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Case No: BM20C00312

IN THE FAMILY COURT AT BIRMINGHAM

Priory Courts
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Birmingham
B4 6DS

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Before:

DISTRICT JUDGE WEBB

Between:

BIRMINGHAM CITY COUNCIL

Applicant

- and -

(1) MOTHER

(2) FATHER

(3-4) THE CHILDREN

(Via their Children's Guardian)

Respondents

Ms Andrea DAVIES (instructed by the Local authority Legal Department) appeared for the **Applicant**

Miss Rebecca CROSS (instructed by Greens Solicitors) appeared for the **First Respondent**

Mr Thomas DUGGAN (instructed by DM Partnership) appeared for the **Second Respondent.**

Miss Kristina BROWN (instructed by Anthony Collins) appeared for the **Children's Guardian.**

JUDGMENT

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DISTRICT JUDGE WEBB :

1. Before me today is the case of Birmingham Children's Trust versus Mother and Father. Mother and Father have two children, V, who is now six and T, who is now three.
2. Ms Davies has appeared on behalf of Birmingham City Council, Miss Cross on behalf of Mother, Mr Duggan on behalf of Father and Miss Brown on behalf of the children via their Children's Guardian. The matter has proceeded before me on two days last week and concludes today, 10 August 2022 with this extempore judgment (of which I have now approved the transcript).
3. The Local Authority seek a Special Guardianship Order for V in favour of her paternal grandparents. This is agreed by all parties. They further seek a placement order in respect of T, this is opposed by all other parties. The Local Authority is seeking to place T in an open adoptive placement allowing limited parental contact. The key dispute is the appropriateness and indeed proportionality of a placement order in the context of a child with severe disabilities and a life limiting condition. The other significant feature is the effect of learning difficulties in respect of the parents and T.
4. Before providing this formal judgment, I have explained to the parents the order I am making and the effects of that in more simple terms. They have confirmed through their advocates they understand and wish to remain to listen to the full judgment.

Background

5. Birmingham City Council issued an application for care orders on 11 December 2020 and an application for a placement order on 18 February 2022. The final agreed threshold states that V and T are at risk of significant harm as a consequence of their additional needs and the parents' inability to care for the children given the children's needs and their own limitations. V has a diagnosis of developmental delay, T suffered

brain damage following difficulties during labour and he has a number of very serious health conditions.

6. It is accepted that the parents struggled to care for T following his birth and on 13 February 2020 T presented as blue in colour, cold and sweaty, waxy in appearance and showing signs of distress. The parents had not realised he required medical assistance. On a separate occasion, V had some discharge out of her ear and the parents had not used the appropriate medication appropriately.
7. The parents have conceded that they were unable to meet T's basic needs and as a result of this T has suffered physical harm. Examples of their inability to learn the required skills include repeated attempts to demonstrate how T should be fed on specialist milk with concerns being raised on seven occasions. The parents had also failed to order essential items including milk and various medications and that led to a risk of T being in increased pain. It was accepted by everyone that the parents had their own learning difficulties and that the children had particular learning and care needs, this unfortunate combination resulted in the parents not providing consistent and safe parenting.
8. On 16 December 2020 the matter came before Recorder Worsley. He made an interim care order with V remaining at home and T remaining at A Hospice. By its very name, it is clear that the hospice is a place for children who require palliative care. This means that these children have shortened life expectancies.
9. By the time the matter came before Recorder Robinson on 29 January 2021, a kinship assessment of the paternal grandparents had been undertaken and was positive in respect of V. By May 2021 the parents had both formally confirmed that they did not seek return of T to their care, accepting they would be unable to provide for his complex health needs.

10. When the matter came before me on 2 June 2021, I determined a residential assessment of the parents was necessary to determine whether they were in a position to care for V. That assessment took place at Dudley Lodge and the assessment was negative. By October 2021, V had moved to the care of her paternal grandmother. The matter was due to reach an issues resolution hearing on 21 March 2022 and by that time, the parents both accepted that V should remain in the care of her paternal grandparents, under a special guardianship order.

11. The matter came before me again on 3 May 2022, and at that point, for the first time in the proceedings, it looked as if it was possible that T could move from the Hospice to a familial caring setting. Potential foster carers had met with the social work team. They had significant experience of caring for children with profound needs like T, and they were looking to care for a child with disabilities and had a suitably adapted home with the requisite care equipment. They had expressed an interest in moving forward to adoption and indeed had adopted other disabled children some of whom lived with them into adulthood and continued to live with them.

12. As such when the case came to a final hearing the issues had simplified. It was accepted that T would not be returning home. The issue for T was whether he would be made subject to a care order, with a plan of long-term foster care, or whether he would be made subject to a placement order, with what was described by the local authority as a ‘time-limited search’ for adoptive parents. In relation to V the issues were narrower. It was accepted that she would remain with her grandparents under a special guardianship order, though inevitably there were outstanding issues in terms of the various care plans and the contact between siblings and parents.

The Written Evidence

T's Medical Condition.

13. T has hypoxic ischemic encephalopathy; a brain dysfunction or injury which occurs as a result of a lack of oxygen or blood to the brain, in this case at birth. He has cerebral palsy which in T's case has resulted in developmental delay, physical difficulties and involuntary muscle movement. He also has epilepsy, similar to Lennox-Gastaut syndrome epilepsy, which demonstrates itself in seizures, which can be severe.
14. As a result of these complications, he further suffers gastro-oesophageal reflux disease, which is acid from the stomach leaking into the gullet and as a result of this, he has had an operation called a fundoplication to his upper stomach. He is fed via a tube to his stomach. He further suffers severe global developmental delay, possible sclerosis in the spine, talipes club foot, drooling and recurrent ear infections. He is a profoundly disabled young child. That evidence is best supplied in a statement prepared for the court by a Consultant in General Paediatrics at Birmingham Children's Hospital, dated 26 April 2022.
15. One other piece of evidence which is not in written form before the court but is referred to in the social work evidence, and not challenged by any party is the view of the treating paediatricians that T has a 60% chance of surviving to the age of twenty and therefore, clearly has a potential mortality before reaching twenty years old of 40%.

