well as travelling to contact with B and C a similar distance away in a different direction, attending CAMHS and that could not be right.

188) Mr Malik asks me to keep firmly in mind that what really tipped this finely balanced case for the local authority was the June drug test result. For the guardian the position might appear more clear cut but she has focussed on the negatives of remaining and, Mr Malik suggested, had made some 'over the top comments' about risk of fatal accident to D and mother dating men during the proceedings, back-tracking when challenged on these points. This showed the really negative view the guardian has, says Mr Malik.

For A

189) Mr Porter says that if A feels her voice has been ignored it will cause her significant emotional harm. At nearly 15 and competent, her wishes and feelings should carry very great weight. If she sees the court believing in M and listening to her she is likely to feel more secure. If she can trust in the court system her anxiety will reduce.

190) She can if she needs to remove herself from a situation. Her Aunt P is only 3 minutes away and A puts her on a par with M. And there is the added benefit of CAMHS continuity.

191) It is obvious that A and M love each other. That cannot be replicated in foster care.

192) Mr Porter referred to the ramifications of A and D being placed together in foster care. A is likely to carry the burden of telling the family how D is doing and that could be a source of anxiety. And in 6 months she could be saying farewell to her.

193) And how, Mr Porter asks, would A cope on her own in Bournemouth. She will want to go out, especially over the summer. There may be risks around drugs and alcohol. We do not know what the risk of A running is but she may well agonise over whether to run.

194) Like Mr Malik, Mr Porter referred to the long school run and travelling to contact, all at a time when A will be in her GCSE year and doing mock exams. This is also likely to raise her anxiety levels.

195) All professionals describe the huge harm of removal; they do not, says Mr Porter, describe the risks at home in the same adjectival terms.

The guardian

196) Mr Hawkins started by pointing out that Ms Deem has worked as would be expected to support the children remaining at home, which makes it all the more puzzling why M has not been open and honest with her at all times.

197) Mr Hawkins supports a finding, given the test readings, that M's drug use is greater than she would admit. This is the root of the problems so far as the guardian is concerned. The overarching point is that no matter what support and how regular drug testing there is, the significant risks for the children, particularly D, cannot be reduced.

198) Given the backdrop of these proceedings we may, says Mr Hawkins, have expected to see improvement in A attending school. We cannot trust M to ensure that she gets to school. The guardian has more confidence that foster carers providing consistent support and boundaries would get her to school.

199) The guardian accepts that in the shorter term there is unlikely to be the same damage for B and C but the court is in a position to make final decisions about them as well as A. The only way we will see improvements is for them to be removed. They are all very defensive at the moment. M was clear in her evidence that the damage to the children was all to do with domestic violence, ignoring concerns about drugs and her history. Her view is that the only damage to the children since separation has been caused by the local authority. The children need reparative and therapeutic care which M cannot provide.

200) At the conclusion of submissions I canvassed another risk of removal – that without the children there could be regression of M's mental health and lapsing to further drug use. I raised that in the context of impact on the children of being anxious about deterioration in their mother while not being with her (and perhaps feeling responsible for it).

201) In response Mr Hand said that M is a survivor – she has been through a lot but has kept going. A may internalise M's reaction but she will be given care to reason it through. And in the long-term the children have to break free of internalising M's problems. It was, Mr Hand accepted, a matter to go into the balance sheet.

Analysis and discussion

202) The decisions whether to make final or interim orders and whether to remove the children are in this case acutely difficult and, in my view, finely balanced.

203) The court must pay considerable weight to the unanimous view of experienced professional and expert evidence, particularly where Ms Deem has had long experience of the family. I also bear in mind that M was not an impressive witness and I have found that she has not been truthful with professionals or the court.

204) That said, I have to consider the evidence in its entirety. What has struck me is the sharp change in direction the case took on the back of Dr Jefferis report and the June drugs test. Dr Jefferis was not in his report necessarily advocating removal, merely pointing out the vulnerable position of the mother and the damage to the children and the monitoring and support that would be needed.

205) I have set out the risks that have been identified and some findings about drug use (findings which I made with all the evidence in mind). I have set out the evidence of professionals and the mother about the extent of those risks, the

likelihood of them happening, the consequences if they do happen and whether they can be managed or mitigated. I need to reach my own conclusions on these matters having regard to the totality of the evidence. Of course, the risks, and their consequences and management should not be addressed in isolation. I will consider each of the risks initially separately and then together.

