[2022] EWFC 117 (B)

ZE20C00658

Before HHJ LAZARUS

SITTING IN THE FAMILY COURT AT BROMLEY

15 September 2022

LB OF Z

And

M

F

X

(by his Children's Guardian)

Mark Love for and instructed by the LB of Z.

Nkumbe Ekaney KC and Sharan Bhachu (instructed by Charlotte Collier of Taylor Rose MW) for M.

Alison Hosking of Sparlings Solicitors for F.

Damien Stuart (instructed by Deborah Marsden of Creighton & Partners) for the Children's Guardian.

JUDGMENT

1. OVERVIEW
2. X is the 8th child of M and was born in late 2020. Care proceedings were begun shortly after his birth. He has lived throughout his life with his mother in a variety of placements but has now been living in the community at home with her for the last almost 2 months. All the parties to this case agree that is where he should stay, assisted by a 12 month Supervision Order.
3. X has 7 siblings, 6 of whom are his full siblings. They range in age from 22 to 9. The eldest is his half-sibling and was placed with a relative at a young age, the next 3 were placed with a paternal aunt when they were toddlers, 2 of whom she went on to care for through their minority. The youngest 3 were the subject of care proceedings which concluded before me in 2020 with final care orders and their placement in long term foster care. M creditably conceded those final orders in 2020, given the children's enhanced needs and her own vulnerabilities and capabilities to meet those needs.
4. Those children had been left with significant trauma, emotional damage and attachment disorder due to their exposure to emotional and domestic abuse, instability, neglect and their parents' dysfunctional volatile behaviours.
5. M is a 39 year old woman with a complex and painful background. Her own childhood was repeatedly traumatic and her experiences included sexual and emotional abuse, chronic neglect, instability and exposure to volatile and unsupportive relationships. She has experienced ongoing

trauma from dysfunctional intimate relationships and the losses of her children. She has a mild learning disability that was diagnosed in 2001 and has a diagnosis of moderate Emotionally Unstable Personality Disorder. This was first diagnosed in 2013 and was confirmed again by consultant psychiatrist Dr McDermott in 2018 in the context of the previous proceedings and most recently in her updating report in these proceedings. She has experienced typical difficulties associated with this diagnosis including difficulty in reflective functioning, poor self-esteem, patterns of poor relationships and instability, difficulties trusting others, difficulties controlling and modulating her emotional responses under stress, impulsivity, mood fluctuation, suicidal feelings and self-harm. She regularly misused cannabis. She has made significant progress since the conclusion of the 2020 proceedings which is discussed further below.

6. X's father is also 39 and currently serving a prison sentence for burglary. F is likely to be released at the end of 2024. He has had little involvement in these proceedings but has been advised and represented. His relationship with M was unstable, volatile and violent. Although his position has varied slightly through the proceedings, and he has expressed reservations about M's abilities as X gets older, he supports X remaining with M under a Supervision Order. He is concerned that the LA should follow through with its support for M and X. He has never met X due to his prison sentence and does not seek any contact with X. He acknowledges that if his position were to change there would need to be a risk assessment.
7. F has not yet told his current partner about X. It is likely that she will be upset and angry as X was conceived during his ongoing relationship with her, during the previous proceedings. Both X's parents concede that they succumbed unwisely to meeting up and had a one-night stand. They have not otherwise resumed their previous relationship. Other family members and mutual acquaintances are aware of X's existence and parentage. F's partner's ignorance of X is an issue that will need to be addressed and carefully handled. Initially, F refuted paternity but it was established by DNA paternity testing in August 2021. This led to a significant delay in the proceedings which had been listed for a final hearing in September 2021.
8. At that point, the LA's case and care plan for adoption were based on the recent outcome of the previous proceedings and the negative conclusions of the various reports from those proceedings, and the negative assessment from the London Infant and Family Team (LIFT) multi-disciplinary assessment in June 2021. Their report was a central part of the evidence and was inevitably highly influential in determining the LA's care plan. In brief, their overall conclusion was: M was too damaged and dysfunctional due to her traumatic experiences and EUPD to be able to meet X's needs within his timescales; she lacked attunement and an ability to reflect, and was unable to acknowledge her role in her older children's experiences; she required therapy to address her emotional regulation, insight, low self-esteem and problem-solving skills; X should be removed from her care.
9. Given that the plan at that time was for adoption, it then became necessary to investigate whether paternal family members could provide appropriate alternative care. The paternal aunt who had cared for two of X's older siblings was the subject of a Special Guardianship assessment which concluded in January 2022 with a positive recommendation.
10. The extension of time due to the clarification of X's paternity and the Special Guardianship assessment also meant that an updating report could be obtained from Dr McDermott in November 2021, and that M had an extended opportunity to parent X and work with professionals. To a very significant extent, by the time of the relisted final hearing in late January 2022, her behaviour, coping skills, presentation and care of X refuted many of the conclusions set out in those earlier reports.
11. At the relisted hearing in January 2022, the LA's care plan had been modified to supporting a Special Guardianship Order to X's paternal aunt. This was resisted by M, and the Children's Guardian