The Social Work Evidence

16. The initial Social Work Evidence Template was provided by a social worker who described the situation in the family in early 2020. It is clear that T was at risk of very significant ill health as a result of the parents being unable to identify the fact that he was unwell. A particular incident occurred on 13 February 2020, when a community

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nurse visited T, she found him “waxy” in appearance. Her view was that if her visit had been thirty minutes later, T could have died. This was not challenged.

17. That social worker identified the learning difficulties the parents experienced, Mother has an IQ of sixty-two and significant limitations which deem her to experience a learning difficulty. Father has an IQ of sixty-three which, again, presents in almost entirely global impairment. As a result of this, the hearing has proceeded with the benefit of an intermediary as far as Father is concerned.
18. The social worker presented a full picture of the inability of the parents to care particularly for T. The father responded as early as 16 February 2021, accepting the difficulties and stated at paragraph 53 of his statement:-

"In respect of my precious and much-loved son, T, it is with great sadness that I'm compelled to accept that T has a range of complex and changing needs that nothing but a specialist placement with professional carers can provide the love, care and attention he deserves."

19. Again, very bravely, Mother made a statement very shortly after in very similar terms.
20. Moving on, a second social worker (‘the allocated social worker’), and the social worker who has been involved for the majority of this case, became involved. She described in her witness statement of 24 February 2022, that the Dudley Lodge assessment ended up as unsuccessful after three months with the parents consistently struggling to meet V's needs. Her view for T was that his needs would be best met living in a family setting. Her view is that T, like any child his age, should have the opportunity to be cared for in a family setting without the intrusion of the local authority in his life. The conclusion was that the LA proposed adoption as a final care plan.
21. It was accepted by the allocated social worker that T would need ongoing support from disability services and adult social care. Whilst this was the evidence of the allocated

social worker, it was supported by the team manager, the Head of Service and the Independent Reviewing Officer. This proposal was ratified further by the Agency Decision Maker and so, it is a corporate decision.

22. Further information was provided by the team manager who brought the situation up to date in a witness statement from July of this year. This reported T had been in hospital for two weeks in July as a result of respiratory problems, that Mother had met the prospective foster carers, the foster carers were based in South-West of England and they were delighted at the prospect of caring for T and, indeed, had already begun to love him. It is clear the social work team had done a huge amount of work looking at a safe process for T's transfer to this new placement.
23. I should at this point say, no one is saying that this placement is not a placement which should be very actively considered and which, on the face of it, has very significant merits. These are people who have been foster carers for seventeen years and have adopted ten children with varying disabilities. The Children's Guardian has some residual concerns about some elements of the assessment of these potential carers, based predominantly on the extent of T's disabilities, but it is accepted for the purposes of today that the mode of direction of travel is for these people to care for T, and the real issue for me to decide is the mode of the care, be it through endorsing a plan of adoption or under a care plan with long-term foster care.

Additional Evidence Provided by the Local Authority

24. The final piece of significant written evidence comes from a family team worker at the Children's Hospice. She confirms:

"As a family team worker for T and his family, I had a general overview and support to T."

25. This statement is based on recorded electronic notes made by the clinic and nursing staff on the days which the parents attended. Interestingly, the clinical staff have not been asked by the local authority to supervise contact, so it appears that the parents were able to attend, but once they were in the unit they basically looked after T in the presence but not supervision of staff members. They confirmed that contact between T and his parents has been on a Saturday once a week for two hours, with video during the week. Staff had reported contact is favourable between T, his parents and his sister V, as well as extended family, his grandmother, niece, aunt and uncle who made occasional visits to the hospice. T recognised his immediate family, mother and V showed his pleasure in recognition and smiles. Hospice staff had not reported any issues with contact between T and family members.

The Children's Guardian's Analysis

26. The Children's Guardian completed her PLO analysis on 29 April 2022. I am indebted to her detailed description of T's health needs, which I found the most useful starting point to understand his profound disabilities. She confirmed that T has nine diagnoses, which requires twenty-four-hour care. He has the involvement of twenty-one professionals in his care and takes fifteen medications each day.
27. In her analysis, the Children's Guardian confirmed that she could not support a return of T or V to their parents' care. At paragraph 40 of the report, she commented on V stating,
- "V identified her parents, T, grandparents and cousins as people who made her happy. V said she had no worries and was not sad about anything."
28. She describes T as a sociable and a pleasant young boy, he is reportedly happiest when he is 'people watching'. He enjoys interaction, he smiles when people talk to him and

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likes receiving hugs. It is The Guardian's view that she is able to support the local authority's view that due to the complexity and the uniqueness of V and T's individual needs, she supports separate placements. She however differs in terms of the plan for T and is clearly significantly opposed to the plan of adoption. She suggests that the allocated social worker has failed to give proper weight to the research evidence in relation to brain impaired children. She states this indicated that brain impaired children would react to sight, smell and hearing and thus, T would be able to identify his parents or V's features by their distinctive sounds and smells.

29. She refers to a piece of research by Reed and Harrison from 2002, which stated that social workers were at risk of erroneously assuming that contact with family is less significant in the context of disabled children. She said studies confirmed that the need for family contact for this group was at least as great as for non-disabled children.
30. She set out the arguments in favour of adoption, and she accepts that there are arguments in favour, which I will not set out now because they are rehearsed elsewhere. Conversely, she outlined twenty-five arguments against adoption. She was particularly concerned about the life-limiting condition. She states at paragraph 88 of her report, "Every moment with his parents and sister is crucial for T due to his health needs and his presentation over recent months." She continues at paragraph 89, "It is for these reasons that it is my view that a plan of adoption in T's care would be disruptive for him". At paragraph 93 she states, "it is for this reason I strongly oppose the local authority's care plan of adoption."