M's mental health

206) I share the concerns about conducting by telephone an important psychological assessment with a mother who may have difficulties in verbal presentation and understanding. It is undoubtedly sub-optimal. The question is whether it undermines the reliability of the assessment.

207) The following conclusions seem to me to be inescapable and obvious:

a) M has been seriously psychologically damaged by her childhood experience, compounded by an 18-year abusive relationship with F;

b) she has over the last 20 years used drugs as a maladaptive coping mechanism;

c) she should have therapy;

d) she has in the past been reluctant to address her need for therapy;

e) therapy would be emotionally challenging for her.

208) Dr Jefferis' findings to this effect are inevitable. It could be said that the court would have reached these conclusions without a psychological assessment.

209) What I agree we do not have is a mental health disorder requiring treatment. Nor is there evidence of chronic low mood and depression. Rather the mother tends to react to situations with low mood and depressive episodes. I accept the medical records only show 3 such episodes, usually associated with difficulty managing with or without F.

210) Mr Hand described M as a survivor. Superficially I agree. But I also agree with Mr Jefferis that there are parallel aspects to M – the survivor who appears to be managing and saying "no problem here" on the one hand, on the other the vulnerable individual turning to drugs to cope with difficult unaddressed psychological and emotional issues rooted in her deep history.

211) I agree this makes predictions for future risk more difficult, both in terms of the prospects for therapeutic treatment of M and her insight into the children's needs and treatment.

212) There are however features in this case which suggest that these risks might be managed or mitigated:

a) the reciprocal warm and loving relationship between M and the children;

b) M's demonstrated ability to provide for the children's physical care needs and to provide emotional warmth;

c) her willingness to engage with professionals and schools around ELSA, nurture classes and CAMHS, demonstrating an understanding that the children have emotional needs arising from the harm they have suffered;

d) a growing sense of responsibility for that harm (albeit I accept relatively recent, emerging and still somewhat limited);

e) a strong professional and family support network which she is comfortable using;

f) she has started counselling;

g) absence of mental health disorder or illness;

h) reactive rather than chronic depression and anxiety

i) she is, as Mr Hand says, a survivor.

Domestic abuse/risky relationships

213) Given that M 's mother was in an abusive relationship and M entered an 18-year relationship with F at 15 which became abusive, it is unsurprising that M normalised abuse and was unable to see its true impact on her or the children. It might be said that two lengthy separations in 2013 and 2017 should have given her the space in which to gain some understanding, but that clearly did not happen.

214) Although I am not asked to make findings about whether M also behaved abusively, I bear in mind that she was cautioned in 2013 and 2014 for assault and that F says it was not all one-sided. The serious allegations of abuse contained in the accepted threshold relate to F's behaviour.

215) M is clearly vulnerable to harmful abusive relationships. The question really is: what has changed to make that risk manageable or mitigate it?

216) I take into account these protective factors:

a) M acted protectively on separating from F not only by getting a non-molestation injunction but reporting breaches and supporting prosecution, even when this meant F going to prison;

b) the local authority accepts there is no credible evidence of M and F getting back together since F's release from prison;

c) I accept as a matter of fact that the last time M saw F (other than in court) was in December 2020 when he came to the family home in breach of the injunction and she reported him;

d) M has positively engaged in work with the DAIT, has undertaken the Freedom Project and is reported by Ms Knight to have good understanding and is able reflect on F's behaviours;

e) M is able to describe in her evidence controlling and violent behaviour and feeling she has been able to live her own life for the first time, feeling a stronger person for it;

f) she also acknowledges the harmful impact on the children of experiencing domestic abuse, albeit this is a fairly recent development;

g) she has demonstrated her learning by stopping a new relationship as soon as she realised it was unsafe.

Drug abuse

217) This is, it seems to me, the most problematic area, although I agree it is rooted in M psychological damage.

218) There are a number of features which heighten risk and make it unpredictable:

a) M has only ever lived with drug use, both by her mother and her since 14;

b) M turns to drugs as a maladaptive coping mechanism in response to stress;

c) stressful situations are therefore likely to trigger use;

d) M has been reluctant to admit a problem with drugs and minimises her use;

e) she has used cocaine when pregnant with D and in the full glare of these proceedings (indeed, on her case, only a week before a sample was taken);

f) she has not been open and honest with professionals or the court about her drug use;

g) this makes working with M more difficult;

h) the potential for parenting, particularly of an entirely dependent infant, to be compromised.

