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(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

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RE: K AND P (CARE ORDER)

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GILLEN J

[1] This judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and adult members of the family must be strictly preserved.

[2] There is before me an application by a Health and Social Services Trust which I do not propose to identify ("the Trust") seeking a care order under Article 50 of the Children (NI) Order 1995 ("the 1995 order") in relation to two children whom I shall identify K (now aged 14) and P (now aged 11).

BACKGROUND

[3] The mother of these two children is C. N is the father of K. Mr Fee QC who acted on his behalf indicated that he had no objection to the making of a care order. N does have parental responsibility although he and C divorced a number of years ago. The father of the child P is R. Mr Donaldson QC who appeared on his behalf indicated that he did not resist the making of a care order.

[4] C had three children N (over 18), F (over 18) and K of whom N was the father. She had a fourth child P of whom N was not the father. F,her daughter, has two children. The family have been known to Social Services for a number of years, the main involvement being in 1998 with K and P. Concerns then focused on poor attendance at school, failure to avail of medical screening, concerns regarding C's mental health and her lack of cooperation with professional bodies in respect of meeting the needs of the children. The history of school attendance difficulties had been surfacing as far back as 1992 and in 1994 it had been noted that there had been limited contact with Health Services regarding the younger children in the house. At

that time C's mental illness was noted as a potential risk factor. In 1995 problems arose with reference to C's continual refusal to allow any health visitors to examine her children or provide immunisations. In November 1998 K and P were placed in foster care. However on 12 January 1999 at a looked after review it was decided that it was preferable to return the children to their mother's care as they were failing to thrive in foster care. Undertakings were given that the children would attend school regularly, regular health checks would be maintained and Social Services would be kept updated on events.

[5] Thereafter, the school attendance issue has been a major problem. K, now aged 14, has not attended school since primary 7. Her mother maintains she will not send K to any school other than a particular college where K does not have a place. P continues to have a very poor school attendance. A letter from the principal of the primary school where he attended dated 16 January 2004 stated that in the year so far ie 1 September 2003 – 16 January 2004 he had attended only for 9 days. He now has special education needs because of his non attendance but C has refused to allow P's needs to be assessed by the school and by an educational psychologist. I have before me a report of January 2005 from Dr S Hutton whose specialist field is Community Paediatrics and who is a Consultant Paediatrician with Community Child Health. Dr Hutton concluded that whilst there had been a long history of non cooperation with health, education and social services professionals and the family, in her view the most damaging consequence of the family's failure to cooperate had been the lack of formal education obtained by P and K. Although the children presented as healthy and well looked after from a physical point of view, their educational potential had undoubtedly been severely compromised by their failure to attend school. There was nothing on physical examination of any of the children to account for the school absence. Steps had been taken by the Education Department in the Youth Court to resolve K's non school attendance and P's poor attendance (recorded between 2002/2003 as achieving 5% attendance). The outcome of the court proceedings was that C was fined, with her conviction being affirmed on appeal. On 2 July 2004 the Trust initiated care proceedings. Thereafter the issues which prompted care proceedings according to the Trust remained unaddressed without any cooperation with social services from C. Efforts to promote K's education were thwarted by C as were efforts to assess P's educational needs. In October 2004 because of the complexity of the matter the case was transferred to the High Court. Between February 2005 and March 2005 C had evaded social services who had no knowledge of where she was living with K and P at that stage albeit that they were the subject of interim care orders. In March 2005, K and P were removed and placed in foster care. I observe at this stage that I was satisfied with the evidence that since being placed in foster care, albeit that this is short/medium term foster care, the children have improved enormously with regular attendance at school. As I will dilate upon when dealing with the evidence P's belief that he

was ill, a circumstance occasioned by C, has now abated and he is behaving much more like a normal boy of his age. There has been a very considerable improvement in their lives and attitudes.