wished to hear from the expert witnesses before reaching her conclusions given that their conclusions differed markedly from her own perceptions of M's improved capabilities. The court heard from key expert witnesses and, in particular, three witnesses from LIFT.

12. A number of difficulties and concerns had been raised following the filing of their report, including what appeared to be: failures to consider any changes M had shown; failure to provide notes of meetings and observations; refusal for key witnesses to attend; and concerns as to their methods and approach. Unfortunately, such major concerns emerged during the course of their oral evidence at the hearing, that the parties provided a joint statement to the court criticising the LIFT assessment, and the LA specifically confirmed that it did not feel able to rely upon it. These matters will be discussed in more detail later in this judgment.
13. Inevitably, this led to further consideration of the way ahead in these already delayed proceedings and how to address gaps in the evidence as a result of both the problems with the LIFT assessment and M's evident improvements. Ultimately the parties agreed on and the court approved a Marschak Interaction Method (MIM) assessment of attachment patterns due to the concerns existing as to M's abilities in relation to mentalisation and attunement and therapeutic needs. This in turn led to further clarification of the recommendations from the MIM assessment author, the development of a transition plan (including a further move of M and X from the residential unit to another parent and baby foster placement as a bridging placement), the execution of that transition plan and the development of a final care plan.
14. The case was listed for a resumption of the part-heard final hearing in September 2022. During the summer there was a successful implementation and review of the transition plan and rehabilitation home into the community, which has led to the current agreed supervision plan.

15. M'S PRESENTATION & BEHAVIOUR
16. During the course of these proceedings and to date, it has been noticeable to this court and to the Children's Guardian and the IRO that M has presented very differently than she used to, and in particular in contrast with her behaviour during the previous proceedings. She has particularly impressed the Children's Guardian, who had also represented the younger children in those proceedings, with the progress and improvements she has shown. Previously, M presented both in court and to professionals involved in those proceedings as trying hard to please but also chaotic, anxious, outspoken, defensive, confused, refusing or unable to acknowledge serious concerns, lurching from crisis to crisis, and emotionally unstable. This has emphatically and obviously not been the case in these proceedings.
17. She has largely worked well and co-operatively in difficult circumstances with the social work team and in less than ideal placements. She has satisfied the professional parties in this case that she has proper insight into the previous concerns and has been described by the social worker as honest and open and understanding of her own role in that history. She has remained free of destabilising or abusive relationships since before the conclusion of the last proceedings. Although she has ongoing vulnerabilities and weaknesses, and requires ongoing support and therapy, it has become clear to the professionals that M has not simply matured and turned a corner, but has made significant meaningful and consistent changes, and has shown herself to be a determined, child-focussed mother in whose care X has thrived.
18. Initially M was placed in a parent and baby foster placement. This was not a suitable cultural match, and due to the inevitable delays and length of these proceedings it lasted for far longer than is usual for such placements until February 2022 when M and X moved to a largely independent annexe of a residential unit.
19. Over time it emerged that the foster carer was not supportive nor co-operative with a number of issues, including for example: X's needs for access to the garden, modest rearrangement of the

