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IN THE FAMILY COURT

(Sitting at East London)

Neutral Citation Number: [2022] EWFC 156

11 Westferry Circus
London
E14 4HD

Friday, 24 June 2022

Before:

HER HONOUR JUDGE REARDON

(In Private)

B E T W E E N :

LONDON BOROUGH OF BARKING AND DAGENHAM

Applicant

- and -

(1) QN-Z

(2) RZ

(3) P (A CHILD)

Respondents

MS D. SEITLER (instructed by Legal Services, London Borough of Barking and Dagenham)
appeared on behalf of the Applicant.

MS J. BRINDLE (of Counsel) appeared on behalf of the First Respondent.

MS Z. MCGRATH (of Counsel) appeared on behalf of the Second Respondent.

MS A. CATTLE (of Powell Spencer & Partners) appeared on behalf of the Guardian.

J U D G M E N T

HER HONOUR JUDGE REARDON:

- 1 This is my judgment following a final hearing in proceedings which concern a little girl, PN-Z, born in 2013 and aged nine. P's parents are QN-Z and RZ. I will refer to them in this judgment as "the mother" and "the father".
- 2 The application is brought by the London Borough of Barking and Dagenham and is an application for a final care order.
- 3 P has been represented in these proceedings by her Children's Guardian, Pravina Gulabivala.
- 4 The mother has some difficulties in her cognitive functioning and was assisted at this hearing by a court-appointed intermediary. The hearing took place as an attended hearing, save that the father, who lives abroad, attended remotely, as did members of the paternal family who attended some of the hearing with the agreement of all the parties.

Background

- 5 P's parents are first cousins. The father was brought up in the Middle East and the mother in London. They married in 2012 and the mother moved to the father's home country to live with him. P was born in London in 2013. Shortly after her birth she was diagnosed with an extremely rare genetic disorder, Tyrosinemia Type II. The condition was inherited from the mother who also has it. Tyrosinemia Type II can affect the eyes, skin and intellectual development. Management involves a protein restricted diet with amino acid supplementation. The patient's tyrosine and phenylalanine levels are monitored through weekly blood spots which are taken at home and sent to the hospital overseeing the care, which in P's case is Great Ormond Street. It is necessary to adjust both the patient's dietary intake and the supplements in response to fluctuations in tyrosine and phenylalanine levels. P also has Raynaud's Syndrome, a condition which causes pain and swelling to the feet. That is not connected to the Tyrosinemia Type II.
- 6 For the first two years of P's life the mother travelled between London and the Middle East with P. The parents' relationship came to an end in 2015 and at that point the mother returned permanently to London to live in her family home with her own mother, P's maternal grandmother. She has remained living there with P since 2015. The mother's relationship with her own mother has been strained in the past and P has witnessed arguments, although things have been more stable in recent months.
- 7 The mother has a history of poor mental health dating back to her teenage years. She has been diagnosed with anxiety and depression and has self-harmed, most recently in late 2019 or early 2020.
- 8 P's contact with her father after her parents separated was limited. He has not seen her face to face since 2015, when she was two years old. In 2020, the local authority made contact with him and since then virtual contact has taken place fairly frequently by Facetime facilitated by the mother. The father has remarried and has another child, a little girl called S, who is now aged two.
- 9 The local authority became involved with the family in 2018 after a referral made by Great Ormond Street. The hospital reported that the mother had not been consistent in attending

appointments for P and monitoring her health condition. In particular, the blood spots were not regularly returned to the hospital which meant that they were unable to monitor and respond to changes in P's levels. The hospital had tried to provide support from a community nurse but the mother resisted and there were occasions when professionals were not permitted entry into the home.

- 10 P was placed on a child protection plan in April 2019 and support from a family support worker was put in place. This led to improvements in the management of P's condition and the case was stepped down to a child in need plan in November 2019. However, the situation deteriorated almost immediately and, in particular, the mother stopped returning the blood spots to the hospital between November 2019 and January 2020. The mother initially argued that she had been sending the blood spots but they had got lost in the post, but that is not a position that she has maintained in these proceedings.
- 11 In March 2020, P was placed on a child protection plan again, and shortly afterwards the local authority started the pre-proceedings process. A report was commissioned from an independent social worker, Liselle Harold, who considered that the mother would require a lot of support but was cautiously optimistic about her ability to make improvements in P's care. In particular, Ms Harold made some recommendations for strengthening the mother's support network. A family group conference was held and family members, including the father and P's maternal aunt, agreed to offer support. Once again, some improvements were made and the local authority decided at that stage not to issue proceedings.
- 12 The decision was taken to issue care proceedings in April 2021. That followed a pattern of increasing concerns, including reports from Great Ormond Street that P was not taking her supplements regularly and reports from the family support worker that the mother was not engaging with the advice and support offered and that she had not been compliant with her own mental health treatment. On 27 July 2021, P was made subject to an interim supervision order.
- 13 On 9 February 2022, the local authority filed its final evidence and a care plan, in which it sought a final care order for P on a plan for placement in foster care. That was not agreed by either parent and the case was listed for final hearing. This hearing date is the earliest that the court was able to achieve.

Outline of the issues and the positions of the parties

- 14 There is a limited amount that is factually in dispute in this case. There are some differences between the mother and the local authority about the extent to which P's needs have been met by the mother in the past. However, the mother accepts that the threshold criteria are met broadly in the terms alleged by the local authority. The key issue in this case is the mother's ability in the long-term to provide good enough care for P.
- 15 The mother has made allegations of domestic abuse against the father in her written evidence and to the independent social worker. Those allegations have been strongly denied by the father. Findings have not been sought by any party and I am entirely satisfied, in the context of this case, that it is unnecessary for me to determine those allegations. This is a classic welfare case which requires the court to balance the advantages and disadvantages of the outcomes proposed by the parties.
- 16 The local authority seeks a final care order. The plan is that P should be placed in foster care immediately at the conclusion of this hearing. The local authority has filed two care plans. The first, filed with its final evidence in February 2022, proposed that P would have

weekly contact with each of her parents, to be kept under review. On the penultimate day of the hearing, the local authority filed an amended care plan in which it set out a proposal to reduce P's contact with both of her parents if a final order is made to the level of four times a year.

- 17 The mother opposes the local authority's application and seeks for P to remain in her care.
- 18 The father also opposes the application. His primary position is that P should continue to live with her mother. If the court does not permit that, he wishes to put himself forward to care for her. In order to achieve that, the father proposes that the case is adjourned for a further assessment of him to be carried out. He says that there are gaps in the assessment undertaken in these proceedings and he has not had a fair opportunity to demonstrate what he can offer his daughter.
- 19 The Guardian supports the local authority's application for a final care order. However, she does not agree that the level of contact in the final care plan, that being contact on four occasions a year with each parent, would meet P's needs. She accepts that contact should be kept under review and reduced if the placement is undermined but thinks that P's relationships with her family need to be sustained and weekly contact would be appropriate.

