Neutral Citation No: [2019] NIFam 8	*Ref:* OHA10891
*Judgment: approved by the Court for handing down (subject to editorial corrections)**	*Delivered:* 08/03/2019

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

14/222428 & 18/018236

IN THE MATTER OF A & B (CARE ORDER: FREEING ORDER: POST ADOPTION CONTACT)

O'HARA J

The names of the parties in this case have been anonymised in order to protect the interests of the children to whom the case relates. Nothing must be published or reported which directly or indirectly leads to the identity of the children being revealed.

Introduction

[1] This case involves 2 children – a girl, A, who is nearly 4 years old and a boy, B, who is approximately 18 months old. The applicant Health & Social Care Trust (the Trust) seeks a care order in respect of each child and orders freeing them both for adoption on the basis that their mother is unreasonably withholding her consent to them being adopted so that her consent should be dispensed with. The mother, on the other hand, seeks the return of each child to her care and challenges almost every element of the Trust case.

[2] The case is unusual in that the mother, who is Polish, was described by a number of witnesses as being almost uniquely disengaged from her children. Her contact with them was portrayed to me as being of a type seldom seen. The mother has none of the problems often associated with parents in this court such as addictions or limited intelligence. For her part she denies the coldness and distance described and suggests, with the support of the Polish Consul, that the issues which have emerged are due, in large part, to cultural differences between Poles and Northern Irish people. A sign of the distance between the parties is that while the mother contends that the children should be returned to her immediately, the Trust and the Guardian ad Litem recommend, almost uniquely in recent years, that there

should be no direct contact between the mother and the children if they are freed for adoption.

Background

[3] The mother has two older children, C and D, by her ex-husband, also a Pole. C and D are still children but are significantly older than A and B. The mother, her then husband and C and D lived in Northern Ireland for some years before the parents separated in or about 2013. Unfortunately there was significant domestic violence in the relationship with the father in particular being abusive, especially with alcohol taken. However the children also alleged that their mother was abusive to them.

[4] The father of A and B is also a foreign national though not Polish. He has played no part in these proceedings because when approached by the Trust, after the mother eventually identified him as A's father, he denied even knowing her, never mind having been in any form of relationship with her. It is a concern that if the mother's identification of him as the father is correct, she continued or resumed her relationship with him and as a result conceived B despite his rejection of any responsibility for A.

[5] The Trust intervened and took C and D into care in May 2015 with A following in July 2015, when she was approximately three months old. C and D's names had been on the child protection register since July 2013. Efforts had been made to support the mother but they met with very little positive response. The issues could not be put down to the father because he was out of the home by then. There was, however, an intervening issue which complicates the story. From some point, probably in 2014, the mother began to feel unwell and was diagnosed in the summer of 2015 as having a cyst on her brain. The problems which this caused her included headaches, vomiting, interference with her vision and some unsteadiness on her feet. She was admitted to hospital on 14 August 2015, operated on successfully on 18 August and discharged on 28 August. A written report from Mr Philip Weir, consultant neurosurgeon, who was not required to give oral evidence, confirmed that when he last reviewed the mother in April 2016, her headaches had largely resolved and any residual headaches were of a different character to the headaches associated with the cyst. She had no visual symptoms and no balance disorder at that point.

[6] This episode was obviously very distressing for the mother. It is, however, her case that after the successful treatment she was in a position to care for her children again by October 2015. In fact her contention is that she expected the children to be returned to her at that point. The Trust case is that there were already long established concerns about the mother's care of C and D, so much so that A was placed on the child protection register on her birth in March 2015.

[7] The Trust did not return C, D and A to their mother, either in October 2015 or at all. Instead it initiated care proceedings which were dealt with on the papers, in effect uncontested, in November 2016 in the Family Care Centre. Threshold criteria were agreed and signed by the mother in respect of all three children, with care orders being made for C and D. I attach particular significance to numbers 4, 5, 6 and 7 which are all matters which are independent of the mother's ill health. For ease of reference those criteria are as follows with the mother being referred to as the first-named respondent and her ex-husband as the second-named respondent:

> "4.The first-named respondent displayed a lack of emotional warmth towards the children and tried to distance herself from them at the time of their reception into foster care. In doing so the first-named respondent demonstrated a lack of insight into the children's emotional wellbeing.
>
> 5. The first-named respondent physically chastised C.
>
> 6. The children witnessed domestic violence perpetrated by the second-named respondent. The first-named respondent failed to safeguard the children from this. The children's exposure to domestic incidents and acrimony has impacted upon their emotional health.
>
> 7. The first-named respondent has previous inconsistent engagement with the parenting assessment and other services offered by the applicant."