rooms and furnishings within the home, outdoor activities and facilitating M's and X's access to the community, prevented M from joining Christmas celebrations, and showed an apparent refusal to adapt and alter in response to requests from the professionals, to the extent that the social work team and the Children's Guardian both considered that her role was actively unhelpful and difficult to manage within already challenging care proceedings. Notwithstanding these difficulties, including the foster carer imposing an unplanned visit of her male partner from abroad, M remained co-operative and appropriate despite her own vulnerabilities within that difficult and inappropriately managed placement which in the end lasted for over a year.

20. Again, notwithstanding the upheaval and the presence of vulnerable and challenging families at the residential unit to which she moved in February 2022, M managed herself extremely well and was observed to co-operate well with staff and residents and to be meeting her own and X's needs admirably. A transition plan home was implemented in May 2022, which also involved a further change of placement to a bridging foster placement. Since mid-July M and X have been living at home full-time. This was also a disruptive and challenging process, but was again managed well by M.
21. The social worker has also noted that despite M's vulnerabilities she has in fact been able to maintain and build a good working relationship with her, and M has demonstrated trust in her, has shared information and sought advice and support appropriately. She has engaged extremely well with the Family Support Worker who provides weekly visits and direct work with M at home.

22. M'S MENTAL HEALTH
23. In November 2021 when she most recently reported, Dr McDermott noted a number of commendable positive signs of progress over the previous three years since she last reported, and conceded that other practitioners might consider M had moved out of the category of personality disorder into that of personality difficulty, albeit she still confirmed her opinion that M suffers from Emotionally Unstable Personality Disorder.
24. Overall, she was cautious about M's ability to access and make use of appropriate therapy that would be required to address her underlying personality disorder issues, largely due to concerns about waiting lists and referral times. She found M to be distressed ('anxiously dysregulated') and to the extent of being unable to think about or discuss several concerning matters during this updating assessment, but did conclude that if M engaged in and completed a course of appropriate therapy, she would more likely than not be able to benefit in terms of her reflective functioning and consequently her parenting. She considered this reflective functioning, or mentalisation, to be a key aspect of M's capabilities in the context of her diagnosis and her history of personal and parenting difficulties. She deferred to others on the question of whether M could cope with parenting alongside undertaking therapy. However, when considering her more negative opinions of M, she had also placed a good deal of reliance on key negative observations and conclusions set out in the LIFT assessment. For reasons that are discussed below, this reliance resulted in those aspects of Dr McDermott's report unfortunately and inevitably being of less help and value than they might otherwise have been.
25. Some of the progress noted by Dr McDermott included weekly sessions undertaken by M over a 4 month period in late 2020 with her allocated care co-ordinator from the multi-disciplinary ADAPT mental health team, supervised by a clinical psychologist. This was stabilisation work focussing on managing emotions in preparation for further regular psychological therapies. She was considered to have been committed, attending all appointments, fully compliant with intensive work and to have made positive changes in managing her condition. Unfortunately, progression of this work was interrupted by her move from that Health Trust area when she was placed with X in the parent and

baby placement at the start of these proceedings. This engagement and progress were considered to be particularly positive factors by Dr McDermott.