The law

- 20 I may only make the order sought by the local authority if I am satisfied that the threshold criteria in s.31 of the Children Act are met; that is, that at the relevant date P was suffering or likely to suffer significant harm attributable to the care being given to her by her parents not being what it would be reasonable to expect a parent to give. If the threshold criteria are met, P's welfare is my paramount consideration and I must evaluate it with regards to all the factors that are relevant to her best interests. I shall use the welfare checklist in s.1 of the Children Act as a guide.
- 21 The order sought by the local authority represents an interference with P's and her parents' rights to respect for their private and family life. I may only make such an order if I am satisfied it is necessary and proportionate to the identified risks.
- 22 The task for the court is to identify the realistic options for P's future care and then to consider the advantages and disadvantages of each option side by side. I am required to conduct a full and holistic welfare analysis which weighs up the pros and cons of each option. I must not work through the options in order excluding one after another until only one remains.
- 23 Finally, I must have regard to the authorities concerning parents with a learning disability or other cognitive difficulties, including, in particular, the President's guidance of April 2018 and the authorities highlighted in that guidance, *Re D (A Child) (No.3)* [2016] EWFC 1, *A Local Authority v G (Parent with Learning Difficulty)* [2017] EWFC B94, and the 2021 Good Practice Guidance. What those sources all emphasise is that there is an obligation on the State to provide support to such parents to care for their children to the best of their ability. It may well be, and often is, the case that a parent whose cognitive functioning is limited may need local authority support in the long-term and the usual assumptions, for example that support will be gradually tapered down until the family is operating independently, may not apply.

The Evidence

The social work evidence

- 24 I have considered evidence from two local authority social workers who have been allocated to this case, Esther Danquah, who was the allocated social worker until April 2022 and prepared the original final care plan, and Fatmata Koroma, who took over after Ms Danquah left the local authority and is the current allocated social worker. Factually, the evidence of both social workers was largely unchallenged. As I have explained, the background is not significantly in dispute, at least as to the overall themes if not the detail of individual events.
- 25 Having heard the evidence of both social workers, I was left significantly concerned about the local authority's presentation of this case. My concerns centred on three areas.
- 26 First, neither social worker, in my judgment, had paid any real attention to the authorities and guidance in respect of parents with cognitive difficulties. That guidance has been in place for some years and all local authorities should be aware of it. The written and oral evidence of both social workers, together with the background material provided by the local authority, made it clear that throughout its involvement with the family the local authority has worked on the basis that support will not be available in the long-term. The expectation in both the child protection plans and during the pre-proceedings process was that support would be tapered down and the mother would be expected in due course to manage largely independently. In her written statement, Ms Danquah said, in the context of the support that the mother would need, that the local authority "deem it is not fair on P that Children's Services would be involved in her life until she is an adult"; apparently missing the obvious point that Children's Services would be far more heavily involved in P's life if she spends the rest of her childhood in foster care.
- 27 In Ms Koroma's witness statement she said that she thought the mother could make the changes needed with support but went on to say, "however, it is my view that she would require ongoing support to sustain these changes"; the implication being that such support could not be made available. In her oral evidence Ms Koroma referred more than once to an expectation that if P were to remain in her mother's care there would come a time, probably after the end of a twelve month supervision order, when the local authority is no longer involved.
- 28 It is questionable whether an assumption that services will be withdrawn over time is ever appropriate as a blanket approach for any family. It is certainly not appropriate, in my judgment, for a family where the health condition shared by mother and child, and the mother's cognitive deficits, mean that both are likely to need considerable support in the long-term from both health and social care.
- 29 Secondly, the written and oral evidence of both social workers, in my judgment, demonstrated a linear, "pass/fail" approach to the options for P that ran contrary to the authorities. One clear and quite startling example of this approach is the fact that neither Ms Danquah nor Ms Koroma had given any thought to the possibility of the father caring for P after the receipt of a negative independent social worker assessment. When asked about the advantages and disadvantages of this option, Ms Koroma simply said that the parenting assessment had been "negative". When pressed further on that, she admitted that she had not read all of it. Ms Danquah said that she had based her planning on the fact that the assessment was negative and that "the local authority was holding to that." When questioned, she too admitted that she had not re-read that document before the hearing and could not remember any of its content.

- 30 This linear approach fed into the written evidence of both social workers and, most importantly, into the final evidence and care plan prepared by Ms Danquah. Under the heading “Realistic options analysis”, the only option identified as realistic is a placement in long-term foster care. The advantages of that option are listed but there is no acknowledgement that this option carries any disadvantages. The mother appears in the table of options only to be dismissed with the words “This is not a realistic option”, and there is no identification, in that section at least, of the benefits to P of remaining in her mother’s care. The father does not appear in the table of options at all. In my view, the local authority’s evidence in this respect is seriously deficient.
- 31 Thirdly, the local authority’s care planning for P was characterised by a “one size fits all” approach that emerged several times and at different points in the evidence. It was very apparent in both social workers’ evidence about the care plan. Despite the fact that this is a nine year old girl with a significant medical condition, the local authority have given little or no thought to the type of placement required, how prospective carers would be trained and supported to meet her needs, or how a move to foster care would impact on P. Ms Danquah’s final statement was completely silent on these issues. Ms Koroma was asked what would happen if the foster carers struggled to manage P’s condition, given that, as I explain below, no training can take place before a move to their care. She had clearly never thought about this possibility and ultimately suggested that if there were problems they could call an ambulance. It was clear that this was the first time these issues had really been considered by the local authority.
- 32 A further and very concerning example of a “one size fits all” approach was in the local authority’s thinking about contact. I have referred already to the change in the final care plan which took place during this hearing and without explanation. It was not practical to recall Ms Koroma on this point so I asked Ms Seitler, on behalf of the local authority, to explain its thinking. I was told that the rationale for the substantial reduction was that this is a long-term placement. I was reminded of Ms Koroma’s evidence when asked to explain the thinking behind the original plan for weekly supervised contact for two hours on each occasion. Her answer was: “I have arranged contacts with parents before.” It did not seem that at any point in this case the local authority have given any meaningful thought to what P’s own particular needs and circumstances would require.
- 33 In her closing submissions on behalf of the father, Ms McGrath told me that her client felt that the local authority had not been considering P as an individual and that the care plans provided were generic. She said it had seemed to him that the local authority was grabbing at straws for a placement willing to accept P rather than the starting point being what she requires. I agree with that perception. It is striking that when giving evidence about a possible foster placement in Dagenham, the local authority’s initial preferred option, Ms Koroma was anxious to emphasise that the carer was Muslim, despite the fact that the mother’s family at least is not particularly religiously observant. But after the Guardian had visited and expressed concerns about that placement, the local authority proposed a white family in Romford about whom almost nothing is known other than that they have two children in placement already.
- 34 I appreciate, as the Guardian has pointed out, that there is currently a real shortage of foster placements and that an extensive search was undertaken by the local authority before it was able to find any placement prepared to accept P. I do not for a moment criticise the Family Finding Team for the efforts they have made, which appear to have been exhaustive. Where I do find fault with the local authority is in its failure to engage honestly with the difficulties inherent in a plan for long-term foster care for this particular child and to put the risks and

disadvantages of this option properly before the court. The local authority has, in my judgment, presented the option of foster care as a panacea without any real consideration of the likely reality.