219) Against that, these seem to me to be the features that suggest the situation may be manageable:

a) M did not start using cocaine until she was 27;

b) during the relationship with F there was poly-substance misuse – since separation she has only been using cocaine;

c) although I have found that she has used more cocaine than she admits there appears to have been some reduction (although a higher level in April/May);

d) her dishonesty about drugs is driven by the need, as she sees it, to fight for the children and not to admit to anything which might lead to them being taken away;

e) this was not helped by being told be honest and we can work with you, only to find that the care plan changed to removal when she admitted using;

f) more regular drug testing should address the question of openness and honesty in a practical way;

g) although M may not have accepted fully the impact on the children of drug use, she has engaged effectively with REACH and Ms Bentley describes in depth working around coping mechanisms;

h) the more recent REACH drug tests have been negative;

i) during the relationship F supplied the drugs she used;

j) more recently, she told me, any drugs she has used were provided by a friend free, so she has not had to resort to criminal activity to fund a drug habit (and there is no evidence of sex working/shoplifting);

k) nor is there evidence of dangerous people associated with drugs use/dealing ‘coming into the children’s orbit’ as Dr Jefferis described it;

l) there is no direct evidence that her drug use has <u>actually</u> impacted on the parenting she has given the children (and I will not repeat here all the positives that are recorded);

m) there are no reports for example of M being under the influence of drugs or the come down effects at school or during regular professional visits;

n) indeed, the assumption was that M had stopped using, reflected in the positive parenting assessment;

o) the strong and supportive family network M has;

p) cocaine is used for the 10-15 minute high it gives (perhaps up to an hour) and it is followed by a come down (with a cycle then of needing the high again);

q) I do not have any evidence to contradict M's evidence that the drugs were kept in a locked box in a drawer and I accept they were, so reducing direct risk of the children finding them;

r) although I accept that use of any drug is inappropriate to parenting, I do not consider that the potentially disastrous risks the guardian suggests is a serious possibility in this case.

220) The positive June drug test results have been pivotal in these proceedings. It is important to avoid reductive thinking by focussing so closely on this negative development that the wider context becomes lost, including the balance of harm in removal.

221) I made the point during the hearing that while the other local authority in Dorset, Bournemouth, Poole and Christchurch Council (BCP), has signed up to the Parental Substance Misuse Court (a slimmed down version of a Family Drug and Alcohol Court which has been run successfully at Bournemouth over many years), Dorset Council has not.

222) I forewarned Mr Hand that I intended to mention this in my judgment to give Dorset an opportunity to respond. I was pleased to hear from him that the Director of Children's Services had indicated a wish to discuss participation in a Family Drugs and Alcohol Court.

223) The relevance of this in the present case is that, if this had been a BCP case M would probably have been admitted to the PSMC process, providing her with a substance misuse co-ordinator to assist her with groups and other support and being available to her to discuss risks around lapsing and coping mechanisms to help her stay clean. What difference that would have made for M I cannot be sure, but it may be seen as a lost opportunity.

224) It is also of note that engagement in FDAC was also considered in *Re S* a potentially good reason for extending the case timetable.

Final or interim orders

225) The court must avoid delay for the children unless it is necessary and purposeful. All the professionals say I have enough information now to make final orders for A, B and C. They say the children need a decision now so they can move on.

226) But for the ongoing special guardianship assessment of Aunt P, I would agree. That assessment cannot be said to be hopeless (otherwise why would the local authority have suggested it). So I have to assume at the moment that there is a realistic prospect of a placement with Aunt P at the end of the assessment. Such a placement would need to be rigorously tested before being signed off with special guardianship orders.

