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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

FAMILY DIVISION

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IN THE MATTER OF C (FREEING FOR ADOPTION: CONTACT)

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GILLEN J

There are a number of applications before me in relation to one child, namely C, born on 12 June 2000. The married parents of this child are M, the father, and A the mother. There is an application by a Health and Social Services Trust which I do not propose to name and which I shall refer to as "the Trust". The application by this Trust is for an order freeing C for adoption pursuant to Article 18 of the Adoption (Northern Ireland) Order 1987 ("the 1987 Order") without parental consent. M neither consents nor objects to the application to free the child for adoption. A opposes the application. There was also an application on the part of J the maternal uncle of C, CM the maternal aunt of C and S, the maternal grandmother of C for contact with C pursuant to Article 53 of the Children (Northern Ireland) Order 1995 ("the 1995 Order") but these have subsequently been dismissed by me as will appear in this judgment.

This child is the subject of a care order made by this court on 20 March 2001. On that date the parties agreed the threshold criteria and I shall refer to these criteria in extenso in the course of this judgment.

The contention of the Trust essentially is that the rehabilitation of this child with the mother is not appropriate in view of her previous history of mental disorder embracing as it does evidence of alcohol abuse, criminal activity, unstable and inappropriate living conditions, chaotic lifestyle, self-abuse, participation in violent and aggressive incidents and an inability to change or avail of professional assistance. In these circumstances it is argued that adoption is in the best interests of this child and that the consent of the parents is being withheld unreasonably. The father played very little part in this case and indicated through counsel that he neither objected nor consented to the application. The mother's case was that the child should be returned to her care either now or in the near future. She acknowledged that the past had been an unsatisfactory and unhappy one. In essence however she now claimed that there was evidence to the effect that the birth of the child had brought about a seminal change in her lifestyle and behaviour. She relied on the principle that it is desirable for a child to be reared, where possible, within the confines of her natural family and that there should be compelling factors to override the prima facie right of a child to an upbringing by its natural parent (see Re K (a minor) (Ward: Care and Control) 1 WLR 431 at 437B and Re D (Care: Natural Parent Presumption) (1999) 1 FLR 134). She argued that she had not been afforded an opportunity to prove her parenting skills with

this child since her birth. The case was that she now had a new motivation to cooperate with the professionals and to change her lifestyle.

Background and history of A

The historical background to the birth of this child has largely been unchallenged in this case. It is sad tale emanating essentially from the fact that A suffers from a severe mental impairment as defined in the Mental Health (Northern Ireland) Order 1986 (the "1986 Order"). It has bedevilled her life to date and has been of such a degree that from time to time it has warranted her detention in hospital for medical treatment under the provision of the 1986 Order. I heard evidence from a distinguished consultant psychiatrist with a speciality in learning disabilities Dr C M Merriott MB BCH FRCPsych who indicated that C's mental handicap is of unknown cause although there is a history of head injury in early childhood and a family history of mental handicap. She had a chaotic and unstructured early life. There has developed a pattern of conduct which included impulsive behaviour, a lack of capacity to protect herself against exploitation and physical violence, involvement in criminal activities and aggressive behaviour developing during her late childhood. This was already well established when she was first referred to the mental handicap services in 1986. Her offending behaviours have, in the view of Dr Merriott, been significantly contributed to by her lack of judgement and poor impulse control accentuated on occasions by the influence of alcohol or drugs. On examination she has demonstrated an impairment across all elements of functioning intellectual,

social and emotional. Sadly she exhibits a superficial impression of being more able than in fact is the case. However, Dr Merriott concludes that her thought processes are simple and she has difficulty with complex or abstract concepts. Her ability to link cause and effect in respect of her own or others actions is very limited. Her judgement is poor and she repeatedly makes inappropriate judgements in respect of other people. Her capacity to predict the probable outcome of events is similarly limited. The condition has caused her to have a longstanding distrust of authority figures, particularly social services.