- 35 I was left, after hearing the social work evidence, with the impression that there have been significant gaps in the local authority's thinking and planning for P. Overall, what was missing was anything approaching the sort of holistic balancing exercise or weighing up the pros and cons that is required when a decision of this significance falls to be taken. That does not mean, of course, that I must dismiss the local authority's case but it means I must take extra care to conduct the balancing exercise myself and that the views and recommendations of the local authority can carry only limited weight.

The evidence of the family support worker, Jade McKenzie

- 36 Ms McKenzie is the current family support worker allocated to the family. She has been providing four hours of support per week. A few weeks before this hearing, the time increased to six hours spread over three sessions and for a further family support worker to be allocated. I have considered Ms McKenzie's evidence alongside the written notes in the bundle. It is clear from the notes and her evidence that she has built a good relationship with the mother and has been providing substantial support. I accept that the support provided goes beyond the four hours per week that she was initially asked to provide and also includes considerable ad hoc involvement with the mother through texts and phone calls.
- 37 It is clear that Ms McKenzie's involvement, and that of the previous family support worker, Ms McDonald, has been key to ensuring that P's medical needs have been met. Ms McKenzie is on a WhatsApp group with the mother, the allocated social worker and the Great Ormond Street nurse, which is used to prompt the mother about things like blood spots and medical appointments and which the mother uses from time to time to ask advice. Overall, the evidence suggests that the mother has worked well with both recent family support workers. Ms McKenzie told me that the mother would generally follow advice, although she said it definitely takes a few attempts and a few different ways of explaining and giving reasons before she does so.

The expert evidence

- 38 Evidence as to the mother's mental health and cognitive functioning is contained in two psychiatric reports prepared by Dr McClintock and a psychological assessment carried out by Dr Parsons. Those reports were all prepared in the pre-proceedings process, so some time ago. Neither was required to give oral evidence.
- 39 Dr McClintock expressed the view that the mother was suffering from clinical depression with features of low mood and anxiety. She described a history of self-harm in her teenage years and again more recently. Dr McClintock suggested that the mother might have an emotionally unstable personality disorder but that that diagnosis was complicated by what he suspected were difficulties with her cognitive functioning. He recommended a cognitive assessment.
- 40 Dr Parsons, who carried out a cognitive assessment as part of his psychological report, considered the mother to be functioning in the borderline range of adult intellectual ability, specifically he thought she had significant difficulties understanding information given verbally. He made a number of recommendations about how information should be provided to her and suggested that any parenting assessment should use the PAMS model.

Dr Parsons was of the view that the mother did not meet the criteria for a personality disorder but that she did have emotionally unstable personality traits. He thought that she had an insecure adult attachment style which might cause her to experience conflict between her need for support and a fear of intimacy and the expectation of being hurt. He noted that she had a history of oppositional behaviour and a need to challenge boundaries. He thought she might benefit from some therapeutic input but that there would be a need to allow for her verbal deficits. As a result, he suggested therapy using the “toolbox” method, that is giving the individual specific skills to deal with specific problems.

The evidence of the independent social worker, Liselle Harold

- 41 Ms Harold’s two assessments of the mother were both carried out using the PAMS method. The first was conducted in September 2020, during the pre-proceedings period, and the second in these proceedings in November 2021. Ms Harold gave oral evidence before me.
- 42 As I have already summarised, Ms Harold’s recommendation in her first report was that the mother could continue to care for P although she thought that she would require a great deal of family support and would be unlikely to be able to manage if she was the sole carer in a household. She would be reliant on the support of the maternal grandmother, although that was problematic in light of their difficult relationship.
- 43 By the time Ms Harold prepared her second report a further two years had elapsed and she was able to review progress made and not made. She concluded that there had been some progress. The mother had engaged with talking therapy. Her communications with professionals had improved and Ms Harold thought that she had developed some insight into her emotions. She had also improved in managing P’s health condition. However, Ms Harold concluded that the mother continued to require a high level of support in a number of parenting domains. She observed that she still lacked insight into her own level of need and her difficulties accepting advice and guidance. She was clearly ambivalent about the role of professionals in her life. She told Ms Harold that she felt part of a team and this had given her a sense of empowerment but at other times she seemed keen that professionals should no longer be involved and would speak about all concerns being in the past. She was particularly resistant to suggestions made by professionals that she should undertake more activities with P outside the home.
- 44 Ms Harold expressed a particular concern about the mother’s own vulnerability, which manifested itself in two ways. The first was in the mother’s care for her own health. The mother accepted that she was not compliant herself with her treatment regime, meaning that at times she would become tired and found it hard to care for P, and also that it was difficult for her to model the compliance which P needed to follow. The other concern was in the mother’s online friendships and relationships. She told Ms Harold that she had met a man online and was planning to take P to the USA to meet him as soon as the proceedings concluded. Ms Harold expressed particular concern that the mother had been sending money to people she had met online.
- 45 Ms Harold concluded with the following observation:
- “The previous report identified that Ms N-Z’s learning needs, mental health needs and her difficulties remaining focused will always impact on her providing consistent parenting. It was therefore recognised that Ms N-Z will always require high support and engagement and it was hoped that this could potentially be provided from family. This

support does not appear to be forthcoming. I am of the view that Ms N-Z's needs are so great she is not able to care for P as a sole carer."