227) I do not agree that process should happen outside the court proceedings in the context of care reviews. There are a number of disadvantages which are not mentioned by the local authority in its evidence or considered by the guardian:

a) loss of court oversight over a process that requires a rigorous and balanced approach;

b) loss of representation for the parents and no independent tribunal to which they could make representations other than by applying to discharge the care order (for which they would not have automatic legal aid);

c) no opportunity for Aunt P to challenge a negative assessment other than by representations to the local authority, application by M to discharge the care order or judicial review;

d) the children would not have the benefit of a children's guardian overseeing and checking the assessment and any special guardianship support plan (and in my experience the guardian is often the source of questions which result in plans being clarified or strengthened);

e) it is better that the court has available all realistic options when considering what if any final orders to make.

228) I balance against those disadvantages the potential harm to the children caused by delay:

a) it is not suggested that any catastrophic harm is likely to happen to A, B or C in the 3 or 4 months it will take to complete assessments of Aunt P;

b) rather the concern is that the children will not get the reparative and attuned care they need now, especially A;

c) A's schooling needs to be addressed urgently.

229) I also bear in mind the mitigating features I have identified above when considering mental health, domestic abuse and drug use risks.

230) Finally, I consider the risks of harm to the children of removal (whether under final or interim orders) which I find as follows:

a) removal against their expressed wishes and feelings will cause the children significant emotional harm, especially for A who is more vulnerable;

b) although I bear in mind that I need to look at the long-term welfare of the children and not short-term problems (when looking at final orders at least) I do not under-estimate the long-term impact on the children of removal and, for A, a strong sense that the justice system did not listen to her as she grows up (although I accept that this may be addressed in part at least through reasoning as part of reparative parenting);

c) separation of the children from each other as well as from their mother will compound the emotional harm;

d) A is likely to worry about B and C as well as her mother;

e) I am very concerned about the plan for A and D to be placed together only for D then to be removed again into an adoptive placement, causing A further significant emotional harm, quite likely coinciding with mock exams or the run up to GCSEs;

f) and if A and D are placed now in different placements that is something else for A to worry about;

g) if D is removed now it is very difficult to see how there could be any going back and the road to adoption would be pretty much set (absent her father or a kinship carer being positively assessed);

h) the children cannot be told that their foster placements are long-term while there is an outstanding assessment of Aunt P, causing them uncertainty and lack of stability, with less prospect of settling into foster placements;

i) if that assessment is successful it means a further move for them;

j) I am far less confident about the prospects of getting A into a taxi at 7.15 in the morning to get to school regularly, even with supportive parenting by an experienced foster carer;

k) and if she does it means a 3 hour round journey every day on top of the school day and homework;

l) or a change of school, loss of existing friendships and interruption of CAMHS involvement;

m) in addition A would have to cope with travel to and from contact with B and C a similar distance away (or at some other midway location);

n) I hope that with support from A's school, the social work team, CAMHS and the family, and the knowledge that she is able to remain at home at least for now, A will be encouraged to get to school – a collaborative approach is needed about this;

o) I accept, for the reasons given by Dr Jefferis, that the risks of A going missing and becoming exposed to severe risk of exploitation may be relatively small (although not to be discounted entirely);

p) it is likely though that A would at least think about running back to her mother with the prospect of recovery orders if she does and, even if she doesn't run, there is a serious risk she may become depressed.

231) My conclusion is that final orders should not be made at this stage for any of the children. I do not consider removal would be proportionate to the identified risks at this interim stage.

232) The question then is whether the case is made out for removal of any of the children under interim orders.

233) The parents accept that the test for interim orders under section 38 of the 1989 Act is made out. I remind myself that removal should only happen where it is necessary for the child's immediate safety and after balancing the risks of remaining and removal.

234) For A, B and C the risks are not such as to require their immediate removal. Indeed there would be much greater risks for the children's emotional welfare removing them at this stage for the reasons I have given above.

235) For D removal would mean no going back. There is no evidence of actual harm to D. She appears to be thriving in her mother's care and meeting all developmental milestones. I do not consider there to be any significant risks to her in the interim in respect of M's mental health or domestic abuse which are

not manageable with support. The only identifiable risk is continued drug use. While I accept that nothing can completely protect against that, I consider the risk can be managed for the reasons given above.

236) For D the essential question is the balance between the risk of some catastrophic harm arising from incapacity through drug use on the one hand and going to down the road to adoption on the other. As I consider the risk of harm from remaining with M is manageable in the interim at least (and do not share the guardian's heightened concern), the balance is in my judgment against removal at this stage.