Oral Evidence

31. I heard oral evidence from the allocated social worker and the Children's Guardian. They were both subject to detailed and forensic cross-examination. I have read the

bundle which exceeds 2,500 pages and I have considered submissions from all parties.

The fact I do not refer to a document or a piece of evidence does not mean I have not considered it.

The allocated social worker

32. The allocated social worker was put in the position of being the flag bearer for what was a corporate decision. This, at times, put her in a very difficult position, particularly as she had moved on from that particular role. It was clear that she had grown to know the family well, and she spoke warmly of T and V. It was clear that the local authority had formed a corporate view that there was a risk that T was being disadvantaged as a result of his disabilities. The allocated social worker and the local authority legal team were very keen to avoid discrimination on that basis. As such, the corporate view was T should not be denied the chance of permanency via adoption purely as a result of his disabilities.
33. The allocated social worker had accepted throughout the duration of the case that finding a permanent placement would be difficult, but she steadfastly refused to rule it out. It is hugely to her and the team's credit that they appear to have identified a family which is initially prepared to foster T and is actively considering adoption. This placement may well be the best option for T.
34. It is my conclusion that the desire to secure this placement and the perhaps unique opportunities it offers has led to the local authority focusing on achieving that end and, to some extent has led them to ignore other options. The most glaring example of this is in the last social work evidence template of the allocated social worker; in her matrix of realistic options she considers the options of adoption versus returning home but does not even add long-term foster care to the matrix. This omission put the allocated

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social worker in an impossible position; clearly long-term foster care was a realistic option for any child approaching four with an older sibling remaining in the family group. The failure to acknowledge this and thus the failure to attempt the side-by-side holistic analysis the court requires left the allocated social worker advancing one option without any proper consideration of the other realistic option.

35. During cross-examination, a number of evidential points arose. The allocated social worker was reflective on T's ability to differentiate between carers and family. She was unable to say that she accepted the quality of recognition was different in relation to family members, as opposed to frequent carers. The general thrust of her evidence on this point was that she felt it was familiarity rather than family bond which created the recognition and pleasure which she accepted T felt on seeing family. This is a nuanced point and, perhaps, could only definitively be decided by expert evidence. But it did appear at odds from the report of long-term carers, as set out in the letter from the Hospice.
36. She conceded there was a bond, particularly between Mother and T, stating "he has a very good bond with his mother. I think they have a very secure bond." She accepted that T would need support throughout his life but differentiated between support from a disability assistance social worker who would look at the practicalities of T's care, and a social worker in the position of parental responsibility, making decisions about care.
37. I detected a nervousness in jeopardising this particular placement. Firstly, there was real energy to her evidence when she described the placement. It was clear that she regarded this as an almost unique opportunity for T to have a life which was not institutionalised. Secondly, when asked why these carers preferred adoption over

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fostering, she indicated that in the past they had experienced difficulties managing contact with birth parents, and so preferred adopting. This was a telling piece of evidence. She accepted that T's health needs would increase over time, making any placement more rather than less demanding.

38. She was clear the placement breakdown was more likely in a foster placement rather than in an adoptive placement. Statistically she is correct, however, this argument has less force in this scenario when the foster placement is the potential adoptive placement. It is the same carers performing the same role, but under a different legal framework. It is entirely possible that the placement would be more stable with the assistance of a care plan and appropriate funding. If it were possible to remove the parental contact from the equation, I can see the argument she is making, because we would have a life without state and birth parental intrusion. However, no party in this case suggests it is appropriate in this case to prohibit parental contact, the only difference is frequency of contact, as the plan is for twelve contacts per year under long-term foster care and six under an open adoption. I thus struggle with the enhanced chance of breakdown under adoption.
39. I found her to be entirely motivated and centred on T's welfare. She indicated that, "I sing to him, talk about birds, these are the things he likes." This is indicative of a committed social worker, who had taken the time to know T in a very real and personal way. She was determined to see the end of institutionalisation of T and her view that T would be better off in a family scenario was sound and not challenged.
40. A huge issue arose in relation to end of life care. The evidence available stated T had a 60% chance of reaching twenty. The question was what role his birth parents would have in any decision-making under an adoptive placement. The clear legal answer is

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none. With the parents' and local authority's parental responsibility ended any input would be entirely at the discretion of the adoptive parents.

41. The allocated social worker's view was that the adoptive parents would consider the birth parents' view. She would not concede that this lack of legal status would not be in T's interest.
42. Miss Brown highlighted that if there were to be a decision as to the ending of lifesaving care the adoptive parents were free to make that decision and could do so alone in what would clearly be the most stressful of situations. She contrasted the position to under a care order, where the local authority could not agree to such withdrawal and thus an application would have to be made to the High Court where T would be represented, and the full welfare issues canvassed. This example very starkly illustrates the different positions and the potential exclusion of the birth parents from decision-making and, indeed, even attendance at death in this scenario.
43. The allocated social worker maintained the local authority's plan was to have a time-limited placement order and conceded that a situation could arise where these prospective carers were prepared to care under a foster placement but would not proceed to adoption. In those circumstances, the local authority wanted the flexibility to seek alternative adopters and, indeed, would start that search as soon as a placement order was made to run parallel with the placement with this family. It was suggested that there had been real difficulties in finding a foster placement during the currency of this case. It was suggested this rendered this course of action unrealistic and she did not accept this. This appeared to be against the weight of evidence which clearly demonstrated finding any sort of carers was difficult and identifying prospective adopters willing to take on a child with these needs, and the requirement of an open

adoption seemed almost impossible. The best argument for this is that it has not been possible to place T with any carers of any form for eighteen months.