26. This approach has continued during these proceedings with her compliance and engagement with the MIM assessment which followed from the attempted final hearing in January 2022. That process observed a good bond between X and M but also made recommendations as to Theraplay work for M and X, and Schema therapy for M to mitigate risks associated with her vulnerabilities and to assist the attachment process and M's attunement, with which work she has also fully and positively engaged. M has worked closely and positively with her mental health advocate and GP for a re-referral to ADAPT and for a review of her medications as necessary.
27. What is apparent currently to the professional parties involved and is accepted by this court, and has been the case now over many months, is that M's mental health is now stable and greatly improved. She has completely given up using cannabis and has stuck rigorously to using her medication. She has attributed much of her improvement to these steps. She has shown some ongoing trust and sensitivity issues in these proceedings, particularly relating to the social worker contacting a neighbouring local authority and her GP in relation to her mental health issues. However, this sensitivity has been limited to those issues. She has, on a few occasions when under particular stress, been witnessed by the social worker to show a degree of unhelpful anxiety and defensiveness with a loss of perspective. However, she has been able to seek and accept support from her mental health advocate and from other professionals in breaking down problems into manageable issues, and she has attended appointments and sought and taken up help and advice.
28. It appears clear to all professionals that M is fully committed and engaged in all work, appointments, therapy and support that have been advised and that will continue to be expected of her as part of the supervision plan.

29. THE LIFT ASSESSMENT

29.1. LIFT & BeST? TRIAL BACKGROUND

A) BeST? is a Randomised Controlled Trial research exercise, approved in 2019 for incorporation into appropriate care proceedings in a specific geographical area by the President of the Family Division. It aims to evaluate outcomes of a parenting intervention using a mental health focussed model by the London Infant Family Team (LIFT), compared with social work care Service as Usual (SAU).[1] [2] It is derived from the New Orleans Intervention Method (NIM) that has been developed in the United States and a study undertaken at Glasgow University in conjunction with the provision of Children's Services and the judicial process in that Scottish jurisdiction.
B) It is clearly an exercise of potentially huge significance that is looking at the outcomes for children involved in care proceedings following these different paths, and great care has been taken in preparing the ground for the project, which is managed by a combination of the NSPCC, local health authorities and local councils.[3]
C) Every family in care proceedings or in the PLO in the research area with at least one child aged 0-5, who is placed in foster carer, a parent and baby foster placement, or within a kinship placement are given an opportunity to participate in the BeST? Services Trial. Once parents have

[1] University of Glasgow - Schools - School of Health & Wellbeing - Research - Mental Health and Wellbeing - Research - Research projects - The BeST? Services Trial
[2] media.gla.ac.uk/web/researchinstitutes/IHW/BeST_Services_Trial_social_media_clip_FULL_HD.mp4
[3] New Orleans intervention model: early implementation - GOV.UK (www.gov.uk)

received explanations and provide consent to be part of the research trial, they are randomly allocated to one of the two services, either LIFT or SAU. Once allocated to LIFT, the initial assessment is by the LIFT multi-disciplinary team and takes up to 18 weeks.

D) LIFT then determines by that assessment whether it will offer an additional treatment and intervention to some families. If that goes ahead, it can take an additional period of 3-7 months, depending on what the court recommends, and the process comes out of the PLO 26 week time limit. The BeST? research team will then follow those children and will meet them and their carers 3 times over the next 2.5 years, to see how they are developing over time, in terms of their social, emotional, and mental health. If, however, that initial assessment does not lead to LIFT offering the additional intervention programme but is negative, the report is filed as would be usual as an expert parenting assessment and the case returns to court under the usual PLO timetable and moves on to the Issue Resolution Hearing.

E) The LIFT assessment process, like other expert assessments, is governed by the relevant Rules of Court, Practice Directions and guidance.

29.2. IN THIS CASE

A) In this case, M consented to being involved in this trial and was allocated to assessment by LIFT in January 2021. LIFT carried out its assessment in early to mid-2021 and their report was filed in June 2021. Most of their work was conducted by remote interviews over a video call, due to the Covid-19 pandemic restrictions in place at the time. There was then a single visit into their unit in central London for a 'still face' procedure and then for the concluding feedback meeting.

B) Their opinion set out in the report was as follows:

'M attended the LIFT assessment appointments which shows a commitment to X, and she demonstrated an ability to prioritise X' instrumental needs whilst in a structured mother and baby placement. It is clear that M loves her son and wants the best for him. However, observations indicate that M struggles to attend to X's emotional needs, particularly when she becomes emotionally dysregulated.