[6] The problem of the poor school attendance was well highlighted by the Guardian ad litem in her report of 24 June 2005 when she noted as follows:

> "4.35 K's attendance from primary 4 to primary 7 is recorded as follows:
>
> 1999 to 2000 – 75.82% aged 9 years – primary 5. Attended 144 days out of a possible 188 days. Absent 44 days.
>
> 2000 to 2001 – 61.5% aged 10 years. Attended 113.5 out of a possible 186 days. Absent 72.5 days.
>
> 2001 to 2002 – Attended 97 days out of a possible 183 days. Absent 86 days.
>
> 2002 to 2003 – Attendance nil % - not registered at any secondary school.
>
> 2003 to 2004 – Attendance nil % - not registered at any secondary school.
>
> 2004 to 2005 – Attendance nil % - not registered at any secondary school."

[7] C had not attended meetings in K's primary 7 year to discuss K's post primary education. C did not complete the transfer form nor fill in the schools of choice for K. When the Board contacted the child's father, his first preference of school was oversubscribed as was the second preference. C continued to favour the former because of its integrated status and also quoted "health reasons" for K's needs at a school near home. The Education Department was unable to resolve the matter and brought proceedings against C in May 2003 as indicated above. The issue of K's school attendance precipitated the initiation of care proceedings. Home tuition was organised for K. An educational psychology assessment to determine her learning needs was organised through her father. C arrived during the course of the assessment and ordered K to leave. She was reportedly unhappy about the condition/venue of the assessment. At this time (December 2004) efforts to encourage C's agreement to allow K to attend for home tuition included changing the venue of the tuition to one which would meet with C's approval. Home tuition for K was arranged at a local hospital. However despite the change of venue, C continued not to allow K to resume home

tuition as from 17 November 2004. Until K was placed in foster care, she was not in receipt of any education. In the months until June 2005 K attended home tuition two times a week for one hour and 30 minutes. This is a child who could easily manage the Northern Ireland curriculum in a mainstream setting.

[8] The denial of an education to this child, as well the disadvantage to her of academic inequality, has caused her to miss out on the social life surrounding school attendance, the ability to pursue sport through school and all the accompanying social opportunities and social skills which participation in school life promotes.

[9] P's educational attendance was equally lamentable. The Guardian ad litem records his educational attendance as follows at paragraph 4.112 of her report of June 2005:

> "1999 to 2000 – 43.6%
> 2000 to 2001 – 23.39%
> 2001 to 2002 – 14.75%
> 2002 to 2003 – 5.03%
> 2003 to 2004 – 7.30%
> 2004 to Feb 2005 – 54.39%, 124 out of 228."

[10] P was made subject to an interim care order in July 2004 and since that time there were four attempts by the Educational Psychology Department to assess his educational needs. He was not brought for assessments by his mother who refused to give her consent to those assessments. During the period P was subject to an interim care order and living in the care of his mother, his school was unaware as to where he was living. He was placed in alternative care in March 2005 and since this time his school attendance has been 100%. The foster carer indicated that in June 2005, sports week, it emerged that this was the first sports week P had ever attended. He fully participated in all activities which included swimming and kayaking and thoroughly enjoyed himself. An Educational Psychologist carried out the assessment of P on 19 April 1995.

THE EVIDENCE IN THE CASE

[11] Two medical witnesses gave evidence before me:

1. Dr Brenda Robson

This witness is a distinguished Chartered Psychologist who had prepared two reports relevant to these children dated 24 March 2005 and 8 April 2005. In the course of those reports and her evidence before me, the following matters emerged. Her interviews with C raised very serious concerns in respect of K

and P's well-being. Whilst this witness is a Child Psychologist and would not attempt to identify or diagnose C's mental health problems, it was clear to her that she was extremely paranoid and had a distorted sense of reality. C evidently believes that K and P suffer from a terminal illness, that they are likely to die in childhood, and she has even identified the cemetery where she will bury them. P is perceived by C to have numerous other serious ailments. From what C said, P believes that he is a terminally ill child. It is impossible to imagine how this affects his own mental health and well-being. The children do not attend schools or indeed have contact with outside agencies because professionals are all perceived as trying to harm the children. It was the witnesses' view that the children must be aware of their mother's fears and it is unknown to what extent the children will have taken on board those fears themselves. It was the witnesses fear that in C's frame of mind, she might cause the children to have physical symptoms by her treatment of them. When the witness had spoken to P and asked him if he used to play outside he said "I do play outside but I get really tired and probably go sick. I need to stay in bed." Her report continues:

> "I asked P what he did in all the many days when he was not at school and he said `I would be in bed a lot when I am not at school.' P then said `I always feel ill if I am not at school.' I asked him how he feels when he is at school `I mostly felt alright at school.' He then said that the food he was given at school sometimes made him ill."

Subsequently in the course of Dr Robson's report the following was recorded:

> "I asked P what he thought about his health now and he said `I feel I still have a bad sickness'. He said that he felt different from other boys because of his sickness and he did not know what could be done about it. P said that he might die. He said he thinks a lot about his sickness and worries about what will happen to him."

[12] Dr Robson made clear that K shares a mirror image view of what her mother thinks. The following extract appears from Dr Robson's report:

> "I asked K about P's health. K made various comments about this. She stated `P is ill. He has cystic fibrosis. I don't really know what that is. His lungs are damaged. It gives him allergies, chocolate makes him ill. P gets tired and sick. He gets ill if he plays outside and he has to come home and go to bed.' I said to K that there was no

> mention in medical records that P has cystic fibrosis and a medical examination last year did not find ill health. K became defensive and said `he definitely has cystic fibrosis. There was a diagnosis. Mummy said there was a diagnosis years ago'. I asked K about her own health and she said that she also has cystic fibrosis but she is not feeling so sick at the present time. I asked K what her mother did to treat her illnesses `mum would give us medicine'."

Dr Robson later recorded what had happened when she had pressed K about this:

> "I gently suggested to K that perhaps her mother was wrong and she and P do not have serious health problems. K became angry and defensive and I thought she might walk out of our meeting. She stated: `I don't want to talk about P. I am here to talk about me. Mummy knows all that is wrong with us, it's all medical'."

[13] The fact of the matter is that there is clear medical evidence before me that there is absolutely nothing wrong with either of these children from a medical point of view.

[14] It was Dr Robson's conclusion that K had a warped and damaged view of the world and has been greatly influenced by her mother. Listening to K in her opinion was very much like listening to C. She is completely loyal to her mother , very defensive and will not consider any criticism of her mother's care or mental health. She sees her mother's paranoid behaviour as acceptable and a realistic reaction to her life experiences. It was for that reason that at this time whilst Dr Robson recommended K and P should remain in foster care, she felt that K was influencing P in a negative way and advised they should be in different placements. However she is now satisfied that they can be together although the situation does need to be monitored.

[15] In cross-examination the witness accepted that she did not rule out rehabilitation of these children with their mother in future. Her whole approach to the world is affected by her belief system and this is influencing the children. If C was agreeable work could be commenced with the children's belief system but this would not be successful if they were living with their mother at this stage. Whilst she accepted that children can have the potential to accommodate and understand mental illness, in her view if the mother remains paranoid, it is very difficult for these children to live with this even if they do understand it. They need to be protected from it. In Dr