Miss Dinsmore QC who appeared on behalf of the Trust helpfully assembled in her opening submissions a battery of instances of dysfunctional and anti-social behaviour which have seared this young woman's past. They include:

(a) Countless incidents of abuse of alcohol and solvents. In September 1989, when A was only 16, she had appeared in court charged with the abduction of an 18 month child in circumstances where she claimed she had been in an inebriated state at a party and had taken the child with the intention of allegedly keeping it overnight. A number of other instances revealed that whilst under close scrutiny and subject to a structured regime A could behaviour appropriately, once she was no longer subject to that supervision and regime, she was unable to sustain her appropriate behaviour. An example of this was as early as December 1997 when she had been admitted to Muckamore Abbey Hospital under Article 4 of the Mental Health

(Northern Ireland) Order 1986. During this admission hospital security staff drafted a package of support to help A return to live in the community. It was agreed that she could return to live with her mother on trial basis and a contract of responsible behaviour was agreed which included abstaining from alcohol. The support included a five day placement at Broadway workshops (a sheltered workshop for the learning disability) and community and hospital social support. Trial leave commenced on 4 March 1998. This placement only lasted for a number of weeks. On 31 March 1998 she arrived at the workshops obviously still under the influence of alcohol from the previous evening. She appeared to be coughing up blood and arrangements were made for medical treatment. In discussion with the medical staff at Muckamore Abbey Hospital it was agreed that arrangements for her to return to the hospital would be implemented. In realising that re-admission to hospital was imminent she left the workshop before hospital transport arrived. Attempts to locate her whereabouts by both police and hospital staff were unsuccessful, she had not returned to her mother's home, and she remained missing for 28 days. Her mother reported that whilst A had been living with her she had continued to drink alcohol often into the early hours of the morning, and that on one occasion she had brought two men back to the house and had become very very aggressive when her mother made them leave. Her sister reported that she and A had argued and that A had broken glass in her front door. I fear that his strain has continued throughout her life and I echo the concerns issued by Dr Merriott that whereas now she may well

be behaving well in the structured and supervised contact of Muckamore Abbey Hospital, the fear is that once taken out of the structure she would regress to her former method of chaotic living. In August 1999 she was arrested following an alleged serious attack on another woman. The police at that stage advised of their regular involvement over the previous eight months. Following these charges she was granted bail on 10 August 1999 but thereafter there are a number of incidents where she presented to the social workers in a drunken and aggressive condition. On 11 January 2000 Homefirst Learning Disability Services were contacted by A's family to complain about her behaviour over the Christmas period. They said that A had been to their houses on a number of occasions in a drunken and aggressive condition, that she had beaten her mother and smashed ornaments, had dented a living room door and had trailed a hi-fi system up and down the street. On foot of this family members obtained a non-molestation order against her. This sorry pattern of alcohol abuse continued throughout 2000 with various dates being recorded by social workers who gave evidence before me.

(b) Criminal Activity

Regretfully this history of alcohol abuse is coupled with criminal activity. In the book of evidence before the following incidents were revealed:

(i) Between September and November 1988 she was interviewed by police in connection with burglaries, hoax fire calls and obstructing police business. It was discovered that she had committed a number of thefts

involving substantial amounts of money. As a result she received a training school order. (She had already received such a training order for theft in November 1986). In March 1989, during a period of abscondment from the training school, she alleged to her mother that she had been raped, but ran away when her mother attempted to report the incident. Following her release in September 1990 from the Young Offenders' Centre her lifestyle remained erratic. In April 1991 she was alleged to have committed an assault on a man aged about 50 in which he suffered one broken rib. In February 1992 she was before the courts on a charge of attempted robbery. In April 1992, aged 18, she was transferred from Maghaberry Prison to Fintona North a semi-secure ward in Muckamore Abbey Hospital on an interim hospital order. Following conviction for the attempted armed robbery mentioned above she was subjected to a hospital order with a restriction of time for four years on 1 July 1993. She continued to be detained under Part III of the Mental Health (Northern Ireland) Order 1986 without restriction of time after 1 July 1997. During the four years of her first admission she made some therapeutic progress, but she absconded from the hospital on many occasions at times for lengthy periods. Her history of criminal violence has continued unabated even subsequent to the birth of C on 6 June 2000. The report of CMcCE a social worker at a fostering centre in Belfast who gave evidence before me records at page 206 of the trial bundle as follows:

> "C refers to having changed and matured since C's birth. The Trust indicated in the statement of evidence that C during June, July, August and September of 2000 continued to consume alcohol and

was involved in a number of violent and aggressive incidents, which include the following:

- On 8 August 2000 M obtained an interim non-molestation and occupation order for 8 weeks in response to harassment and alleged assaults from C during their separation;

- On 7 September 2000 Oldpark RUC contacted the Trust re several untoward incidents during August involving C.

- On 17 August 2000 a woman from Andersonstown was found by routine police patrol outside C's house. She alleged she and her male friend had been brought to the house and assaulted by C. C made counter allegations. All parties were intoxicated and no further complaint was made;

- On 24 August 2000 C was alleged to have assaulted a male and female at her home having consumed alcohol. The male had been hit over the head with a bottle of vodka and slashed across the face with a kitchen knife. The female had substantial amounts of hair pulled out and bruising. C was subsequently charged with causing actual bodily harm."

