Neutral Citation No. [2015] NIFam 13 | *Ref:* **OHA9717**

Judgment: approved by the Court for handing down | *Delivered:* **07/07/2015**

*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION

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IN THE MATTER OF THE CHILDREN (NI) ORDER 1995

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RE M (A CHILD: CARE ORDER: MOTHER WITH DISSOCIATIVE IDENTITY DISORDER)

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O'HARA J

[1] In order to protect the child who is the subject of these proceedings nothing must be reported which would serve to identify the child or her parents or any of the parties.

[2] The Health and Social Care Trust which is applying for a care order has been represented by Mrs Keegan QC with Ms C Sholdis. The mother has been represented by Mr McGuigan QC with Ms J Gilkenson instructed by the Official Solicitor. The father has been represented by Ms C McCloskey and the Guardian Ad Litem by Ms McBride QC with Ms M McHugh

[3] This case involves a girl (M) who is now two years old. Her mother (P) suffers from Dissociative Identity Disorder. In January 2015 I gave a judgment in which I held that P does not have legal capacity because of the fact and extent of her DID. The question in these proceedings is whether I should make a care order under the Children (NI) Order 1995 in respect of M or whether, as P wants, I should make no order and allow M to be returned to the care of her mother.

[4] The application for a care order is consented to by M's father R. He has conceded appropriate threshold criteria and agrees that M should live with his mother and stepfather (who I will refer to as the parental grandparents). That is a home which he shares with them but the applicant Trust has made it clear that it is the parental grandparents who will be the primary carers for M.

[5] While some of the background to this case is set out in my judgment of January 2015 it must now be explained in greater detail. Some of this has been

supplied by Dr Rachel Thomas who is a child and adolescent clinical psychologist as well as an adult psychologist. She is also an adult psychoanalytic psychotherapist whose current main post is as clinical lead and deputy clinical director for the Clinic of Dissociative Studies. That clinic is one of only two specialist national therapeutic centres in the United Kingdom specialising in work with patients with severe dissociative disorders including DID. Dr Thomas was instructed in this case because of her greater familiarity with DID than any of the experts who had previously reported. It is unusual to allow additional expert reports in children's cases and will become even more so in future but the rarity of the condition allied to its extremity justified that step being taken here.

[6] In her evidence in January Dr Maria O'Kane, consultant psychiatrist, had described P as being the person most severely affected by DID she had seen in more than ten years running an adult personality disorder clinic. Dr Thomas assessed P as being average compared to other troubled adults she sees but added that only the most severe cases are referred to her clinic. Accordingly there is no conflict between the experts – they agreed that P is a woman deeply affected by her psychiatric condition.

[7] It is worth repeating why P is so troubled. As Dr Thomas said, her DID is the product of severe recurrent childhood trauma at the hands of a number of perpetrators of sexual abuse. In an effort to cope with this abuse her mind has shattered into fragmented states or personalities. There can be amnesia between these personalities and P can "switch" from one identity or "alter" to another with some regularity. While she has tried to develop a pattern of leaving notes for the next personality to be informed by, it cannot be assumed that each personality or identity leaves notes. P herself is 26 years old but her other identities can be young girls under ten or teenagers with quite different behaviours. The evidence of Dr Thomas was that according to international guidelines therapeutic intervention for a person such as P takes a minimum of five years. This involves bi-weekly therapy in a supported care package. While some people revert to a single personality others do not and the best that can be aimed for is multiple personalities which can work together. For approximately two years P has been working with a particularly good therapist whose efforts have been praised by the experts in this case but that work has been disrupted by M's birth and by the stress involved in these proceedings and extended social work intervention. It is soon to be further disrupted because although P and R are no longer in a relationship she is again pregnant by him.

[8] Dr Thomas was quite clear that despite the work done by P with a therapist there is significant on-going risk to M. This is despite the fact that M has never been physically harmed by P. She was however in her mother's care in November 2014 when P tried to hang herself. That incident alone caused Dr Thomas great concern but over and above that she was emphatic that nobody knows what goes on in P's mind and it is impossible to know what occurs in the gaps when she switches from

one personality to another. One of the major concerns is the possibility of P being contacted by one of her abusers.

[9] Perhaps the most pointed evidence given by Dr Thomas was as to the effect on M of her mother's different personalities. She said that M could only find these "alters" difficult and emotionally confusing. What M would experience would be the same physical person in front of her but that person's identity and therefore her conduct switching from that of a four year old girl to a teenager to a woman in her 20s. This is not a fanciful description of what can happen – it is the reality of P's life, caused overwhelmingly by the sordid conduct and abuse by others which leaves her in my judgment, for the present at least, unable to care for M.

[10] P's separation from R has been a major complication. It might just have been possible, though with some difficulty, for her to protect M in her care if R was with her, if R had recognised the difficulties associated with her condition and if other supports had been in place. Without his presence none of the possibilities suggested by P can possibly work at this time. That is not to say that the picture may not change but it is likely to take some years of emotionally exhausting, painful and difficult therapy before P can be considered as a full-time carer for M. Even that will depend on how the therapy progresses and what stage it reaches. Dr Thomas suggested that if one allows for the interruptions and obstacles to date P has only completed the equivalent of one year's therapy. There is still therefore a long way to go and M's needs have to be given priority.