Robson's view it would affect the mental health of the child by living with her mother in these circumstances. She recognised that the children have very strong emotional attachments to her but this is an unhealthy and warped attachment. Although the children quite clearly express a desire to live with their mother, this must be disregarded in these circumstances. When pressed about the decision in 1999 to return the children to her care because they were not thriving, Dr Robson indicated that she had disagreed with this decision and in any event we now know the consequences of this. In her opinion the children had been subjected to emotional abuse, educational neglect and physical neglect. These are overriding factors. I observe at this stage that when C gave evidence, and in the course of cross-examination by Miss Dinsmore QC on her behalf, it was suggested that Dr Robson had made up her evidence that C said she believed the children suffered from cystic fibrosis and that the boy had seizures or diabetes. I reject this entirely. I believe entirely what Dr Robson said to me in this regard. I have no doubt that C told Dr Robson that she views these children as terminally ill, that both children suffer from cystic fibrosis, that P was suffering also from diabetes, chest infection, liver damage and seizures. I also believe she told Dr Robson that she believed that doctors now wished to kill her children so that any evidence of medical negligence can be removed. She also stated that doctors have refused to treat the children's cystic fibrosis because they want the children to die. If there was any doubt about this scenario, it has only to be observed that C identified precisely the same problems to the next witness, Dr Chada.

2. Dr Chada

[16] Dr Chada is a consultant psychiatrist. She examined C for the purpose of preparing a report for this case. In the course of that report, her examination-in-chief and her cross-examination, the following matters emerged:

(i) There is no doubt that C suffers from a serious mental illness. In the past she has been diagnosed with paranoid psychosis and then with a bipolar disorder (previously known as maniac depression). Dr Chada felt that the most likely diagnosis is schizo-affective disorder. Regardless of the specific nature of the diagnosis, C certainly suffers from a psychotic illness as a result of which she has fixed, firmly held beliefs (delusions) in a number of areas. Of particular relevance to these proceedings she believes professionals working within the Health and Social Services Trust are conspiring against her. That applies both to their contact with her children and in relation to her own previous admissions to hospital. She also believes that K and P suffer from cystic fibrosis. This is a delusional belief. She has no insight into her mental illness. There is no doubt her mental illness is directly responsible for her beliefs about her children and her treatment of them.

(ii) Dr Chada said that whilst it is quite clear that C may be damaging her children physiologically in the long run she found nothing in the notes and records or in C's history to suggest the children would be at significant risk of physical harm from their mother. She indicated that there is no reason generally why psychotic persons should not look after children. Children often understand the condition and can deal with it. It was Dr Chada's view that if C took medication, and improved her ability to look after the children the children could return providing some work was being done with them.

(iii) C however has no insight into her illness and will therefore not readily accept treatment. Since her illness has clearly gone untreated for approximately 15 years, and the fact that these delusions are now fixed, this may mean that she is unlikely to respond well to treatment in any event. Dr Chada felt however that since the notes and records did indicate that she had responded at one time to a mood stabiliser and anti-psychotic medication, a trial of medication would be certainly worthwhile if should be in agreement. However the crucial factor was that this would have to be an intermuscular injection. The timescale for this to work could be over a number of months before any effect could take place.

(iv) Dr Chada recognised that the primary effect on the children was psychological. In cross-examination by Mr Toner on behalf of the Trust, she conceded that not only had she not seen the children, but she was neither an expert on parenting or children. The best she could say was that she had dealt with parents who bring up children with serious mental illnesses if supports can be put in place. In answer to Mr Long QC on behalf of the guardian ad litem, she said that the children might be able to return if she undertook treatment albeit this would take months to have any effect, and that she must be seen to be moderating her delusional beliefs.

Ms M

[17] She is a social worker from the Health and Social Services Trust who had been involved with K and P. In the course of her reports, her examination-in-chief and her cross-examination the following matters emerged.

(i) K and P were now in foster care and working with a consultant psychologist, Dr Lynn McLaughlin. This work had commenced on 23 June 2005 on a fortnightly basis. Dr McLaughlin had indicated that this was long term work and was only now at very early stages. However it did appear that both children were beginning to foster a working relationship with this child psychologist and there was a mutual agreement to continue the work.

(ii) A care plan, which was amended during the course of this hearing, indicated that whilst the Trust now favoured a care order with the children remaining in the care of foster carers, it would consider reunification in the event that:

(a) C showed a sustained commitment to improving her mental health by accepting advice and services, particularly medical treatment.

(b) C's mental health significantly improves.