On 2 March 2001 C was found guilty of offences of violence following a trial at Antrim Crown Court. On 30 April 2001 she was given a four year hospital order for this offence. In December or thereabouts of this year the Court of Appeal affirmed that decision. My understanding is that other charges involving assault may still be outstanding.

It is clear that C is an extremely vulnerable young woman. Dr Merriott gave evidence that she would be subject to predatory males and is liable to be sexually and otherwise exploited by them. She has alleged on a number of occasions that she has been raped, for example, in March 1998 by

her uncle, in April 2000 by a man on the Rathcoole estate when she had been drinking in his home and on 28 April 2000 she told the police that she had been raped five times in a period of two years. She has clearly mixed in wholly inappropriate company which has exposed her to physical and mental risk.

Over the years she has exhibited manifest opposition to those in authority and has manifested difficulty working with professionals in the social work field. This mode of behaviour is of course rooted in her mental condition and despite the patient indulgence shown by these social workers over the years, they have been subjected to aggressive and abusive behaviour. Her life, which I perceive to have been one of virtually relentless misery, has been punctuated by an abject inability to avail of professional assistance. In the trial bundle of discovery documents at page 69 the social worker LC records for 3 August 2000 "advised (community mental health) that C is alone - … in her experience accepts involvement which is very low key. Increased packages of support have always resulted in C withdrawing her co-operation". Any good intentions which she exhibits in terms of accepting help soon descend into self-defeating rejection. Instances where the social workers have been exposed to anger and aggressive outbursts from her gather momentum as one reads through the papers in this case and I simply illustrate this by reference to incidents on 21 October 1999, 25 April 2000, 28 April 2000, 7 August 2000 and 31 August 2000 where these professionals have been so exposed. That unstable dynamic that drives her

aggression is accompanied by a chaotic and at times nomadic lifestyle involving numerous changes of address and prolonged periods of hospitalisation. Far from being seen as a haven of respite, hospital treatment has resulted in numerous instances of her absconding to pursue her hysterical chaos. I share entirely the view expressed by Dr Merriott that this young woman is not the author of her own destiny. She suffers from severe mental impairment and the tragic history of social dysfunction and her inability to function unsupported is a clear manifestation of the condition. In this distinguished doctor's opinion, she is not able to make judgements about a child and does not possess the ability to act in a sufficiently consistent and predictable manner to ensure the safety of such a child. She suffers from a constellation of disabilities which ensures that she simply cannot prevent herself getting into these chaotic situations and renders her unable to extricate herself therefrom. She is profoundly vulnerable and incapable of protecting herself from the attentions of more astute predatory males. It was Dr Merriott's conclusion that if everything went extremely well for her in terms of her treatment and progress a best case scenario would still take up to six years before she could be confident that she could safely care for a child. It would be up to four years before she could even begin to return to the community and commence an appropriate assessment.

Senior and junior counsel on behalf of C strenuously argued that the birth of C has been a turning point in her life. It was submitted that she had

never had an opportunity to look after this child (the child was taken within two days of the birth and given into foster care) and that since the admission to hospital in September 2001 she has not absconded, she has not consumed alcohol, has attended all contacts and has co-operated with hospital staff. Regretfully, however Dr Merriott's view was that this simply reflected the sufficient and appropriate supports that are available in hospital. Without such a structured and supportive environment it was her conclusion, which I fully accept, that C, because of her mental condition, could not sustain the practical skills which she currently possesses. A child of such tender years as C requires sustained commitment in order to protect her from exposure to a world characterised by unpredictable dangers in order that she may grow and develop normally. The essence of the problem here is that the medical evidence, convincingly and cogently presented by Dr Merriott, establishes that A simply could not sustain her present good intentions even though she is currently highly motivated within a tightly controlled environment. The chilling reality is that when she is severely impaired, particularly when under the influence and drugs, she can neither fend for herself or her child. In such a condition she is prey to others, particularly men, and might not feed, wash or protect either herself or the child. Her tendency to abscond from difficult situations could leave C defenceless and exposed.

I pause to observe at this stage in this the saddest of cases that I have no doubt whatsoever that A loves this child profoundly, wishes to care for

her and would not never deliberately hurt her. In her evidence before me A manifested the warmth of her feelings for the child and I observed literally scores of photographs which she has caused to be taken of her and the child all of which poignantly illustrated the depth of her affections. Regretfully, however, as Dr Swann another extremely distinguished medical consultant to give evidence before me conceded, there is an enormous leap between her present intentions and even a starting point to consider parenting of this child. She is a prisoner of her history and her medical condition and Dr Swann indicated that none of the historical factors augurs well for her capacity to parent in the future.