44. The allocated social worker accepted that T would always need a detailed and involved care package but believed that there were adoptive parents with the skills to coordinate a package. It was suggested it would be better for T to have the local authority involved with the statutory duty to consider needs and coordinate and, on occasions, fund services. She did not accept that position.
45. She confirmed the prospective carers had been fostering for seventeen years and had adopted ten children with varying degrees of disability, some of these remain in their home in adulthood. She accepted that the plan for adoption would halve familial contact from twelve times a year to six. She viewed six times a year as "suitable for permanency". It was put to her that as T could not possibly understand the nature of the placement, all he would experience is a halving in contact with those with whom he had a bond. The allocated social worker did not accept the usual arguments of too much contact undermining placement stability did not apply in a case where T would simply accept the care given to him. The allocated social worker's view was, "We should not ignore the intrusion." Clearly, any intrusion would be into the lives of the carers and not T.
46. It was put to her that T's level of stability and security was not going to be affected by the label put on his care. It was suggested to her that there was some distinctive advantage to foster care, such as a right to respite from care. Her view was that as a child receiving palliative care T would still have a right to respite at Hospice. This is simply wrong. The Hospice is a charity and in reality was likely to supply respite, but

it is not a right the adopted parents had to insist on in the way that foster carers would have the right to such care.

47. This case revealed some large and difficult issues. How do we ensure disabled children are not discriminated against in the care system? How does a child's reduced life expectancy and possible need for end-of-life care during his childhood impact on the welfare of that child under different legal frameworks? Does the accepted position the parents are unable to care due to inadequacy of parenting rather than personal fault impact on their future involvement in the child's life in this scenario? How does a profoundly disabled child experience relationships and are those relationship with family of a different quality to those with other carers?
48. Unfortunately, the starkness of the local authority position led to an attempt to portray it as absurd and to completely undermine the validity of the social work undertaken. I did not find this helpful.
49. I found the allocated social worker to be a committed social worker who focussed on T's needs. However, the failure to recognise long-term foster care as a realistic option left her appearing closed to options. She adopted unreasonable positions in relation to the prospects of breakdown between different modes of care and chances of finding alternative adoptive carers, and this undermined her evidence to some extent. However, she did provide a clear narrative that institutionalisation was not in T's best interests and whilst it was difficult to find a family setting, it was not impossible, and she was clearly very determined to give T the best chance at permanency. In doing so, I consider she placed too much weight on protecting the wishes of these particular carers, in effect, seeking an option which provided these carers with the most freedom of decision-

making and did not fully acknowledge that this significantly reduced the role of the birth family.

The Children's Guardian

50. The Children's Guardian had real doubts about the placement. She felt the information was incomplete. She agreed the carers deserved credit for coming forward but was concerned as to how they cared for so many disabled children, including those with cerebral palsy. Her view was there was insufficient information to determine if they had their requisite skills to care for T. Her view was T required care, which was 'experienced, responsive and attuned'. She was significantly concerned that once placement occurred, contact may well cease, even with a post-adoption contact order. She indicated in her experience the observation of contact orders can cease very quickly after adoption.
51. A major concern of hers was decision-making with regard to health issues. She felt that, once a carer was caring under an adoptive placement, there was a real risk they would make their own decisions. She stated, "they are bearing the burden of care. I do not think they will comply with anything other than what their hearts or guts is telling them". This appears to me to be a far too wide assumption, but it does contain a central truth that it will be their decision to make, and those decisions will be made once they have devoted time and energy to T. There is a real risk that they may be less open to other's views and input at that stage.
52. She was concerned that professionals were, in her view, making assumptions that a child with disabilities could not form bonds or attachments. She was also worried about V's contact with T under an adoptive relationship. The grandparents, as she suggested,

would need to fund the travel, and that would be an additional burden. Her view, bluntly, was that adoption was not a realistic option.

53. Her evidence allowed me an opportunity to better understand T's actual healthcare needs. It was accepted that he needed to be moved every three to four hours throughout the night and needed to be monitored. The agreed position was that this was not waking monitoring, but rather having a person nearby who could respond to an alarm sounding triggered by the various monitors he has. I was not informed as to how often the person monitoring was woken in the night, how long the turning over would take and how frequently sleep would be disrupted significantly for health reasons such as suction of mucus. I am surprised that the local authority did not have a very clear picture of this.
54. I also did not have a picture as to how those interventions would change over time. For example, would two people be required to carry out some of these tasks as T grows and becomes heavier? Miss Cross, on my request, provided an analysis of the evidence of care presently provided overnight, and excerpts from this include the following from the lead Nurse at the Hospice:

"T requires all his personal care needs to be met throughout a twenty-four-hour period. This involves him being washed, dressed, nappy change and ensuring he does not develop any pressure ulcers.

T has slept well overnight, repositioned regularly, checked every ten to fifteen minutes. Pad changed, passed urine only.

Repositioned every few hours, pad changed, passed urine, bowl smear only. Has been unsettled overnight, shouting out. Now sleeping and settled, checked every ten to fifteen minutes.

He has been very unsettled overnight, periodically screaming, aching, grinding teeth, retching and gagging and generally difficult to console. Pyrexial through regular paracetamol has been administered, he has been awake most of the night and was reportedly unsettled yesterday.

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T has been struggling with bradycardia overnight, during which his heart rate drops to under forty. This has been raised with the consultant and is being monitored. T is able to be stimulated and woken during these episodes, and needs to be taken to A&E if needed."