- 46 Whilst recognising that the ultimate balancing exercise is mine to undertake, I accept and rely on the majority of Ms Harold's evidence which I considered overall to be balanced and fair. I make three observations. The first is that Ms Harold clearly anticipated in her first report that the primary source of support for the mother would be the family network and there is little indication in her report that she anticipated the possibility that the local authority would play any significant long-term role. She refers a number of times in her report to the point when services will cease. As I have explained, I consider that to be an incorrect assumption.
- 47 The second is that the evidence as a whole suggests that since Ms Harold completed her second report, in November 2021, the progress made by the mother has continued. In this context I rely, in particular, on the updating reports from Great Ormond Street, which confirmed that blood spots had been consistently sent in, a report from P's school that the mother is working well with them and is fully engaged, and the evidence of the family support worker summarised earlier in this judgment. In Ms Harold's report and in her oral evidence, she said that she thought the mother would need someone in the home with her undertaking a co-parenting role for P in order to provide good enough care. That observation needs to be considered in the light of the continued progress that has been made with a much lower level of support in the eight months since the report was prepared.
- 48 The third observation is that although the impact on P of a move to foster care was not strictly within her remit, Ms Harold acknowledged that this would be a huge and traumatic change for P and emphasised that the feature that distinguished this option from a move to the father's home country was the fact that P would have the ability to maintain continued contact with her mother and to sustain the relationships she has now. She was clear in her oral evidence that she thought P's bond with her mother was a significant factor.
- 49 Ms Harold also carried out a remote parenting assessment of the father. The father has challenged her conclusions, which are that P should not move to his home country to live with him. Ms Harold accepted in her oral evidence, as she did in the report itself, that there were limitations to her assessment given its nature. Despite that, I am satisfied that the report covers all relevant issues and puts them before the court in a balanced manner. Ms Harold's conclusion that the father was not in a position to provide a home for P is primarily based not on the father's parenting capacity or lack of it, but on the fact that Ms Harold thought that a move to the father's home country was not a feasible plan for P given her additional needs. In fact, she observed in her oral evidence, that she thought the father had a lot of strengths in terms of his parenting capacity.
- 50 At a pre-trial review in advance of this hearing, the father made a Part 25 application for a further independent social work assessment. He struggled, however, to articulate what had been left out of Ms Harold's report or where her approach was deficient. I refused the application at that stage, partly because it was not obvious to me that there were any gaps in Ms Harold's report. I remain of that view having heard Ms Harold give evidence and having heard her evidence challenged under cross-examination. I consider this to have been a fair and a comprehensive report.

The evidence of the mother

- 51 The mother had the support of her intermediary while giving evidence and was given frequent breaks. I have borne in mind when considering the mother's evidence the evidence

of Dr Parsons and Ms Harold. I am very aware that the mother's verbal skills are particularly low and that her sometimes assertive style can mask a lack of understanding. I have been anxious to satisfy myself that the mother has understood the questions asked and been able to give her best evidence in response.

- 52 The mother has accepted that she has not previously managed her own or P's condition well. There were some inconsistencies in her evidence about the history. At times she had a tendency to be defensive and to deny but at other times she accepted faults in her care of P and I thought that she did recognise where P's needs have been neglected in the past. Overall, the mother showed more insight than I had expected from my reading of the papers.
- 53 The mother is obviously P's primary attachment figure and that came through in her evidence with her very close knowledge of P. She was very attuned to P's personality, her likes and dislikes and, indeed, her health condition and her health needs. Of course, the mother's knowledge cuts both ways in that, given her level of understanding of what P's condition requires, she might have been expected to manage it better than she has done in the past.
- 54 The mother was evasive in her evidence on one issue relating to her own sexual history. Given that the father was present in this hearing, I can well understand why she was reluctant to give me that information and I am satisfied that this is not an issue which should carry significant weight in my analysis.
- 55 The key issue in this case is the mother's attitude to ongoing local authority involvement. There is evidence in the bundle that she has resented professional involvement and at times has been resistant, for example, to social worker visits. When the Guardian visited her on 9 May, it was apparent that the mother did not accept that she needs continued professional support. The mother told me, when asked about offers of support that she has rejected in the past, "I am the type of mum that I like to do everything myself and I was very naïve at that time." When she was asked how she felt about the family support workers coming to the house, she said she thought she did need them "at the moment with Social Services in my life just so they can report back to the social worker that I am doing a good job." She said she would accept their help if they felt she needed it "until they are 100 per cent sure I can do it with help from family members." I thought the mother was very ambivalent about the prospect of the local authority remaining involved in the longer term. I observe at this point that it is not surprising that the mother has not anticipated long-term local authority involvement, given that the local authority has been of a similar view.

The father's evidence

- 56 The father is in a difficult position putting forward a positive case at this hearing because the reality is that he has not seen P in person since she was a very small child and, because of the language and geographical barriers, he has not yet had any real chance to build up a secure relationship with her. I do not doubt the father's commitment. He has engaged throughout these proceedings and before, since the local authority first made contact with him in 2020. He has undertaken his own research into P's condition. He has done as much as he can but his knowledge, unlike the mother's, is theoretical rather than practical. He is open to learning about P's medical needs and I am satisfied that he would have capacity to manage her condition if provided with training.
- 57 At times the father appeared to minimise the difficulties that P might face in making a transition from the UK to the father's home country. That, in my judgment, is not something for which he can be criticised. It is natural for any parent to want to overcome

obstacles of that nature and it is very hard for a parent who does not have a close day to day relationship with a child to know how they will respond to significant change.

- 58 A practical problem facing the father is that he has been refused a visa to travel to the UK to visit P. It is very unfortunate that this is the case. It is easy to see if the father had had the opportunity to spend time with P over the period of local authority involvement that her relationship with him could have developed and he might have been able to provide a considerable amount of support. During the course of this hearing, the local authority was asked if it would support the father by writing a letter he could use in a future visa application. On the final day of the hearing the parties were told the local authority was not prepared to do that for reasons which were not clear to me. In my view, it would be entirely appropriate for the local authority to write a letter confirming the purposes of the intended visit, which might provide the immigration authorities with some reassurance. As was pointed out on behalf of the father, if a care order is made and the local authority shares parental responsibility for P, there will be an obligation on them to support her relationships with family members, including her father.

The evidence of the paternal family

- 59 Viability assessments have been carried out of P's paternal grandparents and paternal aunt, both of which were negative. The family members indicated that they wished to challenge those assessments although no further application has been made. At the pre-trial review I determined that it would not be proportionate or necessary to join the family members as parties given that they were only putting themselves forward as a back-up to the father and many of the same considerations, particularly geography and language, applied as much to them as to him. Therefore, they were not required to give formal evidence but they were invited to and did attend parts of the hearing that related to them. The family heard, in particular, the evidence of the social worker who carried out the viability assessment and the evidence of the father. I have also given them the opportunity at various points in the hearing to address me directly and convey their views. In this way I have gathered the views of the paternal grandmother, the paternal aunt and the father's wife.
- 60 My conclusions in relation to the paternal family are that there exists a substantial and very capable family network in the father's home country which has the capacity to provide strong and robust support for the father as a carer. As with the case put on behalf of the father, the drawbacks to a plan for P to move to the father's home country and to live with her paternal family have nothing to do with the family themselves.