(c) The children had sufficient knowledge and understanding of C's mental health history so as not to be adversely affected by reunification. The Trust intended to achieve this by the continuing work with Dr McLaughlin.

In the meantime K's father N was being assessed as a potential carer for her.

(iii) The children had improved enormously over the period that they had been in foster care. K is a sporty girl and is now involving herself in a plethora of sports at school. The Trust have taken on board her wish to attend a particular school and have made appropriate arrangements. She is going into the year behind her chronological age. P is also behind in his school work but , progress is being made.

(iv) In cross-examination by Ms Dinsmore QC on behalf of the mother, she accepted the children's wishes and feelings amount to a desire to return to live with their mother. They had been returned to her after the previous episode of care in 1999 largely because of their wish to do so .However the witness was adamant that before there was any prospect of reunification this time steps must be taken to ensure this is not a false dawn as had occurred in the previous instance in 1999.

Respondent mother C

[18] In the course of her statements before me of May 2005 and September 2005 , evidence-in-chief and in cross-examination the following matters emerged:

(i) Her position was that the children should be returned forthwith to her. She did not accept that she had mental health problems but she was ready to embark on counselling. She refused however to take medication because she had a fear of what tablets would do to her.

(ii) She stoutly resisted the suggestion that the threshold criteria had been passed.

(iii) Her excuse for the poor school attendance that P was unable to take the bullying at school and that K had not been sent to an appropriate school. If they were returned to her they would go to school. As far as the cystic fibrosis was concerned she formed this conclusion because of what a doctor had told her. It was her case that both Dr Robson and Dr Chada had misinterpreted what she had said and she asserted that she did not think that Patrick suffered cystic fibrosis. As to her own mental health, she denied that she had ever suffered poor mental health and claimed that she was unaware of the diagnosis mentioned by Dr Chada. She asserted that she was as sane as anyone here. Whilst accepting that she did need to go for counselling, she countered this by adding that everyone needs some kind of therapy. However she was not prepared to ask the Trust for assistance and would probably go to her own doctor to obtain the counselling necessary.

[19] Sadly I formed the impression whilst watching this witness that Dr Chada had clearly made an accurate diagnosis and that she is desperately in need for appropriate treatment. The saddest aspect about this case is that she clearly does love her children but is at this time incapable of caring for them due to the mental condition which she steadfastly refuses to acknowledge or accept appropriate treatment for.

Guardian ad litem

[20] The guardian ad litem had presented reports to the court and in the course of those reports, her examination-in-chief and her cross-examination, the following points emerged:

(i) She was satisfied that there was some prospect of reunification between the children and their mother if:

(a) There was amelioration of the circumstances in terms of the mother's understanding of her diagnosis of mental health and the availing of services offered by the Trust for her treatment.

(b) Work with K and P continued so that their understanding of how to cope with their mother was advanced.

(c) Counselling and treatment of the mother was made available with the relevant Trust. However the mother did not currently want to engage in this.

(ii) She rejected the notion that the children could stay with the mother at this stage because even if the children were counselled and understood the work going on with the mother, it would be very difficult for them to say to

her that she was not mentally ill and to reject what she was saying to them. The witness accepted that these are delightful, well mannered children who clearly have a great warmth and love for their mother, consistently wishing to go back to her, but in the absence of the steps mentioned above this is now impossible.

[21[The guardian ad litem was satisfied that the foster parents are working well with the two children together and K is not attempting in any way to interfere with the therapy for P. They are both having therapy once per fortnight separately and this is progressing well.

[22] Contact between the children and their mother is facilitated two times weekly, once after school and once at a weekend for approximately four hours. That contact is supervised. K's contact with her father is to be renegotiated following the end of school holidays.

[23] The guardian approved of the Trust's conclusion that K's father will be assessed as a carer. She did note also that C was making some progress with a working relationship with the supervising social worker. Thus the previous pattern of poor engagement or avoidance of social workers has altered as C has largely engaged with contact arrangements to see her children.