55. The Children's Guardian's view was that this was properly described as 'twenty-four-hour care' and would have a physical and emotional drain on any carer's resources. As T suffers from epilepsy, there was always a possibility of fatal seizures, which meant the need for monitoring was significant.

56. On the issue of T having a different reaction with family to carers, the Children's Guardian stated,

"I specifically asked contact workers and they've all agreed there is a difference in his response to family as opposed to professionals. The professionals say there is a difference, he smiles and thrashes his legs."

57. In a similar way to the allocated social worker, the Children's Guardian was subject to detailed forensic cross-examination, aimed at undermining her credibility. She accepted that whilst she had experience with disabled children both as a frontline social worker and a Children's Guardian, the numbers were relatively small, with three cases as a social worker where children had complex needs, and two cases as a Children's Guardian. It was successfully established by Ms Davies that this was a level of experience which would be less than those social workers exclusively working with disabled children as a speciality.

58. It came as a surprise to me that the Children's Guardian had never actually met T face-to-face. She had met him twice via video call, though I struggle how this would give a full impression of him to her. She had made attempts to speak to carers recently but it appeared that whilst messages had been left, they had not been responded to. The suggestion was that this lack of physically meeting T left her in a weak position to comment on bonds. There is some merit to this argument. I do think a face-to-face

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meeting was required, and it weakened her evidence as opposed to the allocated social worker, who had clearly met T many times and had formed a bond. However, the Children's Guardian was clear as to her methodology. She had spoken to numerous professionals and carers, and they all commented on the different quality of their relationship between T and his family and T and others.

59. She accepted that generally, disabled children should be given the same opportunities as non-disabled children, but said that these opportunities cannot, necessarily, be delivered in the same way. She was clear that T could not go through life without a social worker due to his medical needs and as such, the usual stated advantage of lack of social work scrutiny did apply. She went further than this stating,

“There is no advantage to there not being social workers, his needs demand a social worker. He would require LA input to manage his care. There is no benefit to him not having a social worker.”

60. Her view was that in most local authorities, the social worker supervising the care planning would be the same social worker as that managing the health-based care and as such there would be no higher level of intrusion. She conceded that she should have made her own investigations in relation to the prospective carers, and that would have allowed her to understand them better. She was very clear that she did not regard open adoption as something that should be considered. I was not helped by this response. In reality, the realistic options in providing safe long-term care were always likely to be long-term foster care or an open adoption. In the same way that the allocated social worker did not properly consider long-term foster care, the Children's Guardian did not consider fully open adoption.
61. The Children's Guardian explained her unwillingness to consider adoption of any form was due to the severance of family ties; she was very clear that the existence of a contact

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order of itself does not stop that severance. She is, of course, correct here, the adopted child is no longer the birth parents' child and the fact they can see the child is very far from remaining linked to that child legally and in terms of parental responsibility. She was clear that T's relationship with his sister were key and reiterated her concern that even with the benefit of the contact order, contact may not continue.

62. She was totally opposed to any reduction in contact below twelve times a year proposed and suggested there was a danger we were looking at the needs of the carers and not the needs of the children to have regular contact. She accepted that adoption did have the benefit of permanency but did not accept that this placement was more stable than an adoptive placement and indicated she had not been able to find any research on children with complex needs and placement breakdown, despite searching for that. She accepted there were disadvantages in long-term foster care and considered breakdown would be disadvantageous. However, it was her view that there was no guarantee that these carers would be able to care for T in any event once he is in their care.
63. She conceded that adopted relationships can be continued but was robust in saying that T has a family, his birth family, and they were not going to go away at eighteen. She was clear she could not see circumstances where alternative carers could come forward to be assessed and care for T within the six-month period suggested and she felt that was entirely unrealistic.
64. As indicated above, I do not regard this case as straightforward as the two professional witnesses seem to. The Children's Guardian explained her concerns in relation to adoption but did not wrestle with the ways open adoption might be made to work. She was not helped by her lack of visiting T and speaking to the respective carers. On the other hand, her understanding and explanation of T's medical position was first rate and

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there was some merit in her canvassing opinion from those intrinsically involved in T's care, rather than relying on what would have been, at best, a couple of observations. Her analysis was exhaustive as to the pros and cons of adoption and long-term foster care and was more persuasive than perhaps her oral evidence.

Findings of Fact

65. It is for party who seeks to advance a fact to prove that fact on the balance of probabilities. I am not going to give myself a Lucas-type direction in this matter, nobody is suggesting anyone has been dishonest as to any matters.
66. The following factual findings are easily made based on the evidence and were not disputed.
- a) T is profoundly disabled,
 - b) his condition will deteriorate,
 - c) he has a 60 per cent chance of reaching 20 years of age and so conversely there is a significant chance he will not live to adulthood,
 - d) any caregiver would need to provide a standard of care which requires skill, and physical and emotional commitment, and this will be physically and emotionally draining over time,
 - e) there is no clarity as to how these needs and thus demands on the carers will change over time.
 - f) There will always be substantial social worker involvement in his life.

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- g) T will have no understanding as to the legal position and issues of stigma therefore do not apply.
- h) It appears that the social work team have found an excellent option. It would be better for T to be cared for in a family setting as opposed to an institutionalised setting.
- i) T has strong bonds with his mother and bonds with other family members.
- j) Contact with family members is beneficial to T.
- k) Mother has fully committed to contact, father a little less so.
- l) Contact with V is beneficial to both T and V.

67. The following findings are more disputed:

- a) On balance, I find that T has a deeper bond with his family than he has with caregivers. I accept the allocated social worker's view that he can form bonds with caregivers and familiarity is an essential element of this, but I find that his bond with his family has a different quality to it. I make this finding on the basis descriptions of his interaction with his family and this is supported by the letter from the Hospice and inquiries made by the Children's Guardian of those involved in his care. I note the Reed and Harrison research from 2002, which I have already referred to and which counsels against making assumptions about the value of contact in disabled children, and emphasis the engagement of senses such as sight, smell and hearing. This indicates that we need to be more

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alive to the possibility that T bonds in ways different to other children.