Evidence as to prospective foster placements

- 61 The local authority has produced two written statements from its Family Finding Team, one dated 23 May this year and one dated 22 June. The search for a suitable placement has not been straightforward. There were no in-house carers available from the local authority who would be able to meet P's needs. The local authority contacted nearly fifty external agencies and identified initially four potential placements, two of which were in East London.
- 62 At the start of the hearing the local authority's preferred option was one of these placements, a single carer in Dagenham. The statement from the family finder described this carer as "experienced in giving one to one care, managing young people with autism, ADHD and ODD." The Guardian was able to visit this prospective carer during the course of the hearing. She is, in fact, a new foster carer, caring for an autistic child who is already in the placement. It emerged from the Guardian's evidence, contrary to the social worker's

understanding, that this carer would not, in fact, be able to take P to school in the mornings. The morning school run is a crucial and sometimes tricky part of P's day, because she has to take one of her amino acid shakes in the morning but frequently struggles to finish it, and does so on the journey to school or once she has arrived. The Guardian expressed the view, having visited this placement, that it would have been very high-risk, and that she did not think the carer would have been able to manage both children's needs.

- 63 In its second statement, produced towards the end of the hearing, the local authority indicated that it had conducted a further search, this time contacting fifty-eight independent agencies. Through this search the local authority has identified a white British family in Romford who currently have two children living with them in long-term placements. There is as yet no further information available about that placement, save that during the course of closing submissions it was confirmed that P could stay in the same school.
- 64 The information I have about potential foster placements for P is limited and uncertain. If an order is made today, the likelihood is that P will be placed with the family in Romford. The advantage of that placement is that it appears that she will be able to continue to attend her current school. I do not know the prospective carers' views about the frequency of ongoing contact between P and her mother or whether weekly contact would be feasible taking into account the carers' other commitments which, with two other foster children in placement, are likely to be considerable.
- 65 A significant problem faced by any foster carer with whom P is placed is that initially at least they will have to manage her medical needs without prior training. The reason for that is that Great Ormond Street has said, not unreasonably, that they cannot commit the resources to training anyone other than a parent until they are certain that P is going to live with them. Training takes about six weeks. That means that in the early weeks and months of the placement, any carers will have to get by without a detailed understanding of how to monitor P's tyrosine and phenylalanine levels and how to manage her diet. Even if I assume that the prospective carers will have the capacity and time to learn, they will be starting from a point where they have no knowledge at all about this condition and will have to build that up very quickly. The learning period will, of course, coincide with the time when P most needs stability and reassurance if she is to have any chance of adjusting to the placement without unmanageable distress and trauma.
- 66 It is important to recognise also that P, like many children with significant health conditions, is often resistant to her treatment regime. That means that any carers will have to build up her trust very quickly if they are going to put in place a routine of ensuring her needs are met. If that does not happen, P is likely to become oppositional and the stress on the placement will be significant.

The evidence of the Guardian

- 67 It was clear from Ms Gulabivala's written report and oral evidence that she has found this a difficult case. She says explicitly in her report that throughout the proceedings she had hoped that P would be able to remain living with her mother. That was, indeed, my sense of her view having been involved with this case, as she has been, since it was issued.
- 68 The Guardian sets out in her report the reasons why she has come to the conclusion, I think with reluctance, that the best option for P would be a move to foster care. Ultimately, her view is that the mother would be unlikely to maintain a good enough standard of care for P on a consistent basis in the long-term.

- 69 In her oral evidence, she emphasised P's vulnerabilities associated with her health condition and her developmental delay. She thought that the next few years would be particularly important if P is not to fall further behind academically. She continues to be worried about P's low weight, although Great Ormond Street has said that there is not a cause for clinical concern, and she was concerned that the mother did not accept that she needs support going forwards. She said that she could not have confidence that the mother would work well with professionals in the future and maintain the current stability that has been achieved.
- 70 On the other hand, the Guardian fully recognised, both in her report and her oral evidence, the disadvantages to P of a move into foster care. Her evidence as to the availability of prospective foster placements was not available when she prepared her final analysis. The fact-finding statement produced by the local authority was prompted by this gap in the evidence. I did not get the sense that Ms Gulabivala was confident that a suitable placement has yet been found for P. She was also particularly concerned about the impact on P of a sudden move to foster care. She did not agree with the local authority's plans to reduce contact, either around the time of the move or later. In the long-term she considered that it was crucial that P should maintain a meaningful relationship with her mother and was worried that if contact reduced to what is essentially identity level contact this would diminish P's relationship with her mother well below the level of her needs.
- 71 Ms Gulabivala's views and recommendations were explored thoroughly in oral evidence. She was very clear about the relative advantages and disadvantages of each option. Her evidence has been of real assistance to me in formulating my own views about this case.

The threshold criteria

- 72 It is not disputed in this case that the threshold criteria are met. A threshold document has been prepared by the local authority and responded to by both parents, although, as is inevitable in the circumstances of this case, its content relates solely to the mother's care of P. It is probably fair to say it is not entirely clear from the threshold documents what, in terms of the detail, is disputed and what is not. The local authority's documents are not always clearly drafted and the mother's responses are at times equivocal.
- 73 On the basis of the documents and the evidence I have read and heard, including the admissions made by the mother, and her written and oral evidence, I make the following headline threshold findings which, in my view, are sufficient to form a platform for the welfare decision.
- 74 The mother has neglected P's health needs. She has not always engaged with the treatment plan set out by Great Ormond Street. She has not always sent in regular blood spots or adhered to P's dietary regime. As a result, there have been several occasions when P's tyrosine levels have been outside the target range. This has put her long-term health and development at risk.
- 75 The mother has suffered from poor mental health in the past and has not always engaged with mental health services. This has affected her ability to provide care for P.
- 76 P has been exposed to conflict in the family home between her mother and her maternal grandmother.

Welfare evaluation

- 77 I intend to use the framework of the welfare checklist, highlighting the factors I consider to be of most relevance.