The mother does not concede that any threshold criteria at all are met in respect of B.

[8] In the context of the current applications in respect of A and B, it is relevant to record the fact that neither C, who is 16-years-old, nor D, who is 11-years-old, has been willing to meet their mother for <u>any</u> contact since June 2016. They also refuse to see their father. C and D are placed together in foster care. A was joined in her different foster care placement by B on his birth. Those foster carers are the prospective adopters.

Evidence

<u>Professor Iwaniec</u>

[9] Professor Dorota Iwaniec, herself Polish, gave evidence based on her written report of January 2016. She was engaged to do an attachment assessment between the three children (B had not yet been born) and their mother, their father and "the emotionally abusive and neglectful behaviour of the mother, her parenting capacity, punitive approach to child rearing and the effects of such parenting on the children's development, behaviour, emotional well-being and welfare."

[10] Professor Iwaniec found the mother to be "quiet, passive, detached and undemonstrative". She answered all the questions asked but "without any reactions or indications of her feelings and intentions". In the mother's opinion, since she was now healthy, she would be able to do a lot more things for herself if the children returned home. Despite having been told by social workers that she had difficulties in showing affection and tender loving care, the mother "could not recognise her shortcomings and emotionally neglective and abusive behaviour".

[11] The Professor asked the mother about her own childhood. She said that she was the eldest of three siblings, that she spent a lot of time staying off school looking after the younger ones, that her parents fought, her father was a drunk and her mother, who was mentally ill, screamed and shouted abusive language. Her mother also hit and smacked the children for no reason. She said that she was never hugged or kissed and never sat on her father's lap. This led the Professor to conclude:

> "Taking into account the way (the mother) was brought up, it is small wonder that she brings up her children in a very similar way to how she was brought up as a child. She simply does not know any better."

[12] Professor Iwaniec described the mother as having a considerable emotional deficit, not understanding her behaviour to be unreasonable and not feeling empathy for the children she inflicted pain on. This was borne out by a contact visit she observed between the mother and C, D and A. A truly miserable session was described at which the children played with each other while the mother "sat in the one spot, not talking to anybody, just watching them". She did not play with, entertain or supervise A who was about nine months old. The Professor said that "out of desperation I asked the mother to organise some activities with the children. She did not respond." In her oral evidence the Professor described this contact as being "of a type seldom seen". She understood how the attachment to A was limited (because A had spent so little time living with her mother) but she could not understand the position with the older two. Even when D got up on her lap and put his head on her shoulder, the mother did not cuddle him. D then got up and left.

[13] The Professor concluded her report by stating:

> "Observation of contact and assessment of (the mother) indicated that she has a fundamental deficit and deficiencies in understanding what the emotional care of children is all about and why it is important to provide a loving, sensitive and caring environment …".

She then added:

> "I do not believe that the mother understands the basic principles of emotional care and the implications for the children if such care is not provided."

The Professor then made a number of suggestions about attachment therapy, counselling and a parenting assessment. All of this was based on her clear understanding of the mother's description of the hopeless parenting she herself had received. The Professor acknowledged that the brain cyst had made the situation worse but the problems she identified were well established before that emerged and the contact which she observed was in January 2016, after the mother said she had recovered and should have had the children home. She was present physically but not emotionally.

[14] In cross-examination by Mrs Dinsmore QC for the mother, it was put to the Professor that she had entirely misunderstood the mother's history and that the person who the mother had actually been describing as being abusive was not her own mother but her mother-in-law. The Professor rejected this as being quite impossible and pointed out that at page three of her report she had recorded the mother complaining of the irony that during a recent visit her mother was telling her how to treat her children despite knowing how badly she had treated her own.

[15] In this cross-examination the Professor was quizzed about the sort of work which might be done to help the mother, some of which had been tried in various ways and some of which had not. What was clear however was that the Professor could not understand why the mother was not delighted to see her children in contact. In the Professor's view it was not in the least surprising that C and D had stopped seeing their mother just a few months after the contact which she has observed.

Dr McCartan

[16] Dr Denise McCartan, Clinical Psychologist, examined the mother in October 2017. She was given a very different account of the mother's childhood, namely that her own mother was loving and took good care of her, that her father had no history of alcohol misuse and that she happily spent a lot of time with her grandparents. When questioned as to what Professor Iwaniec had reported, the mother said to Dr McCartan that the Professor had got it wrong. However, when asked directly by the Doctor "are you saying what you think is the right thing to say", the mother replied "yes".