I have also considered the photographs contained in the witness statement of mother, and these appear from [C62] onwards and show, for example, V embracing a sleeping T, T draped across his mother's lap and V beaming whilst cuddling T. This is the sort of intense sensory interaction that cannot be replicated by adult carers;

- b) I find further that any placement for T has significant risks of breakdown. The demands on carers will be extreme. I find that an adoptive placement has the advantage of the high level of commitment shown by the adopter. Conversely, I find that the caring demands will be so extreme that the availability of financial backing, respite care and expert advice as a right available at all times weigh in favour the sustainability of the placement during difficult times. Therefore, on balance, I see that as neutral; it is the same carers caring for a child they say they already love, and this commitment will remain roughly equal whatever legal label is put on the placement. As such I find the chances of the placement breaking down are roughly equal whether it is an adoptive or foster placement in these particular circumstances;
- c) I find the prospects of contact continuing under adoption are uncertain. I have a mechanism to order it, but enforcement would be in the hands of unsophisticated parents and grandparents who would be busy caring for V. All I can say is contact would not be guaranteed in this scenario. I find the evidence of the carers preferring adoption as it removes the requirement to deal with the difficulties of contact with birth parents worrying;

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- d) I find that adoption would lead to a position where neither the local authority or the birth parents would have any rights in the event that T were to become unwell and decisions needed to be made as to treatment. This is a simple statement of the legal position. As such, there is no guarantee that an adoptive parent will involve the birth parents in key decisions;
- e) I find the prospect of finding other adopted parents in six months fanciful, given the requirements for an open adoption and T's needs. This is supported by the difficulties in finding a foster placement for T in the period since December 2020.

The Relevant Law

68. A court may not make a care or supervision order unless satisfied that the threshold as set out in section 31(2) of the Children Act 1989 is crossed. The burden lies on the local authority to prove the allegations it makes. The standard of proof is the civil standard and thus on the simple balance of probabilities. The starting point and, indeed, the heart of the welfare analysis in the checklist is set out in section 1(3) of the 1989 Act, in cases where adoption is not contemplated and the checklist in section 1(4) of the 2002 Act where adoption is one of the options sought. Where a case is difficult on the facts or finely balanced, Baroness Hale (as she was) provided clear judicial encouragement to address each of the factors in the welfare checklist, in order to ensure that no particular feature of the case is given more weight than it can bear: *Re G (Children)* [2006] UKHL 43 at paragraph 40.
69. When determining these issues, the welfare of the child with whom the court is concerned must be the court's paramount consideration. In cases involving adoption,

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that is the child's welfare throughout his life. The court should have regard to the general principle that delay in determining the issues is likely to prejudice the welfare of the child. The court should make no order in respect of a child, lest it considers that to make an order would be better for the child than to make no order at all.

70. The court must also take into account the Court of Appeal's judgment in the case of *Re B-S (Children)* [2013] EWCA Civ 1146. There are three points that were emphasised in *Re B-S*. First, although the children's interests are paramount, the court must never lose sight of the fact that the children's interests ordinarily include being brought up by the child's natural family, unless the overriding requirement to the child's welfare makes that not possible. Second, the court must consider all the realistic options before making a decision. Thirdly, the court's assessment of the parents' ability to discharge his or her responsibilities towards a child must take into account the proper assistance which the local authority can and should offer.
71. The court must have proper evidence to support a care plan and must explain any decision in a reasoned manner. The court is not confined to those matters which the local authority seeks to prove but any facts that a judge finds are true must be securely founded in evidence. The fairness of the fact-finding process must not be compromised.
72. Within this context, reasonable and realistic options mean options which are genuine possibilities and not theoretical outcomes. In terms of this process, in approaching the realistic options in a case, the court must consider the merits and disadvantages of each realistic option and compare in a holistic way that option with all the other realistic options, having proper regard to the merits and disadvantages of those other options. It

is not appropriate to approach this process in a linear manner by removing options sequentially.

73. The final stage is to cross-reference the suggested course indicated by the welfare analysis with the test of proportionality. The principles of proportionality in accordance with Article 8 of the European Convention of Human Rights and Fundamental Freedoms are engaged and must be analysed alongside the welfare checklist. The court must have regard to the Article 6 and Article 8 ECHR rights of all parties and must be satisfied that any interference with the Article 8 rights of the parties is in accordance with the law, necessary and proportionate. In the event the Article 8 rights of the parents conflict with the Article 8 rights of the child, then it is the child's rights that must be given priority. A care order represents a drastic curtailment of the rights of the parents under Article 8, which can only be justified by pressing concerns for the child's welfare. This is, however, not an absolute right and the court representing the State in certain situations is allowed to interfere with that right, but such interference must be justified, necessary and proportionate.
74. I can only consider making a placement order where the child is subject to a care order and the threshold criteria have been met. I must then make a further decision, and that is the consideration of whether I can properly overcome the parents' objections to making placement orders. This involves consideration of the test set out for dispensing consent under section 52(1)(b) of the Adoption and Children Act 2002, which in turn requires the consideration of the children's welfare interests under section 1 of the same Act. I will be returning to section 1 of the Act, but of course the paramount consideration must be the child's welfare throughout his life, and the key difference between the checklist under the 2002 Act and the 1989 Act is to recognise the complete severance of familial bonds.

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75. I may only dispense with the permission of the parents for a placement order if the child's welfare requires me to do so. The word "requires" means that it is imperative to do so, or it is demanded that I do so by the facts. In other words, there is no other realistic option which properly provides for that child's welfare. In the words of Baroness Hale, "nothing else will do".