- 78 P's wishes and feelings are clearly ascertainable, although she does not know that there is a possibility she may be removed from her mother's care and so she has not been directly asked for her views. She loves her mother deeply and I have no doubt that she wants to remain living with her. Care from her mother and her maternal grandmother is all she has known throughout her life. P's wishes and feelings must be evaluated in the light of her age and understanding. She is nine years old but has a degree of developmental delay. It is likely that she does not have capacity to appreciate the medium to longer term risks to her health and development. The weight I can give to her wishes is limited, but they are important as an indicator of how she may respond if the decision of the court is one that she does not understand or agree with.
- 79 P's physical, emotional and educational needs. At a minimum, P has the needs of any nine year old. She needs a home where she lives with at least one adult with whom she can form a secure relationship and whom she can trust to meet her needs. She needs warmth and affection. She needs to have fun and be stimulated. She needs to have boundaries set for her. She needs to be a loved and valued member of the family where she lives and she needs to feel that she has permanence and belongs there.
- 80 P has existing and strong relationships with her family members. In particular, she has close relationships with her mother and her grandmother, with whom she has always lived, but she is also now developing a meaningful relationship with her father, with whom she has had fairly frequent virtual contact for about two years. She knows her younger half-sister, and a relationship with her is also developing.
- 81 In my judgment, P has a particular and identifiable emotional need, wherever she is living, to retain her relationship with her mother, who has been her primary carer and attachment figure throughout her life. The impact on her of a significant reduction in her mother's role in her life will be very significant, and she will experience this as a huge loss.
- 82 P has additional needs arising out of her Tyrosinemia Type II. She has quite complex medical needs. They require her carer to maintain a close overview of her blood levels, to liaise with Great Ormond Street, to make sure she takes her amino acid supplements and to monitor the food that she eats every single day. That task involves not just weighing the portions she is given and calculating protein limits, but also watching to ensure that she does not help herself to food, as children in most households are able to do, and as she has done before. The carer has to liaise with her school and with the parents of her friends whenever P is out of the home to ensure that those around her understand the seriousness of her condition and what has to be done to ensure her diet is correct.
- 83 As P gets older, she will need support to take on more responsibility for this herself. A condition like hers can be very challenging for a teenager to manage, as the mother's own history has demonstrated. Ordinarily, parenting a teenager involves allowing them to take some risks and to push boundaries. There is less scope for that with P because the risks to her, for example if she were to rebel against her treatment regime, are very high.
- 84 P's educational needs are also enhanced due to her health condition and her developmental delay. She has an education, health and care plan which I have read with care. It is very detailed and was clearly prepared by professionals with a thorough understanding of her functioning. It would, in my view, be difficult to replicate in a different education system, especially if P is being taught in a language that is unfamiliar to her. I note, in particular, that P's writing has been identified as a weakness, both in the EHCP and by the Guardian. She has no understanding of or ability to write in Arabic as yet and it is unclear to me

whether she would be able to develop that skill at all. If she were to transition to an Arabic-speaking environment and educational setting, that would result, in my view, almost inevitably in significant educational setbacks. Whether she would be able to recover from these is very uncertain.

- 85 The effect of change: P has been described by her school as a friendly, happy child. Her mother also said that there is very little that makes her cross or upset and she is usually very cheerful. However, her EHCP highlights the impact of her developmental delay on her ability to relate to her peers and to form friendships and social relationships. It is harder for P to establish and maintain relationships and it requires more work, both on her part and from those around her.
- 86 Two of the options before the court involve very significant change. A move into foster care would be a huge change for P. The Guardian thought she would experience it as a shock. She thought that P would be significantly distressed at her separation from her mother. She would have to form relationships not only with new carers but with any other children in the placement. In my view, she would struggle to adjust and it is likely to take her a considerable period of time.
- 87 A move to the father's home country would also be a very significant change. This would involve not just a change of household routines but a new culture and language. It will take some time, in my judgment, before P becomes comfortable let alone fluent in Arabic. She is likely to learn more slowly than other children because of her delay. In the initial weeks and months, if not longer, it is likely that P would feel that she cannot communicate what she is experiencing adequately to those around her. The effect of this on P will be mitigated by her knowledge of her father and his family. I accept that she knows them and has begun to form relationships with them, but those relationships as yet are still developing and she will have no real memory of spending time with them face to face. In my view, this would also be a profound change and one which has the potential to cause P very significant upset and distress.
- 88 Both of these options would involve the sudden and significant loss of P's mother's day to day presence in her life. That, in my view, will be a huge change for her. She will miss her mother enormously. If she is in foster care, contact can mitigate that loss to an extent. If she is in the father's home country, although virtual contact could take place and I am sure the mother would visit when she could, P is likely to feel that her mother is very far away. Their relationship is likely to be severely limited by the distance.
- 89 P's age, sex, background and relevant characteristics. P's parents are first cousins; their mothers are sisters. Both parents describe themselves as non-practising Muslims. P has lived all of her life in London, aside from two periods of between four and eight months when she was very young and spent time in the Middle East. The mother has also lived in the UK for most of her life and the language in which she and P communicate is English. Some Arabic is spoken in the home by the mother and maternal grandmother and P understands this to an extent but she cannot speak or write Arabic.
- 90 The harm that P has suffered or is at risk of suffering. If P's Tyrosinemia Type II is not managed effectively, she will suffer very serious harm to her health and development. The evidence from Great Ormond Street is that increased tyrosine levels are associated with ocular changes, skin changes, such as painful lesions, poor growth and neurological symptoms. It is important to remember that because of the rarity of this condition the prognosis is unclear. In particular, Great Ormond Street say that it is difficult to predict the

effect of P's condition, especially if poorly controlled, on her future intellectual development.

- 91 Thus far, P has not experienced any ocular or skin symptoms, despite a history of periods of poor adherence to treatment leading to high tyrosine levels, and her physical growth, although she is small, is in line with her centiles. Her treating consultant is of the view that her academic delay could be the result of past poor metabolic control but it is probably more likely to be due to a range of different factors. Wherever P is living, it will be crucial that her condition remains well controlled and that the progress that has been made over the past eight or nine months is maintained. If not, P is likely to suffer significant physical harm and development impairment, due to her condition not being properly managed.
- 92 There are some risks to P arising out of the mother's interactions with people she meets online. In my view, these risks are real but are less acute than those that relate to P's medical condition. The mother is undoubtedly vulnerable, particularly where her own friendships are concerned, and that creates the potential for P to be exposed to unsafe adults. However, these risks can be mitigated, in my judgment, as P grows older by specific work done with her to improve her own understanding of how to keep herself safe online.
- 93 P's prospects of reaching her educational potential will be affected if her education is disrupted, especially by a transition to a different educational system. That is particularly serious for P because she is so delayed. The Guardian explained to me that her reading and writing are well below age-related expectations.
- 94 P's emotional and long-term psychological wellbeing will be significantly affected if her relationship with her mother is lost or substantially diminished. That will be even more the case if she is unable to form secure and supportive relationships with new carers. In the longer term, if her relationship with her mother also dwindles P may well be left adrift in the care system without a sense of belonging anywhere.
- 95 It will be obvious from this analysis that I consider the stakes in this case to be very high indeed and that there is a real and significant risk of P suffering harm whichever of the options before the court is preferred.
- 96 The capacity of P's parents and other potential carers to meet her needs. The mother's capacity to provide good enough care for P is a key issue in this case. In the past the mother has not met P's needs to an acceptable standard. It is necessary to determine whether there is evidence on which the court can be satisfied that things have changed and that she will be able to meet P's needs going forwards.
- 97 It is accepted that since these proceedings were issued there have been improvements in the mother's care of P. The blood spots have been consistently sent to Great Ormond Street and P's levels have been within their target ranges. Ms Harold's evidence is that the mother's care of P overall has improved. The school and the family support worker evidence, which is more recent, indicates that P is now taking 90 per cent of her supplements at home and the school is supporting with the remainder. Overall, the evidence is that P's medical condition is currently sufficiently well managed.
- 98 It is necessary to consider whether the care that the mother is currently providing overall is good enough. The Guardian makes the powerful point that P needs more than just a basic level of care because of her overall functioning and developmental delay. In particular, she needs to be given a high level of stimulation and supported to engage in activities and to form social relationships. The mother's provision of stimulation has been inconsistent and it