[24] The guardian ad litem therefore recommended that care orders be granted in respect of K and P.

Conclusions

[25] I commence my deliberations by recognising the draconian nature of the legislation which is now being invoked by the Trust. I also recognise that the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life and that domestic measures hindering such enjoyment do amount to an interference with the right to such protection under Article 8 of the European Convention of Human Rights and Fundamental Freedoms (ECHR). I also recognise that taking a child into care should normally be regarded as a temporary measure to be discontinued as soon as circumstances permit and that any measures of implementation of temporary care should be consistent with the ultimate aim of reuniting the natural parent and the child wherever possible. I have derived great assistance from two recent cases in the Court of Appeal in Northern Ireland namely AR v Home First Community Trust (2005) NICA 8 and Home First Community Trust and Social Services Trust and SN (2005) NICA 14. In AR v Home First Community Trust Kerr LCJ stated in the course of the judgment of the court:

> "It is unsurprising that research into the subject discloses that it is desirable that permanent arrangements be made for a child as soon as possible. Uncertainty as to his future, even for a very young child, can be deeply unsettling. Changes to daily routine will have an impact and a child needs to feel secure as to who his carers are. It is not difficult to imagine how disturbing it must be for a child to be taken from a caring environment and placed with someone who is unfamiliar to him. It is therefore entirely proper that this factor should have weighed heavily with the Trust and with the judge in deciding what was best for J. But, as we have said, this factor must not be isolated from other matters that should be taken into account in this difficult decision. It is important also to recognise that the long term welfare of a child can be affected by the knowledge that he has been taken from his natural parents, even if he discovers that this was against their will."

[26] I am acutely conscious of the obligation under the Children (NI) Order 1995 to ascertain the wishes and feelings of the children concerned and of the content of Article 12 of the UN Convention of the Rights of the Child which provides that States shall assure to the child who is capable of forming his or her views the right to express those views freely and be provided the opportunity to be heard in any judicial proceedings affecting the child either directly through a representative or an appropriate body. Each child is a person with human dignity and not merely the object of a court dispute. A child's fundamental rights, including the right to be heard, must be respected in all forums. On the other hand, a court must be wary not to give undue weight to the views of the children and I must recognise that the paramount duty on the court under Article 3(1) of the 1995 Order is the welfare of the children.I have taken into account the views of the children in this case as expressed to the social workers and the guardian ad litem but I do not believe that those views coincide with their best interests.

[27] The court may make a care order if it is satisfied that the child has suffered or is likely to suffer significant harm and that the harm or likelihood of harm is attributable to the care given to the child, or is likely to be given to the child if the order were not made, not being what it would be reasonable to expect a parent to give him or her. This is the threshold criteria set out under the 1995 Order. I have absolutely no hesitation in coming to the conclusion that the threshold criteria helpfully set out by the Trust at Bundle 1 page 37 and 38 is accurate. I have come to the conclusion that it is comprehensive and appropriate and I am satisfied that the Trust has proved them to my satisfaction. They have been set out as follows(sic);

(i) C is unable to provide adequate and appropriate conditions within the home conducive to P and K.

(ii) Her failure to ensure the children receive regular education and medical/health care.

(iii) Her failure to ensure the children receive up-to-date immunisations resulting in ongoing risks to health.

(iv) Her inability to meet the emotional needs of the children or indeed address the emotional damage suffered by the children due to poor and inadequate parenting.

(v) C's general inability to ensure the children receive an adequate standard of care.

(vi) C's inability to ensure the children are appropriately supervised and protected from risk within the community.

(vii) Her inability to exercise effective and safe parental control.

(viii) C's failure to address her own psychiatric and/or psychological and/or emotional needs, or to attend appointments offered to her by professionals to consider these issues, the effect upon her as an individual, and the impact upon her ability to safely and adequately care for her two children K and P.