M's experience of abuse and neglect has had a significant impact on her model of parenting and what constitutes safe and equal partner relationships. This impacts on her ability to provide safe and consistent caregiving to her children. M has been able to acknowledge concerns about her abusive partner relationships, and has reflected on the impact on her older children of witnessing partner violence. However, M was not able to demonstrate that she takes appropriate personal responsibility for the consequent harm suffered by her older children.

LIFT's opinion is that M remains vulnerable to abusive relationships, and there is not sufficient evidence that M would be able to take the appropriate steps to safeguard X from future domestic abuse.

M reports some progress in her ability to manage difficult emotions and respond to challenges in a non-violent and non-aggressive way. However, significant further work is required to enable M to consistently manage her emotions, which would be essential in order for her to provide sensitive, attuned care to X. M would be required to engage in a suitable evidence based therapy for 12-18 months to manage her emotionally unstable personality disorder. LIFT understand that it is unlikely that intensive therapy can start until the conclusion of current care proceedings, as stability is usually required for such work to be effective.

In the absence of M's understanding and acceptance of the historic and current safeguarding concerns for her children, and appropriate intensive treatment for her personality disorder, and taking into account her poor problem-solving skills, LIFT consider that it is likely that further patterns of mental instability and domestic abuse will reoccur.

It is LIFT's opinion that despite her love for X and her commitment to the LIFT assessment process, M is currently unable to provide X with safe, sensitive, attuned and stable care, and cannot achieve the changes required to meet her son's needs within X's timescales. It is LIFT's opinion that if X were returned to the care of M, there is a high risk that patterns of unsafe care, emotional harm and neglectful parenting would occur, with a high likelihood of negative consequences for X's social and emotional development and wellbeing. LIFT respectfully recommend that X is not returned to the care of M. LIFT respectfully recommend that M is supported to access the help and support she requires to meet her own complex needs.'

C) From the outset, concerns were raised by those representing M that LIFT had not adequately considered changes and improvements in M's presentation and mental health, and as to their methodology. Directions were made on 23 June and repeated on 4 August (due to apparent non-compliance by LIFT) requesting various clarifications from LIFT, and further directions were made urgently on 6 August in response to a statement dated 4 August from Dr Clare Lamb, the LIFT consultant child and adolescent psychiatrist and a lead clinician of the team. Dr Lamb provided a further statement dated 17 August.

D) Surprisingly, that statement was sent separately by Dr Lamb to HHJ Atkinson, the Designated Family Judge for the Family Court at East London, who is also the Lead Judge for Research across Family Justice, in response to a question asking for an explanation of this LIFT assessment team's understanding of undertaking assessments within care proceedings in this jurisdiction. Dr Lamb did not seek approval from the lead instructing solicitor nor this court in relation to this step, nor sought any clarification of the question she was querying.

E) Unfortunately, this court did not find that the LIFT team's or Dr Lamb's responses to the necessary case management directions in this case were helpful. Firstly, there was significant resistance to any witness other than Dr Lamb attending court. Secondly, notes of assessment sessions and meetings and other source material were not provided as directed, and it was also suggested that such items were not necessary or were adequately available in the lengthy report and would be hard to obtain from NSPCC files; whereas it turned out that some 2000 pages and video footage of the still face exercises undertaken during the assessment were available and proved to be highly relevant.

F) The 'mini multi-disciplinary team' was made up as follows: Ms Watts was the social worker assigned to assess M, Dr Heap was a consultant psychologist assigned to work with the foster carer and also supervised a developmental assessment of X, and Dr Lamb supervised the overall mini-team assessment exercise with fortnightly meetings and provided the final version of the report.

G) It was quickly apparent, given the emphasis placed upon particular interpretations applied to M's reported responses in her interview sessions, that it would be critically important to know how those responses were being obtained and recorded, and how those interpretations were being reached and by whom. But it was only after it was made plain that Ms Watts and Dr Heap might otherwise be subject to a witness summons was their attendance was finally agreed to by Dr Lamb. This proved to be a crucially important case management and forensic step.