It was argued on behalf of A that time should be given for this woman to repair her mental health. In the interim it was suggested long term fostering care should be utilised with the final placement delayed until an assessment of her parenting abilities could be carried out at an appropriate time. Regretfully I am driven to conclude that this would not only be against the interests of this child, but could be grossly harmful and detrimental to her. Dr Swann emphasised that time is of the essence for a child of these tender years. Primary attachments are best stabilised by the age of four and the younger attachments are established the better it is for the child. The optimum situation is to have a child placed in a stable home before the age of 2. As Dr Swann indicated it might be different if this child had been looked after by A even for a short time. Regretfully however there is no attachment to build on in this case. The familiarity that exists between

A and C is similar to that of a familiar aunt and niece. Whilst A has worked hard with the child, it is clear that the relationship falls well short of that of close attachment. The evidence before me was that it could be profoundly disruptive in terms of attachment if a delay in the order of a number of years was introduced into this case exposing as it would this child to further move from foster carer to foster carer with no real likelihood of resolution in the near future. The evidence of Ms C, social worker and Dr Swann was that research has shown that it is clearly in a child's best interests to avoid disruption of attachment within the system and where rehabilitation with a natural parent is not possible, placement should occur before two years of age. Ms CMcCE, a social worker on the adoption team who had taken over this case from Ms C in 2001, gave evidence that adoption would be in the best interests of this child and that given her age it is likely that the Trust will be able to identify appropriate adoptive parents in the very near future if this child is freed for adoption. In essence I have concluded that the view expressed by CMcCE on behalf of the Trust that it is important to secure C's future without delay is unanswerable.

The courts have long experience of the competing arguments as to the merits of adoption against long term foster care. At page 211 of the trial bundle CMcCE in her report has set out the advantages and disadvantages of adoption and long term fostering. Each case however is fact sensitive. Whilst there may well be instances where the advantages of long term fostering will outweigh the advantages of adoption eg. where a child does

not want an adoptive family or where contact with members of the biological family are less complicated to maintain, in this particular instance the security, continuity of care, permanence and sense of belonging which would be afforded to this very young child by adoption seems manifest.

Legal principles

I now turn to consider the legal principles which must govern the factual matters which I have considered above.

In appraising the application of the Trust, I must first consider Article 9 of the Adoption (Northern Ireland) Order 1987 which reads:

> "Duty to promote welfare of child
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> 9. In deciding in any course of action in relation to the adoption of a child, a court or adoption agency shall regard the welfare of the child as the most important consideration and shall –
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> (a) have regard to all the circumstances, full consideration being given to –
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> (i) the need to be satisfied that adoption or adoption by a particular person or person will be in the best interests of the child; and
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> (ii) the need to safeguard and promote the welfare of the child throughout his childhood; and
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> (iii) the importance of providing the child with a stable and harmonious home; and
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> (b) so far as practicable, first ascertain the wishes and feeling of the child regarding the decision and give due consideration to them, having regard to his age and understanding."

This child is obviously far too young to be in a position to allow a court to ascertain her wishes or feelings. However for the reasons I have given

above, and in light of all the circumstances of A's mental condition and the anti-social sequelae deriving therefrom, I have no doubt that it is in the best interests of this child that she be adopted and that such a step is absolutely vital in order to safeguard and promote her welfare and provide her with a stable and harmonious home.

Secondly, I must then turn to consider Articles 16, 17 and 18 of the 1987 Order. In particular I must not make an order unless I am satisfied that each parent freely and with full understanding of what is involved agrees to the making of the adoption order unless the court can dispense with their agreement on one of the grounds mentioned in Article 16(2) of the Order. In this case the Trust argue that under Article 16(2)(b) each parent is withholding his or her agreement unreasonably. The leading authority on the meaning of this article and of the test that the court should apply is the House of Lords decision in Re W (An Infant) (1971) 2 AER 49. During the course of the leading opinion, Lord Hailsham described the test in this way:

> "The test is reasonableness and nothing else. It is not culpability. It is not indifference. It is not failure to discharge parental duties. It is reasonableness and reasonableness in the context of the totality of the circumstances. But although welfare per se is not the test, the fact that a reasonable parent does pay regard to the welfare of his child must enter into the question of reasonableness as a relevant factor. It is relevant in all cases if and to the extent that a reasonable parent must take it into account. It is decisive in those cases where a reasonable parent must so regard it."