[17] The Doctor confirmed that there is no evidence that the brain cyst accounted for the basic parenting difficulties which concerned the Trust. Rather she found that the mother had "narcissistic personality traits which are characterised by a pervasive pattern of grandiosity, need for admiration and lack of empathy for others." As a result, she suggested that the mother "is resistant to accepting

professional help and does not consider change is required. She has the capacity and is motivated to see her children but not to effect and sustain change."

[18] In her oral evidence the Doctor said that if the mother's issues were as a result of a personality trait, which she believed they were, it becomes far harder to effect change. She said professionals cannot help people who do not see their own problems.

Ms Muldoon

[19] The only social worker the parties required to give evidence was Ms Deborah Muldoon, Senior Practitioner. She first became involved in this case in July 2017, shortly before B's birth. She was part of the Home on Time team which tries to work intensively with parents in cases in which it is recognised that because of issues which have already been identified there is a real risk of the child or children needing long-term foster care or adoption. (By the time of Ms Muldoon's involvement, the Trust already had care orders for C and D who had long since stopped seeing their mother and a threshold finding in relation to A.)

[20] In the initial stages Ms Muldoon, who is trained in motivational work, saw the mother four times per week. On some occasions she had the support of a student social worker who is Polish and who speaks Polish. By the time her involvement started, the mother had already been through, inter-alia, a protective parenting assessment, educative work with parenting services and intensive sessions with Barnardos to help improve contact with her children. In light of what she regarded as Professor Iwaniec's important report from January 2016, Ms Muldoon focused significantly on the mother's emotional deficit and explaining very simple parenting like why we hold babies and why we talk to them. In all of this work there was an interpreter present to assist. Frustratingly, the mother simply was not open to doing the work and came to the sessions with a closed mind. This was despite the fact that she showed, though only in flashes, that she could do the work. On those few occasions she was praised and encouraged. The social work team even devised cue cards for the mother which were put on the door of the room in which contact took place. They said things like "smile" and "say hello".

[21] Ms Muldoon referred in her evidence to work and services offered to the mother which were rejected by her. Examples included help from Women's Aid and from counselling services which the mother was dismissive of. The Trust also consulted with a psychologist to identify the correct cycle of therapeutic services. It was, however, the psychologist's view that the timescale for making any meaningful progress in this work far exceeded the needs of the children. The psychologist suggested that if this work was to be done, it would ideally be delivered in Polish. The mother rejected it anyway. When the Trust then tried to use the health visitor to give advice to the mother, she challenged her independence from the Trust and questioned her qualifications and experience.

[22] Ms Muldoon testified how difficult it is to get across to the court just how detached the mother is at contact and how very rare it is to see a parent quite so resistant to change. Very unusually she recommended that there should be no direct contact if the freeing applications are granted because of the destabilising effect on the children of the preparation for contact, the contact itself and the aftermath. (There is however very positive regular contact between the four children through the two sets of foster carers who meet up regularly and not just for an occasional hour or so e.g. they have gone caravanning together.)

[23] If any illustration of the mother's remoteness was needed, Ms Muldoon said that when she asked the mother for early photographs of her and A, when A was at home with her, the mother declined and said that that was not her responsibility or her problem. This was despite knowing that Ms Muldoon was trying to put together a life story book for A.

[24] In cross-examination Ms Muldoon accepted a number of propositions:

- The mother had been a victim of domestic violence.

- The brain cyst has been a significant setback (though there was no evidence of lasting adverse effects after the operation).

- She has said she was well enough to take the children back after October 2015.

- She engages sometimes.

- She is generally polite and not difficult to manage.

- She attends contact regularly and on time.

[25] Having made these appropriate concessions, Ms Muldoon rejected a number of other propositions put to her. She insisted that the contact was not and could not remotely be described as being good. She also maintained, contrary to the mother's case, that the mother was not prohibited from speaking to the children in Polish at contact. She pointed out in fact that an interpreter was present so that anything which was inappropriate could have been stopped. On the contrary, Ms Muldoon said that the mother was encouraged to speak and do so in Polish if she preferred. Ms Muldoon also said that it would be an exaggeration to say that even 5% of the mother's contact was of an acceptable quality. She was referred on a number of occasions to contact records which showed some glimmers of engagement. Sadly those entries were inevitably followed by notes showing how negative, detached and remote the mother was.

The Mother

[26] The mother's early evidence concentrated on her brain cyst, how debilitating it was and how she had actually recovered quicker than expected. Despite this she asserted she still had not fully recovered and did not feel well when in January 2016 she saw Professor Iwaniec. She testified that she had engaged in and learned from the work she had done through the Trust and she felt she had been excessively criticised for how she had tried to care for the children at contact. Understandably she said that she found contact difficult with a social worker and an interpreter present. On some occasions she felt ashamed to be there.