29.3. LIFT WITNESSES

It was only as a result of the questions that could be separately put to each of those three witnesses that the parties and this court learnt the following:

A) Ms Watts was an inexperienced junior social worker of only a few years' experience. She qualified in 2014 and joined LIFT in 2020. Her only similar prior experience had been in preparing a very few section 7 reports within private law proceedings and a maximum of 2 social work assessments in care proceedings under supervision while in her early trainee period. From

2017 to 2020 she worked within the NSPCC providing direct work and support to young people at risk of sexual exploitation. She had no training nor experience in assessing and working with parents with Learning Disability, with mental health issues generally or personality disorders specifically, but had received simply general social work training modules as a student and exposure to individuals with these difficulties during her work at LIFT.

B) However, Ms Watts conducted all the sessions with M. The only contact that Dr Lamb had with M was a single chance encounter bumping into her in a corridor at the LIFT unit, and at the feedback meeting once the report was concluded.

C) Ms Watts had drafted significant and substantive parts of the report and confirmed that key elements of the wording and analysis provided were her own. This included references to psychological or psychiatric labels and terminology such as '*emotional dysregulation*' and '*emotionally aroused*', which she was not qualified to assess or use, and in relation to which she could only cite two comparatively minor examples of anxiety or distress.

D) Dr Lamb could not explain the division of labour and the choice of such an inexperienced social worker to carry out the principal assessment task. Dr Lamb could not adequately explain the contrasting use of an experienced psychologist to carry out the task of working with the foster carer within the assessment process.

E) Dr Lamb could not satisfactorily explain nor demonstrate from the LIFT materials what, if any, appropriate interrogation or supervision of the raw observations by such an inexperienced and insufficiently qualified social work practitioner had been carried out.

F) Dr Lamb acknowledged that while she had oversight of the report and took responsibility for its conclusions, that significant and substantive parts of it had been drafted by Ms Watts and Dr Heap without Dr Lamb having had any direct contact with M at any session herself and in the inadequate context set out above. For example, the specialist descriptor '*emotionally dysregulated*' appears in the Opinion section which Dr Lamb claims to have written, but is a term that was wrongly employed by Ms Watts and simply appears to have been absorbed and repeated by Dr Lamb without adequate interrogation of how and why Ms Watts used it and whether it was justified.

G) The still face procedure used in the assessment (and discussed further below) had been carried out unevenly and with different professionals involved: Ms Watts conducting it with M and Dr Heap with the foster carer.

29.4. LIFT DOCUMENTATION

A) It was only at the outset of the relisted final hearing that it became apparent that in fact assessment documentation including the videos of the still face exercise were readily available, in contrast to the assertion in Dr Lamb's statement of 17 August that the report '*comprises the details, observations, analyses and conclusions of the LIFT interviews and includes verbatim accounts… Our observations… are also reported in detail in the LIFT report and include descriptions of the behaviour observed*.'

B) Again, this late-provided material proved to be a crucial resource in understanding the methods of the assessment process and consequent value of the report:

i) There appeared to be no plan of work, nor assessment structure or protocol, let alone anything that showed M's particular learning difficulty and mental health vulnerabilities had been considered in the plan of the assessment process.

ii) Ms Watts confirmed during her oral evidence that she had not regularly nor promptly written up her notes of her sessions with M, and that as a result she was often only reporting back orally to meetings with Dr Lamb.

iii) Despite the assurance that the process was regularly supervised at fortnightly meetings of the team, there appeared to be no adequate note or account of any in-depth supervision, discussion, interrogation or analysis of Ms Watts' observations or assumptions.

iv) The absence of any evident or documented thought process or critical evaluation of Ms Watts' sessions with M and her responses was striking. The lack of note-taking during these sessions and group supervision meant it was impossible to discern or comprehend the 'evolution of thinking' or critical analysis of the professionals involved in the relevant team meetings.