In Re C (A Minor) (Adoption: Parental Agreement: Contact (1993) 2 FLR 260 the court suggested that the test may be approached by the judge

asking himself whether, having regard to the evidence in applying the current values of our society, the advantages of adoption for the welfare of the child appears sufficiently strong to justify overriding the views and interests of the objecting parent. That is an approach that has received further judicial approval most recently in Re F (Adoption: Freeing Order) 2000 2 FLR 505. I consider however that the test is still well formulated within Re W and the component parts are:

(a) The reasonableness of the parents refusal to consent is judged as at the date of hearing. I have done that in the case of both M and A in this case.

(b) I have taken account of all the circumstances of the case which I have set out earlier in my judgment.

(c) Whilst I have taken the welfare of the child into account, I do not consider it to be the sole or necessary paramount criterion.

(d) I have applied an objective test. Could a reasonable parent in the position of either M or A withhold consent? In my opinion no reasonable parent given the background of A and M and the dangers to which this child would be exposed, could reasonably withhold consent in these circumstances.

(e) I have applied a test of reasonableness and nothing else.

(f) I have been wary not to substitute my own view for that of the reasonable parent.

(g) I recognise there is a band of differing reasons each of which may be reasonable in a given case. In light of all these circumstances and in particular the mental health problems of A I have considered that she is

therefore legally withholding her consent unreasonably. So far as the father is concerned, I do not consider that he has shown the commitment to this child which could afford her the security and stability which she so badly needs. As a guardian ad litem so pertinently observes at paragraphs 7.1 in his latest report:

> "M has not kept contact with his daughter and has let it be known to the social workers involved in the case at both the care order and freeing stages that he did not see himself as being involved in C's life. He appears to be resigned to the care plan taking affect without any real obligation."

I consider this is a fair summary of his views and his approach to this case. He played virtually no part in the hearing other than to be represented by counsel and to indicate that he neither objected nor consented to the application. I am satisfied therefore that he is withholding his agreement unreasonably.

I am satisfied under Article 17(5) that each parent has been given an opportunity of making, if they so wish, a declaration that he or she prefers not to be involved in future questions regarding the adoption of the child.

I am satisfied under Article 18 that this child is subject to a care order made by this court on 20 March 2001 and I am also satisfied on the evidence that it is likely that this child will be placed for adoption.

During the course of this hearing the application under Article 53 by J C M and S was, by consent, dismissed on the basis of an undertaking by the Trust that it will afford to C M and S one thirty minute meeting with the child supervised by Trust staff at a Trust building within one month from the date

of this hearing. Accordingly I need take no further step with those applications.

In coming to the conclusion that a freeing order should be made in this case, I have borne in mind the mother's right, and indeed the father's right, to family life under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (Rome) 4 November 1950 TS71 (1953 Cmd 8969). However this right is circumscribed and is subject to the rights and freedoms of the child and in particular to her right to a stable, secure family life in which she is not at risk of harm. The rights of the children are of primary importance (see Re S and A (Children) (Care Orders: threshold criteria) 2001 3 FCR 589 at page 612g). The principle of proportionality must be applied. As Hale LJ observed in Re C and B (Children) (Care Order: Future Harm) (2001) 1 FLR 611:

> "Intervention in the family must be proportionate, but the aim should be to reunite the family when the circumstances enable that, and the effort should be devoted towards that end. Cutting off all contact and the relationship between the child and their family is only justified by the overriding necessity of the interests of the child."

In my opinion the overriding necessity of the interests of the child in this instance dictates that I should make an order freeing this child for adoption. In coming to this conclusion I should add that the assessment of the Guardian Ad Litem has been invaluable.

I recognise that a freeing order discharges the care order in this instance. However I still have power to make a contact order if I consider it

appropriate. In this instance I think that the "no order" principle should apply with reference to future contact. This will afford the Trust the appropriate flexibility to deal with the situation as it evolves. Suffice to say that I consider that the guardian ad litem and the Trust witnesses are correct in concluding that the current contact between A and C should gradually diminish to a point where the contact is indirect. I share the view of Dr Swann that C will not benefit from continued contact and she will quickly adjust to no longer seeing her mother. As Dr Swann said it will be "like losing a good friend". The child does not understand that A is her mother in that sense and accordingly direct contact seems to me to be no longer in the interests of this child in the near future. Moreover I do not consider there should be any contact of a direct nature between the father and this child.

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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