Submissions

76. Both sides would have me find this is an easy case with a straightforward answer, with the other side's position being absurd. My view is that because of the difficult issues highlighted in this case it is not as straightforward as suggested, and the only way to properly decide it is to follow Baroness Hale's advice as set out in *Re G*.

77. In relation to submissions, a number of points arose which I found were of particular note. For the local authority the following points were raised

a) The local authority was determined not to be discriminatory with regard to a failure to consider and, if appropriate, seek a placement order. The local authority regard T's primary care needs as so great that this factor should be the primary factor of the court. It was submitted the availability of a 'forever family' post-eighteen is a significant advantage of an adoptive placement.

b) It was suggested that most of the scepticism towards adoption was based on an erroneous assumption that it would not be possible to find adopters. Adoption would prioritise T's right to a family life. It was suggested that the Children's Guardian had closed her mind to adoption and thus failed to consider its advantages and thus the disadvantages of

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long-term foster care. It was further suggested she lacked the experience to guide the court on these issues.

- c) It was suggested that the court should not pay too much regard to the end-of-life issues, as they may well not arise during T's minority.

78. For the parents and Children's Guardian, I particularly noted the following:

- a) there was a softer option to adoption via long-term foster care, and their view was that the analysis really needed to stop there. Given the foster carers were the only potential adopters, the usual arguments as to stability were suggested to fall away.
- b) In terms of disability, it was suggested the responsibility of the local authority is not to act in a discriminatory manner. That does not displace the welfare analysis required by the various checklists. T will always have intrusive involvement in his life, and this is a given.
- c) It was strongly suggested that contact is one of the few pleasures he has.
- d) It was further submitted that if the placement broke down, whatever form of placement it was, the outcome was likely to be a return to hospice care and thus, there was not a cataclysmic sequence of events awaiting if placement broke down. It was suggested that T's health has deteriorated, with two recent hospital admissions and thus, there was no guarantee any placement would succeed. It was suggested to me the goals of the court in this case should simply be to preserve the small happiness that T has. It was suggested there were issues post-eighteen, and the parents being able to see T in the event of an adopted environment.

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- e) I was urged not to ignore V, forensically applying the welfare checklist from the 1989 Act to her.

- f) I was urged to see the present care plan as entirely inadequate as it left open a longer search for adopted parents and did not close down the possibility that other adopted parents would not support contact. I was reminded of the real difficulties that these grandparents or parents would have to enforce any orders in their favour. I was correctly returned to the end-of-life position, and the very complex legal and medical environment which would exist.

Analysis and Discussion

79. In this judgment I have decided to look at T first for my decision in relation to T will impact on any subsequent decision-making for V. I proceed on the basis of the findings I have made above, and I propose to carry out a side-by-side analysis of the realistic options in relation to the 2002 checklist.

80. Taking the Section 1(4) checklist criteria in turn –

(a) The child's ascertainable wishes and feelings regarding the decision, (considered in light of the child's age and understanding).

T cannot communicate his wishes and feelings. He is not capable of having a view on the merits of adoption versus long-term foster care. But his wishes can be understood from his reaction to family. Spending time with his family provides him with observable pleasure. It is reasonable to say he would seek pleasure and seek to avoid pain. As such, I can properly determine that he would wish to continue to see his parents and sister as much as he does now. Long-term foster care sees a reduction to

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twelve times a year and special occasions. Adoption sees the reduction to six times a year. I can thus properly determine that T's wishes would be in favour of long-term foster care.

(b) The child's particular needs. I accept the submission of the local authority that providing a safe environment which provides care for T's medical needs must be given very significant weight. He needs skilled, attuned and committed carers, backed by a multi-disciplinary medical and social work team, able to meet those needs, sometimes at short notice. As the proposal is for the same placement, whether under long-term foster care or adoption, I fail to see how this factor is anything but neutral.

(c) The likely effect on the child (throughout his life) of having ceased to be a member of the original family and become an adopted person. Under long-term foster care, parental responsibility lies with the parents and the local authority jointly. If adopted, it lies with the adopted parents. There are some risks to this latter position:

(i) Firstly, contact may not proceed as envisaged or, indeed, ordered and the ability of these parents to litigate given their cognitive difficulties is reduced. Even if the prospect of contact breaking down is remote, the effect of it would be devastating on T, given it is one of his few pleasures.

(ii) Secondly, there is a roughly 40% chance that T will die during his minority. Given his disabilities, there are likely to be many potential issues in the lead up to that point. Decisions to be made on treatment, palliative care, the venue of such care, resuscitation in certain circumstances and hospitalisation are all ones which would fall to be decided by the adopted parents. The local authority seem to fail to realise that removing a parents' rights to be involved as a matter of law in this decision-making is a vast intrusion into the family life of the parents and T. The

most extreme example of this is the position in relation to end of life care and attendance at death if that occurs.

(iii) Thirdly, T's needs are so complex that a variety of opinions have validity in this decision-making. I struggle to see how a family caring for many disabled children and adults has the emotional and intellectual 'bandwidth' to consider carefully all the options available. Would it not be better in this rare and difficult case to share the burden of decision-making?

(iv) Fourthly, it is my assessment that the parents' views have a validity by virtue of their disability. They have the unique experience of being cognitively challenged and as such, may well see the worth and virtue of simple things, rather than viewing the benefits of life seen through the prism of an abled-body person of average or greater intellect. Just because they struggle to articulate their views eloquently, does not mean their views do not have validity.

Taking these four points I find that adoption has risks and consequences in this case. These risks and consequences can be reduced by long term foster care and the availability of both the birth family and the local authority in decision making. This factor in my estimation weighs heavily in favour of long-term foster care against adoption.