is clear from Ms Harold's report that at least in the autumn, when that assessment was carried out, the mother's preferred way of spending the weekend was to stay at home and watch videos or play online games. There is evidence that over the course of these proceedings she has taken P more frequently to see friends or to go out to the park, but my sense from the evidence is that she has needed considerable encouragement to do this. The mother has some close friends who may be able to support her but both have family and other commitments of their own.

- 99 The mother's mental health has fluctuated. When her mental health is poor it affects her ability to care for P. In the past the mother has failed to take medication which has been prescribed for her. Her engagement with therapy is in its early stages. It is, however, true that the mother's mental health has been stable throughout these proceedings, despite what must have been enormous stress for a considerable period of time.
- 100 I remind myself that my focus in this case must be the mother's ability to meet P's needs with support. The initial expectation of Ms Harold was that support could be found within the family network. That has not been possible. The mother's relationship with her own mother has been volatile in the past, although the Guardian thought that it had shifted and become more amicable over the course of these proceedings. However, the maternal grandmother has a number of health difficulties herself and is not in a position to offer meaningful day to day input into P's care.
- 101 I have found the local authority's approach to this case to be flawed in that the expectation thus far has been that the aim must be to reduce and ultimately withdraw support. I am satisfied that that is not an appropriate or realistic approach to this case. In my view, support at approximately the current level (that is, four to six hours of family support worker support each week) is likely to be required indefinitely if the mother is to care for P in the long-term. There is not, in my judgment, evidence to support a suggestion made by Ms Koroma in her evidence that the mother would require twenty-four hour support every day. She does not need someone present in the home overseeing her throughout the day. What she needs is relatively frequent support and reminders to ensure that she is keeping appointments, managing P's condition and keeping her safe and providing her with adequate levels of stimulation and support at home.
- 102 In my view, it is not unreasonable to expect the local authority to make support at that level available on an indefinite basis. It may, in fact, be possible for part of the cost to be funded by health services given the circumstances of this case and the origin of the need but, in any event, the local authority resources required would be very much less than those involved in a placement in long-term foster care.
- 103 I accept that the mother's capacity and willingness to accept support in the future over a sustained and lengthy period is very uncertain. On the one hand, I recognise that she has been resistant to this in the past and that Dr Parsons suggests that an oppositional response may be part of her personality, although he coupled that observation with a caveat that the mother's very low verbal ability must be taken into account and that it is important that the right skills are used in engaging with her. I recognise also that the mother has said, as recently as 9 May to the Guardian, that she does not think she needs ongoing local authority support and that she is looking forward to a time when social workers will no longer be involved in her life. The maternal grandmother, with whom the mother lives, does not see why professionals need to be involved and finds their presence in her home intrusive.
- 104 On the other hand, I have to take into account the nine month period in the latter part of these proceedings when the mother has worked well with family support workers, taken on

board advice and made general improvements in P's care. I have to recognise also the fact that the local authority's approach throughout the three and a half years when they have worked with the mother has been that the aim should be to achieve independence and that the local authority should step away. As I have said, it is perhaps not surprising, in those circumstances, that this is the mother's expectation also.

- 105 On this fundamental issue it is impossible to make a firm prediction. There is a real element of uncertainty about the mother's capacity to sustain the working relationships that she has built up over the course of these proceedings. There are factors pointing in both directions. In my judgment, the prognosis is uncertain but it is not bleak.
- 106 The father has no direct hands-on experience in parenting a child of P's age and, as yet, has only a limited relationship with P herself. Taking on the care of a child in those circumstances would be a challenge for any parent, although not insurmountable when the will is there on the part of the parent and when the child is reasonably receptive to establishing a relationship. I am satisfied that the father has the capacity to develop the skills that he would need to parent P. He is clearly determined and capable. I am sure that he could acquire the knowledge he needs to manage her condition. However, in order to care for her safely the father would need to establish a secure relationship with her very quickly from a standing start and progress is likely to be impeded by (a) P's shock at the move and the loss of her mother; (b) the lack of a shared language in which they can communicate fully and freely, and (c) the complexity of her medical needs. I conclude that the task the father would be facing, if he were to take over P's care now or in the foreseeable future, would be a formidable one.
- 107 It is important to consider what would need to happen in order for the father to be in a position to care for P. In my view, before this could be considered the father and P would need to spend extended periods of time together so that their relationship can develop and P can also get to know his wife and daughter. It would also be essential that the language barrier is overcome, either by P learning Arabic or, more likely, by the father improving his English. The Guardian observed in her final analysis that the father has not as yet taken any meaningful steps to learn English to a standard that would enable him to communicate fully with P but seemed to assume that if she came to live with him in his home country he would get an Arabic tutor for her. In my view, this is expecting too much of P and if the language barrier is to be broken down, the main work needs to be done by the father and not by her.
- 108 Unusually, in this case I need to consider, albeit in very general terms, the capacity of any prospective foster carers to meet P's needs. In most cases the court will assume that a trained foster carer has the capacity to provide a good standard of care. In this case the situation is very much more complicated. Parenting a child with P's condition requires much more than the usual type of care. It is not just a matter of learning the mechanics of weighing out food and supplying the amino acid supplements at the right time. Any new carer will face the much more difficult job of working to secure P's trust so that they can overcome her resistance to the treatment regime, and creating a routine and robust systems in the household so that P's strict diet can be maintained, despite the fact that others in the home, including any other foster children, will not be following it.
- 109 I would be hopeful that an experienced foster carer could develop the necessary skills but it is far from guaranteed that that would be successful and the task will be complicated by the fact that P is certain to be missing her mother desperately and the prospects of her resisting are high. Parenting P will, in my view, be a daunting task for all but the most experienced and dedicated foster carer and even such a person, assuming they could be found, might well not succeed.