[11] On paper Dr Thomas's report seemed to be more optimistic and positive for P than the report referred to in my earlier judgment by Dr Andrea Shortland, a forensic and clinical psychologist. In the event, as Dr Thomas's oral evidence unfolded, there was little or no difference between them and it was agreed that Dr Shortland was not required to give evidence. Her conclusion should however be recorded because it is confirmed by Dr Thomas's later report – that conclusion is that P could not be M's primary care giver. (Both the experts took the view that P has a greater chance of progressing in her therapy if she is not caring for M because this will leave her freer to confront her abusive past and to recover after each session.)

[12] The experts further agree that P needs support from the Trust over and above the on-going expert therapeutic work. They must be correct in that analysis. P is still a young woman. Her personality disorder needs to be treated to maximum effect, both for her own sake and for the sake of M and the child she is carrying at present.

[13] In her evidence Dr Thomas stated that the Trust had gone "over and beyond" its duty to try to keep M with P by not removing her until December 2014. For the Trust Ms Valerie Devine a principal practitioner in child protection said that if she had known in early to mid-2014 what she knows now she would have pushed for M's earlier removal. That she did not do so appears to have been as a result of a lack of familiarity with DID, something for which she cannot be faulted. Since then she

has taken impressive steps to learn more about DID and associated disorders. In the end it was the attempted suicide taken with the reports of Dr Shortland and Dr Brown which prompted the Trust to intervene more decisively and dramatically than it had previously done. I do not accept that the Trust removal of M from her mother's care in December 2014 was anything other than justified in light of the reports which it had to hand at that point and the events which had recently occurred.

[14] It is a positive aspect of this case that a kinship placement has been achieved with M's grandmother and her husband assisted by R. P has raised a number of issues about the family set up which is not without its complications – the grandmother has been married twice before and the grandfather has a substantial criminal conviction though from more than 30 years ago. As matters stand these issues have been investigated by the Trust whose fostering panel gave stage 2 approval to the grandparents as long term kinship carers for M on 4 June 2015. This was confirmed in a report which I sought from the Guardian Ad Litem after the end of the oral hearing. No issue has been raised about the contents of that report on behalf of P.

[15] I am satisfied on the evidence that the parental grandparents can provide a stable and secure home for M. The tensions with P have made this a more difficult exercise than it would otherwise have been. The fact that there have been issues around contact has certainly caused aggravation and have the potential to do so in the future. At this stage however both the Trust and the Guardian endorse a placement with the parental grandparents as the best way forward.

[16] It has to be recorded that P's evidence was that the Trust's intervention was unjustified, that it is wholly wrong to deprive M of her mother's care, that she has never harmed M, that she would not do so and that she would appeal against any decision I make if I do not order M to be returned to her. Sadly within her evidence she herself expressed exactly what the problem is without realising it when she said that M "has five personalities as main carers and all are very unified for her". It is not just that this is abnormal – it is I believe an obvious source of likely significant harm, emotional and very possibly physical, because P is not capable of giving M the care which it is reasonable to expect a parent to give. I do not suggest that she would deliberately harm M physically but there is a clear and substantial risk of such harm as she switches from one identity or alters to another one such as a child under ten.

[17] I emphasise again as I did in my judgment on capacity in January that this set of circumstances does not represent fault on the part of P. Rather it is the consequence of her condition which has been diagnosed and reported on by a series of experts. The Children Order does not require fault – it focuses instead on the protection of the child, in this case a girl of two years.

[18] I accept the Trust's threshold criteria as set out in the document dated 8 June 2015. Mr McGuigan QC was unable to formally concede the criteria for P but he did not submit that any of them was inappropriate or unproven. In light of Dr Thomas's evidence there is a question mark whether P is deliberately manipulative or dishonest at times or whether that is a consequence of her condition. Subject to that caveat, the criteria are proven.

[19] I have considered whether any lesser order or no order can be made in this case. I regret that a care order is inescapable in all the circumstances.

[20] In this of all cases I am conscious of the human rights of both mother and child which rights are being unarguably interfered with by the making of a care order. I regard that interference as being wholly unavoidable. P's multiple personalities, already long established and likely to continue even with intensive therapy, pose a real and serious risk to M. That risk is not capable of being controlled while M is in her mother's care. Her removal is therefore entirely necessary.

[21] The single issue which I have found most troubling is that of the extent of the contact which should be permitted between mother and child under a care order. The Trust's suggestion was once every four weeks. The Guardian proposed more contact, once per fortnight. This led the Trust to reconsider and agree to that level of contact. However Dr Thomas thought that level was "thin" and advanced a case for weekly contact.

[22] I have considered this issue at length. Despite the fact that I recognise and welcome the steps which the Trust has taken in this case over a prolonged period I have found some of the suggestions made about contact to be harsh. For instance it is said that it can take 30-40 minutes to settle on her return to her parental grandparents after contact. That seems to me to be really quite good. It has been suggested that P's interaction at contact can be too formal because, by way of example, she spends too much time teaching M about colours and numbers. Again I find that to be a difficult criticism to accept. I do however accept that there is a question mark about the extent of the emotional engagement between mother and child. At present contact occurs four times per week. I find that a reduction to less than once per week would be an excessive and unjustified interference with the rights of this family. If necessary I will make a contact order to that effect but it would be preferable if the Trust accepted that limited but important alteration to the care plan which otherwise I approve.

[23] I note also that there will continue to be regular reviews of issues such as contact after the care order is made. These may result in contact having to be varied from time to time for good reason e.g. around the time of the birth of P's next child. In the first instance however I conclude that contact should not be reduced below the frequency of weekly contact.