v) The case discussion which took place on about 29 April 2021, which appears to have been pivotal in the decision-making concerning the case, is not recorded and so there was no way of understanding the examination or evaluation process that was carried out by Dr Lamb before she formulated or approved the recommendations set out in the report.

vi) An area of repeated criticism of M in the report, based on Ms Watts' observations and set out in sections of the report largely drafted by her, was her alleged failure to be able to reflect on or acknowledge historic concerns and her own role and responsibility. However, on considering the notes and the content of the report during cross-examination, it became clear that attempts by M to respond to those concerns had been readily dismissed and no account was taken of what M was actually saying in response to complex questions being put to her by an inexperienced social worker, and where M was often using her own words to respond rather than tick-box social work jargon. There did in fact, and I find, appear to be numerous examples of M acknowledging her role in the historic concerns as well as putting forward her own views. (This has been further borne out in her ongoing interactions with the local authority social worker and the Children's Guardian.)

vii) There also appeared to be a lack of opportunity for M to be challenged with the perceived problems arising from her answers, and so she had no opportunity to consider and clarify or respond to any criticisms of the responses she had given to set questions from Ms Watts. This problem was compounded by her responses then being analysed subsequently by a different practitioner Dr Lamb who had never met M and based on oral reports or subsequent notes and interpretation from an inexperienced and insufficiently qualified junior practitioner.

viii) In terms of the still face procedure, the video material that was provided revealed that Ms Watts had proceeded notwithstanding that X was already disconcerted and distressed before the formal exercise began, and that an experienced clinician who might have interpreted whether and how the exercise should proceed was not present. These circumstances were neither set out nor evaluated in the relevant section of the report.

29.5 LIFT USE OF STILL FACE PROCEDURE

A) A still face procedure, described as a '*structured clinical observation*' was carried out with both M and the foster carer, each with X. This procedure at LIFT involved a period of 'normal' interaction between the adult and X, but without touching X, followed by turning away and then turning back to X with a 'still non-expressive face' for a fixed period of time ('separation'), before the carer then resumed normal interaction ('reunion'), albeit still without being permitted to touch X. It was asserted that '*this procedure assesses the quality and style of relationship between infant and caregiver*'.

B) Heavy reliance was placed in the LIFT report and by Dr Lamb on the conclusions that could be drawn from this still face procedure, in particular that X had a meaningful relationship with the foster carer, was accustomed to having his needs met by her and that he can be comforted and soothed. It was asserted, by contrast, that X did not have this type of relationship with M, but that M showed emotional discomfort, was unable to comfort X until she was permitted to pick him up

and hold him, and '*that X's emotional distress acts as a trigger for M, leading to her own emotional dysregulation… at times of stress M is likely to have difficulty in meeting X's emotional needs*'.

C) I was concerned to properly understand the procedure and its application here in order to evaluate the weight that had been given to it in the report. I was assisted by Dr Lamb's evidence, and her provision to me once she had left court of a meta-analysis paper: '*The Many Faces of the Still Face Paradigm: A Review and Meta-Analysis*' published in the journal Developmental Review in June 2009.[4]

D) The review paper covers the hugely varied methods, uses, parameters, conclusions and topics to which the still face procedure has been applied. Key conclusions of the paper include:

- The results of the meta-analyses confirmed the classic still-face effect [on the child] of reduced positive affect and gaze, and increased negative affect, as well as a partial carry-over effect into the reunion episode consisting of lower positive and higher negative affect compared to baseline.

- Additional meta-analyses confirmed the narrative review in finding that higher maternal sensitivity predicted more infant positive affect during the still-face. Infants' higher positive affect and lower negative affect during the still-face were predictive of secure attachment at age 1 year.

- The meta-analytic results for maternal depression were equivocal.

- Implications for future research include a need for studies testing the role of the adults' identity (parent versus stranger, mother versus father) to elucidate the relationship-specificity of the still-face effect.

- Also, the role of maternal sensitivity and temperament as potential moderators of the still-face effect need to be examined further.