(ix) C's failure to co-operate with social services, the Trust, staff or other professionals involved with the children's interests.

[28] In relation to K, her father N agreed the following criteria:

(i) N's failure to adequately assist his ex-wife C with the care of his daughter K.

(ii) N's failure to accept the extent and degree of social services concerns in relation to C.

(iii) N's failure to report all known concerns or issues relating to parenting including school attendance to social services or the Trust.

(iv) N's failure to ensure the child's school attendance or medical health care.

[29] Being satisfied with the evidence of Dr Robson and Dr Chada (to the extent that the latter diagnosed the condition of C) and the evidence of the social worker Ms M, together with the contents of her reports, I therefore conclude that the threshold criteria have been satisfied.

[30] The second stage of the process involves an examination of the care plan and the welfare check list set out in Article 3(3) of the 1995 Order. I have already referred to the current care plan for both these children and I agree with its content. Rehabilitation is considered a possibility provided C takes the steps outlined by the Trust at para 17(ii)of this judgment. In the meantime K's placement with her current foster carers is short/medium term and that of P with his current foster carers is long term. Both children will continue to attend Dr Lynn McLaughlin. I therefore fully approve of the care plan.

[31] Turning to the welfare checklist my views are as follows:

(i) Whilst both children have indicated their wish to be with their mother, I am satisfied that this is an unrealistic assessment of the real dangers that attend upon such a reunion at this stage.

(ii) So far as the physical educational and emotional needs of these children are concerned, it will be clear from the medical evidence that I have read and the conclusions I have drawn in accepting the report of Dr Robson in full that I have clearly come to the conclusion that the emotional, educational and behavioural development of these children clearly requires protection from the distorted and dysfunctional thought processes of their mother at this stage.

(iii) These children have now been living with foster carers for some time and in my opinion any change in those circumstances at this time leading to the return of the care to their mother is likely to bring about emotional, educational and developmental damage to these children.

(iv) It will be clear from what I have said that I am absolutely satisfied that neither parent is capable of meeting the needs of these children for the reasons I have already set out in this judgment. In essence the mother suffers from a mental health condition that renders her incapable of caring for these children. The father of K is incapable of dealing with the deficiencies of C with relation to K, although he is being looked at again in the context of K. The father of P, namely R, has accepted that a care order should be made and I regard him currently as being incapable of meeting the needs of P.

(v) I have considered the range of powers available to the court under this Order in these proceedings. In particular I have looked at the possibility of a supervision order. However I do not believe that any order less than a care

order would afford sufficient parental responsibility to the Trust in order to protect these children.

[32] I recognise that a court shall not make an order unless I consider that doing so would be better for each child than making no order at all. In this instance I have no doubt that the making of a care order would be better for each child than making no order at all in order to protect them appropriately.

[33] I am aware that the mutual enjoyment by parented child of each others company does constitute a fundamental element of family life and domestic measures hindering such enjoyment amount to an interference with the right protected by Article 8 of the ECHR. Any interference constitutes a violation of this Article unless it is "in accordance with the law", pursues an aim or aims that are legitimate under Article 8(2) and can be regarded as "necessary in a democratic society". I consider that a care order is a proportionate response to the legitimate aim of protecting the welfare of each of these children. I do so in the knowledge that the interests of these children must be paramount in any consideration of competing rights.

[34] Before finally making a care order, I must afford the parties the opportunity to make representations about contact. I have listened to the submissions in this matter. It is my view that the current contact with the mother should continue at its present level provided it is appropriately supervised. I do not intend to make any order to that effect because the unfolding nature of the mother's attitude towards her children and the nature of the treatment which she receives or is prepared to accept will be an important factor. Accordingly the Trust must be allowed the flexibility of the no order principle in relation to contact in order to assess the situation as it progresses. This also applies to the degree of contact between K and her father N. That contact should continue in the manner currently controlled by the Trust.

[35] In all the circumstances therefore I consider it appropriate that a care order should be made in the case of each child.