- 110 The range of powers available to the court. The threshold criteria are met enabling me to make a care order as the local authority seeks. If I decide that P should remain in her mother's care, the mother is willing to accept a supervision order. I have the power to adjourn, as the father asks me to do, if I think I need further evidence about his capacity to provide care for P. It would only be appropriate to do so, in my judgment, if I thought there was a realistic prospect of P being placed with her father in the foreseeable future. Proceedings cannot be adjourned indefinitely if there is no real chance of the father taking on P's care within a reasonable period of time.
- 111 I have not been addressed on the possibility of a care order with P remaining at home. That is potentially an option available to me, although I accept that it is one that should generally be reserved for exceptional cases.
- 112 If I do not agree with the local authority's plan for contact, it is open to me to make an order under s.34 of the Children Act.

Discussion of the realistic options: the balancing exercise

- 113 The realistic options for P's placement are that she remains with her mother, she moves into foster care, or that I adjourn for a further assessment of the father. I am fully aware that I am required to weigh up the advantages and disadvantages of each option side by side and that I must not fall into the trap, as the local authority have done, of conducting a linear analysis.
- 114 That said, I have come to the clear conclusion, having had all options in mind throughout this hearing, that of the three options before the court a placement with the father in his home country, either now or in the near future, is one which carries enormous and ultimately probably insurmountable problems. The father himself accepts that it would be very difficult to place P with him now. His case is that there should be a further assessment of him by an independent social worker who can carry out the work in person in his home country. I have to ask myself whether this assessment is necessary and what further information it would provide. A face to face assessment would give the court a fuller and more detailed picture of the home that the father is able to offer P but it would not change the fundamental difficulty with this placement, which is that P would be required to move to a home with family members she does not yet have an established relationship with, in a country where she does not speak the language and in circumstances where her contact with her mother would necessarily be infrequent and limited. These problems are not of the father's making but they are profound.
- 115 In my judgment, there are currently no gaps in the evidence which a further Part 25 assessment undertaken now could fulfil. The only way in which these issues could be resolved, in my judgment, is through time. If the father maintains virtual contact with P and continues to improve his English so that he can communicate meaningfully with her, and is able to travel to visit her so that a full and rich relationship can be established, then it is not impossible that she might be able to make the transition to live with him in his home country at some unspecified point in the future. But that time, in my view, is still some way off and there is much that would need to be done before the court could contemplate a move.
- 116 In my view, the real balancing exercise, and the task which I have found extremely difficult, lies in the evaluation and comparison of the two options of P remaining with her mother and a removal into foster care. If P remains with her mother there is a risk that management of

her condition will deteriorate once more, with consequences of the utmost seriousness for her long-term physical care and development. There is also the less dramatic but still significant risk that she will be under-stimulated and that her mother will not support her to achieve her full potential. And there is a risk, albeit speculative and probably manageable, that she will be exposed to unsafe strangers through the mother's own vulnerability and needs. The Guardian expressed the view, which I take very seriously, that if P remains in her mother's care she is likely to suffer significant harm.

- 117 If a care order is granted, P will be caused significant distress, if not trauma, by the separation from her mother. Whether she can recover from that and form meaningful relationships with a foster family is highly uncertain. It will depend on a number of factors, most of which are impossible to predict. If she does not settle swiftly, the prospects of her carers being able to manage her treatment needs will be reduced. Even if P appears to settle and adjust, I consider it likely that she will experience a sense of loss and dislocation that will resonate throughout her life. Her own developmental delay is likely to make it harder for her to come to terms with what has happened to her. From what I have heard and read about P, I find it extremely difficult to see how she would be able to make sense of a move. The only way in which I can conceive of it working is if she has extensive contact with her family, particularly her mother, so that the relationship survives in a meaningful way. I note that the Guardian at one stage in these proceedings was contemplating an arrangement in which P would remain with her mother but spend extended respite periods with carers who could provide high quality care and support.
- 118 I have power to make an order for weekly contact between P and her mother, which, in my view, is the minimum level she would need, but I am very conscious that that would be a high level of contact for a long-term foster placement and that it has been difficult enough to find a placement which will accept P without imposing a condition that would risk the carers withdrawing or the placement coming under unacceptable strain.
- 119 Although ordinarily the court will assume that a foster placement will meet most of a child's needs to an acceptable standard, there are some cases where a move into foster care is likely to cause a particular child real, non-speculative, enduring and significant harm. In my judgment, this is one of them.
- 120 The advantage to P of remaining in her mother's care is that she will remain at the heart of the family where she knows she belongs, where she is loved and cherished and where all of her important relationships are located. That advantage is not contingent on anything but is as close to a certainty as the court is ever able to come. The value of that to a child like P, who may not be able to live independently in the future and may well need, as her mother does, to share her home with family members into the long-term, cannot be overestimated.
- 121 The advantage to P of a move to foster care is that it is possible, at least, that her health condition will be better managed than it has been in the past, although that is contingent on her carers being able to build a relationship of trust with her relatively swiftly after the move so that she is compliant with her treatment regime, and therefore is far from being guaranteed. It is likely that her need for stimulation and educational support will be met, probably to a higher standard than the mother will be able to manage.
- 122 That is the stark decision facing the court.

Outcome

- 123 I have concluded that I do not have sufficient confidence in the proposal put before the court by the local authority to be satisfied that P's removal into foster care would be a better outcome for her than for her to remain where she is. I make that decision with my eyes fully open to the risks. I realise that the consequence of my decision may be that P suffers disadvantage and harm. I also recognise that in making this decision I am departing from the recommendation of an experienced Children's Guardian, who has carried out a significant amount of work in this case and whose final analysis was careful, thorough and balanced. The reason, ultimately, is that I have given a little more weight to the risks surrounding a foster placement, and I am a little less optimistic about P's relationship with her mother being meaningfully sustained if a care order is in place. For me, and I think also for the Guardian, this was an extremely finely balanced decision.
- 124 The local authority will have to remain involved with the mother and P for the long-term. That will require a shift in thinking, both on the part of the local authority and on the part of the mother. I have every confidence that the local authority can and will put in the resources that are required. The mother's reaction is less predictable but I hope that she will understand how close she came in these proceedings to losing her daughter and that if a future application is to be avoided there is no option for her other than to accept and act on the advice and support of professionals, as she has done for the past nine months.
- 125 I turn finally to the question of what order to make. It appears to be accepted by all parties that if the local authority's care plan is rejected, I should make a twelve month supervision order. I agree that a public law order will be necessary, if only to underline the continued risk that is present in this case. It seems to me that I should give the parties, in particular the local authority, an opportunity to consider whether this may be one of those rare and exceptional cases where a care order at home is appropriate. I am not by any means suggesting that this is inevitable or my preferred outcome but it seems to me that it is one to which I should give some thought before the proceedings conclude.
- 126 That is my judgment.
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