(d) The child's age, sex and background and any of the child's characteristics which the court or the agency considers relevant. T must be seen as a disabled child and deserves all the opportunities of a non-disabled child. Under the Equality Act 2010, the local authority has a duty in the provision of its services not to act in a discriminatory manner. This means T must not be treated in a less favourable way because of his protected characteristics. Furthermore, the local authority in its provision of services

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is required to make adjustments for disabled persons. As such, the local authority must consider adoption. I entirely agree that a failure to do so because of a difficulty in placement as a result of disability would be discriminatory. However, the obligation is to ensure the options are available. The Equality Act is not prescriptive as to what option is chosen, because that becomes a matter of the child's welfare and so falls to be determined under the 2002 Act. All decisions must be made with regard to T's characteristics, but I do not discern these as favouring one form of placement legally. Again, this factor is neutral.

(e) Any harm (within the meaning of the Children Act 1989) which the child has suffered or is at risk of suffering. The two significant areas of potential harm are the risk of placement breakdown and the risk of breakdown in the birth family bond, although this is already factored in above. I have already indicated as a factual finding that I do not discern adoption to be more secure than long-term foster care in this unique situation. Breakdown, however, is a huge risk through no fault of the carer. Legally, the position is far simpler under a care order, for the local authority can simply move T to another placement sadly probably a hospice and can do so under the auspices of that order. If an adoption breaks down or begins to experience difficulties, there are court processes and potential conflict. I find this factor weighs in favour of long-term foster care.

(f) the relationship which the child has with relatives, with any person who is a prospective adopter with whom the child is placed, and with any other person in relation to whom the court or agency considers the relationship to be relevant, including—

(i) the likelihood of any such relationship continuing and the value to the child of its doing so,

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(ii) the ability and willingness of any of the child's relatives, or of any such person, to provide the child with a secure environment in which the child can develop, and otherwise to meet the child's needs,

(iii) the wishes and feelings of any of the child's relatives, or of any such person, regarding the child.

Family life is important. The purpose of adoption is to provide a chance of family life where the birth family cannot provide it. Here, the birth family despite their inadequacies, can provide an essential element of it. This may only be in the form of cuddles and love, but it is family life in the limited ways which T can perceive it. They have demonstrated a continued commitment to T and there is no evidence to suggest that commitment would not continue through T's life. The adoptive carers appear able to provide a family life but their position is not covered by this criteria as T is not placed with those carers as of today. Family members outside the parents have visited T, most significantly the grandparents who will remain very much in V's care. As indicated the birth family remain fully committed to supporting T as best they can and supporting his relationship with V. As such, this factor weighs in favour of long-term foster care.

81. If I first compare the two realistic options side by side, I arrive at a position which weighs in favour of T being cared for under long-term foster care, rather than under adoption. This is not a numerical analysis but a holistic analysis and there are a number of individual factors which support long term foster care and I have indicated at least one factor (the removal of parental responsibility in health decisions) which weighs heavily against adoption. I could stop my analysis there, however, it is accepted that differing views may be taken of the weight given to the factors above. However, when one adds in the proportionality of any action, I struggle to see how it could ever be

proportionate to approve adoption in a scenario where identical care can be provided under long-term foster care. With the same care-givers being involved, it cannot be proportionate to sever familial ties when it is simply not necessary to do so. For this very reason, I have not been able to dispense with parental consent, for there can be no rational argument that the welfare of the child requires me to do so when nothing else will do, when we have an option which so clearly will do so.

82. Finally, it is to be noted that the local authority's position would have adversely impacted on the quiet, almost invisible, V. I remind myself of the importance of the sibling bond. If these children attain adulthood, those bonds will be the most long-lasting they will experience, and I would have been extremely reluctant to do anything which would impact negatively upon them. Had I made a different decision on the welfare checklist for T, I would have had to cross-reference V's position, and then re-evaluate my analysis based on a proportionality decision, factoring in V's position. It is not necessary for me to do so, having made a welfare decision in favour of long-term foster care in relation to T.
83. To satisfy myself that the decision I make is legally correct, I return to the pictures at [C63], [C64] and [C65]. I am totally satisfied that this decision is the appropriate one and a non-discriminatory one. I note that rushing off to provide judgment at two o'clock, I have not provided any written judgment in relation to the contact points, and I am well aware the contact point remains important for the parents.
84. I accept the view that under a long-term foster care, the position should be a guaranteed twelve sessions between T and his parents, and T and V. In addition, there should be special occasions contact. I accept that some of those contacts will be contact with parents and V and, indeed, that makes a lot of sense, but in the event that there are

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contacts which do not involve one or other of those parties, each party is entitled to that twelve. In relation to V, she is entitled to twelve contacts with T and special occasions, as discussed.

85. If we move onto the issue of video contact, I cannot possibly see how video contact between V and her parents should be subject to any real reduction, because it is grandparents speaking to the parents, one of whom is their son, with V (a six-year-old) being present. I suggest that whatever has pertained up to this point continues. The more problematical issue is video contact between T and V, and T and his parents. I do accept that these people taking on this huge burden are entitled to have some privacy, some ability to develop bonds and relationships without contact all the time. I struggle to see how a video call every two weeks to fill the gap would be any problem at all. Whether a video call is needed on the week where they have their face-to-face, I do not really see the merits of that.
86. I think a way around that is that the parents should have the opportunity to send video clips and V should have the opportunity to send video clips which are shared with them by the carers when it suits the carers to do that. What I am in favour of is monthly video contact in a direct chatty way. Monthly face-to-face contact, and additional sending of clips and stories, to be shared between those dates.
87. I accept the Children's Guardian's view that the Care Plans need to be amended to reflect this decision and I adjourn the matter today to allow that process to be completed.

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