237) I have not expressly addressed the welfare checklist but I have had it at the forefront of my mind when considering in particular the children's wishes and feelings, their needs, the likely effect on them of any change in their circumstances, the harm they have suffered or are likely to suffer and the ability of M in particular to meet the children's needs.

238) I will continue the interim supervision orders for A, B and C. No orders are currently in force for D but it seems to me sensible that there should also be an interim supervision order in respect of her, not least so that the local authority are able to undertake visits with or without M's agreement as they are with the older children.

Going forward

239) M must understand that this has been a finely balanced decision – one that was often referred to during the hearing as being on a knife edge. Clearly if any further risk of harm happens over the coming months that fine balance may tip in favour of removal.

240) The local authority will need now to consider its plans moving forward. I would suggest that the following are needed both to ensure rigorous ongoing assessment of M's capacity to change and meet the children's needs and to manage risk:

a) a family group conference to consider the family support network and firm up on arrangements in a written document;

b) continued engagement by M with REACH with close liaison between them and the social worker and regular written reports as to progress, identifying any negatives as well as positive progress;

c) regular (at least weekly) drugs testing to be undertaken by REACH and/or the social work team;

d) M keeping clean of all illegal substances and not drinking;

e) M continuing to work with Dawn Knight around domestic abuse and risky relationships, including any follow up programmes and/or repeat of the Freedom Project;

f) regular reports from DAIT;

g) M to continue with counselling and to consider therapeutic intervention (with consideration being given to respite care for the children with Aunt P or elsewhere in the event that therapeutic work is started which M finds challenging to the point that it might impact on her parenting);

h) regular social work, family support worker and health visitor visits with good communications between them as to M's progress or any ongoing concerns;

i) a new working agreement written in simple terms setting out the expectations;

j) support for A attending school through collaboration between the school, professionals including CAMHS and M;

k) ongoing support for A and CAMHS, including by M;

l) an updating report from Dr Jefferis following a face to face meeting with M to review his recommendations in light of such a meeting, any progress that may have been made and any ongoing risks;

m) if the assessment of Aunt P is looking positive, support for her in seeking appropriate accommodation in order to avoid unnecessary delay in the event of placement with her.

241) Having decided to make interim rather than final orders I have approached the decision about removal through that prism. At the final hearing stage the comparative analysis will be as to the long-term welfare of the children in respect of each of the options before the court.

242) I have not addressed F's contact with the children. That should be considered in the light of my decision and, if any issues arise, I will deal with them at a separate hearing.

243) I would ask Mr Hawkins to send Dr Jefferis a copy of this judgment.

244) That concludes this judgment.

Annex A: Drug and alcohol findings from HST reports

(ND = not detected, NT = not tested)

Report Date/Declared use	Period covered	Cocaine ng/mg[1]	Ketamine ng/mg	Cannabis (THC) ng/mg	Alcohol
31.12.20 • Cannabis stopped 4 months prior • Cocaine stopped 5/6 months prior • Infrequent alcohol	Beginning June-Sept 20	7.2	0.2	0.04	Used but not excessive
	Beginning Sept-Dec 20	3.1	ND	ND	
1.2.21 • Cannabis, cocaine & ketamine until Oct 20 • Small amount of cannabis 3-4 weeks prior • Last alcohol 31.12.20	22.11.20 – 22.12.20	2.8	ND	ND	Used but not excessive
	22.12.20-21.1.21	1.5	ND	ND	
9.6.21 **(same tester as 1.2.21)** • No drugs or alcohol declared	30.11.20-30.12.20	6.8	ND	ND	ND
	30.12.20-29.1.21	4.3	ND	ND	ND
	29.1.21-28.2.21	3.6	ND	ND	ND
	28.2.21-30.3.21	3.0	ND	ND	ND
	30.3.21-29.4.21	2.5	ND	ND	ND
	29.4.21-29.5.21	3.2	ND	ND	ND
21.7.21 (same tester) • No drug use declared • Hair dyed 2 weeks prior	10.4.21-10.5.21	6.6	NT	NT	NT
	10.5.21-9.6.21	4.1	NT	NT	NT
	9.6.21-9.7.21	1.2	NT	NT	NT

[1] Cocaethylene, Benzoylecgonine and Norcocaine were also detected in proportionate amounts to cocaine detected but I have excluded them from the table for the sake of simplicity