[27] The mother queried the proficiency of the different interpreters engaged by the Trust and volunteered that her own proficiency in English had been set back by her brain cyst. Her view was that the Trust did not and will not respect her Polish culture.

[28] In cross-examination by Ms M Smyth QC for the Trust, the mother accepted that the medical evidence appeared to be that she had made a full recovery by the end of 2015. Indeed her own case was that the children should have been returned to her in October 2015. She was unable to explain how Professor Iwaniec, of all people, could have misunderstood her when she gave her childhood history but she still challenged her report and the analysis which flowed from it.

[29] So far as contact was concerned, she asserted that a Polish doctor had told her that she should avoid emotion because it might cause her sickness to return. In this context it is relevant to record that the court had a psychiatric report on the mother from a Polish doctor dated 22 March 2017 which confirmed that she was well and had no medical or psychological conditions which would prevent her fulfilling her role as a mother. That report is entirely silent on the question of her health deteriorating if she shows emotion. There is also a psychological report from Poland dated 20 February 2017 which is broadly positive though, as the psychologist specifically notes, it was based on her self-reporting without access to relevant Trust documents.

[30] In further cross-examination by Ms Smyth and Ms S Simpson QC for the Guardian, the mother was challenged on some of the contact records. These included her not smiling or saying hello to the children or talking to B and on speaking only to adults e.g. at contact on 26 October 2018.

Mr Mullan

[31] The Polish Consul, Mr Jerome Mullan, gave evidence in which he contended as follows:

- The mother is influenced by being a child of parents who grew up during the Soviet occupation/dominance of Poland and therefore finds it very difficult to trust public authorities in Northern Ireland.

- She feels very badly treated and traumatised by her experiences here.

- There were too many different interpreters at difference times, making contact in particular even more awkward and unnatural than it normally is.

- The mother has been denied "her right" to see her older children.

- His consulate should have been contacted to trace well qualified experts to help the mother in her native language.

- There are opportunities to develop and protect the Polish birth culture of the children.

The Guardian ad Litem

[32] The Guardian ad Litem, Ms Sinead Marshall, gave evidence in which she supported the making of freeing orders in respect of A and B. Her involvement in these cases pre-dates that of Ms Muldoon and she was able to explain how C and D had so rejected their parents that they do not even want to have indirect contact with them. Having been received into care, both C and D have disclosed abuse and neglect by both parents. Ms Marshall emphasised that the concerns about the mother were independent of the concerns about the father and also independent of the complications arriving from the brain cyst. She graphically described seeing a contact between the mother and the two younger children at which, as usual, she tried to sit back and simply observe. However this one was so silent, so awkward and so uncomfortable that she had to engage. She said that she had never done that before and that it concerned her greatly. In contrast to the way in which she fails to engage with her children, the Guardian said that the mother speaks significantly more easily to adults. A, in particular, feels rejected by her mother and is adversely affected after contact ends.

[33] Ms Marshall said that she did not believe that the mother's issues were cultural, rather that there was a gap which could not be bridged between her and her children. In these circumstances, and for the first time ever, she recommended that there should be no direct post-adoption contact.

Discussion

[34] This is an exceptionally strange case. If I accept the mother's contentions, she grew up in a happy home in Poland but was then trapped in an abusive marriage to the father of C and D. Having escaped from that, she then had A and B by a new partner. Now that she has recovered fully from her physical ill-health, she is ready

and anxious to resume their care but has been denied by a Trust which is unfairly and excessively critical. She maintains that her contact is better than she is given credit for and that she has benefited from the support she has received from the Trust, even though some of it was unnecessary.

[35] Such an interpretation of the evidence simply does not stand up to even cursory analysis. Some of the most obvious reasons for which it falls down are:

A. The evidence of Ms Muldoon and of Professor Iwaniec, supported by Dr McCartan and the Guardian ad Litem, is that this mother is remarkably emotionally passive and detached from her children to the extent that, quite astonishingly, Ms Muldoon's team put up written reminders to her to say hello and to smile.

B. It is hugely unlikely that Professor Iwaniec so comprehensively misunderstood the mother when she reported her miserable childhood experiences. That history explains why she is as she is and why it is so profoundly difficult for her to change. In her eyes what she is doing is normal.

C. If, however, Professor Iwaniec did get it all wrong, the mother's case gets worse, not better, because there is no explanation for the mother's presentation and her detachment from her children.

[36] I have tried not to underestimate the severity of the set back to the mother's life which the brain cyst represented. Having separated from her violent husband and having had a child by a new partner who then denied knowing her, she must already have been vulnerable and isolated in a country which is not her birth place. To suffer a significant illness at that time must, on any view, have been traumatic. However the concerns about her care significantly pre-date the 2015 diagnosis and it is striking that her two oldest children have simply refused to see her for more than two years.

[37] It is however the reports of her contact with A and B which are most affecting. The almost total absence of warmth or affection is quite remarkable. Professor Iwaniec was incredulous when it was suggested to her that Poles do not smile as much as other people do and Ms Muldoon described clearly how the mother talks freely and jokes with adults, just not with her children. On this evidence I entirely reject the so-called cultural explanation for the mother's almost unique coldness to her children. She would not even put her arm around her son when he sat on her knee! She would not talk to the children or join in games!

[38] I am satisfied that the understanding which Professor Iwaniec gained of the mother's childhood is accurate and that on the other occasions when she has given a different and happier account, she has been deliberately misleading. I am also satisfied that the Trust has tried repeatedly over many years to work with the

mother so as to get her to recognise her weaknesses and to change. The fact that it has been unable to make progress bears out Dr McCartan's opinion as set out at paragraphs 17 and 18 above.

[39] I do not see any prospect for change in the future, never mind any change which will come within the timescale which meets the needs of these two young children. They require stability, security and permanence without waiting even longer for their mother somehow to deal with her multiple problems.

[40] I listened carefully to the evidence of Mr Mullan. Some of his points were well made e.g. the importance of maintaining Polish culture where possible and the possibility of tracing appropriate experts with the assistance of the consulate. However his criticism of the Trust was unfortunate and unjustified. Ms Muldoon and her colleagues cannot be faulted in this case for the prolonged efforts they have made to work with the mother. She has not been treated unfairly – she has just not responded in any meaningful way to the multiple invitations to work with the Trust.

Conclusion

[41] The orders which I have settled upon and which are set out below all represent a significant interference with the mother's rights under both domestic and European law. It is my judgment, however, that they are all necessary by reason of the evidence set out above and the conclusions which I have reached.

[42] As indicated above, the mother conceded threshold criteria in respect of A in November 2016. So far as B is concerned, I consider that threshold criteria have been established in that there was a likelihood, at the time of the Trust intervention in September 2017, that B would suffer significant emotional harm and neglect attributable to the care he was likely to receive from his mother in the following respects:

A. The lack of emotional warmth and commitment displayed by her towards his siblings.

B. The lack of insight on the mother's part into the needs of her children.

C. The failure of the mother to respond to efforts and offers to help her improve her care of her children.

D. The mother's rejection of the need for her to change.

[43] On the basis of these threshold criteria and in the absence of any improvement since September 2017, I conclude that in this case it is entirely unavoidable that care orders should be made for A and B. It is inconceivable that no order at all should be made and on the facts before me no lesser order is an acceptable option. Accordingly, I make care orders for both A and B.

[44] Turning to the applications to free these two children for adoption, they are founded on the contention that the mother is unreasonably withholding her consent to them being adopted so that her consent should be dispensed with. In these circumstances the Trust has to do more than prove that adoption would be better than long-term foster care. It has to prove that adoption is necessary; that onus lies on the Trust because the consequences of freeing a child for adoption are so draconian. A freeing order terminates the mother's legal rights in respect of the children she gave birth to. It should only be made where it is truly necessary.

[45] It is relevant that there are two older half siblings who are in long-term foster care and will not be adopted. To a significant degree that appears to have come about because C and D were significantly older when care orders were made in November 2016. A and B are much younger children. A only lived with her mother for a few months while B never lived with her. They are together in what appears to be a settled long-term placement with foster carers who want to adopt them. Their contact with their mother is exceptionally poor and unrewarding. They have no contact whatever with their alleged father who denies entirely that he ever had a relationship with the mother.

[46] In all of these circumstances I conclude that the children should be freed for adoption because the mother is withholding her consent to that course unreasonably. The advantages of adoption to these children are, in my judgement, self-evident in terms of stability, permanence and security.

[47] In theory the issue of contact is more difficult because it has become very unusual in recent years not to provide for contact after freeing and adoption. This is, however, a case in which I find that the contact is of no benefit whatever for the children. Accordingly I approve the plan for only indirect contact after these freeing orders are made and after the adoptions, in the event that the adoptions proceed.

[48] I welcome especially the extent of the friendship and the relationship between the carers for these four children. It is very important for all four children that this continues to the maximum degree possible because it maintains the link and the relationship between them. That connection is very important to their sense of identity in the future. It is of particular importance to the older two children who will remember A living with them before they went into care.