- On a procedural level, the effects of the timing of the still-face and of the duration of the reunion on infant responses deserve future research attention.

E) In the use of the still face procedure made by LIFT in this assessment, the following matters emerged and caused me significant concern:

i) It was carried out on the first ever occasion that M had attended at the LIFT unit in central London, and she was not permitted to attend with her advocate. This was undoubtedly sub-optimal in increasing her levels of anxiety and stress and does not appear to accord with good practice when working with parents with learning difficulty. It was claimed by Ms Watts that an advocate did not need to be present because it was M's emotional interaction with X that was being observed and on the basis that it was a straightforward process. This betrayed Ms Watts' lack of experience, knowledge and understanding of how to work with such parents.

ii) Different practitioners (Ms Watts with M, Dr Heap with foster carer) carried out the two exercises, rather than there being parity and thereby introducing an additional variable.

iii) X became distressed in the period of time before the exercise was formally begun with M, when a 'baseline' is established. This was not the case during the exercise with the foster carer.

iv) Dr Lamb was unable to answer my query as to any research that existed which dealt with the circumstance where a child was already distressed at the outset of the exercise before it had begun, save to state that it was '*not optimal*'. Neither Dr Lamb nor any other senior practitioner with expertise in this procedure was present to oversee its proper conduct.

v) The report states that '*M became emotionally dysregulated during the separation and reunion which would have increased X's discomfort*.' However, in fact Ms Watt's oral evidence and the video footage appeared to confirm that M actually remained appropriate and quiet and complied with the 'still face' during that phase of the exercise, despite X's distress, in contrast with the wording of the report, albeit showing some entirely reasonable anxiety and distress

[4] The many faces of the Still-Face Paradigm: A review and meta-analysis | Request PDF (researchgate.net)

during the reunion phase when he continued to be upset but she was still not permitted to touch or hold him.

vi) None of the above circumstances and variables appeared to have been taken into account in the LIFT analysis. In particular, I was concerned that the two exercises were portrayed as comparators in the report and used to thereby criticise M, whereas there were significant differences in the two exercises, in particular that X was upset before the exercise even began with M.

vii) The research shows there is a multitude of procedural options that have been used and studied, and these differences have inevitably been shown to have different impacts on babies' responses and hence affect any conclusions that might be drawn in a specific case. It is not a fixed or settled paradigm nor a firmly established procedure with a clearly defined set of rules, outcomes and interpretations.

viii) In some of the documented research touch is incorporated as a significant part of the exercise and not prevented during the baseline and reunion phase, and in other papers it has additionally been observed, understandably, to have a significant impact on the emotional regulation of the child.

ix) The particular iteration of the exercise used here prevented the carer from touching the child in the initial phase and the reunion phase following the still face phase. Notably, X was rapidly comforted and settled down on being physically held and reassured by M after this exercise. She was criticised for being unable to soothe him by words alone. It remains unclear to me why touch was excluded here and M expected to interact with X solely with words. This discriminates in favour of carers who are more adept at or more often use verbal expression with their child, and it may have serious and discriminatory implications for carers whose methods of interacting with their child may understandably include more physical interaction.

x) Although some still face research studies have explored the implications of carers with learning difficulty or mental health issues including borderline personality disorder, there appeared to be no consideration of this element in the exercise undertaken here; either by using appropriately expert practitioners, or by acknowledging and factoring this into the exercise, or by reference to the papers where this had been researched and any conclusions that might or might not be legitimately drawn as a result.

xi) Dr Heap confirmed to me that her only training in the still face procedure had been while employed at LIFT, and primarily via 'Circle of Security' training, in which she explained that the exercise is characterised as an intervention tool rather than an assessment tool, and where it is used to look at how a child cues attention, and at how the parent and child react to each other and how the parent can be supported to respond to their child.

F) The way in which the still face procedure was being relied upon here appears to have failed to take into account the concerns I have discussed above and also ignores areas of uncertainty highlighted in the paper provided to me by Dr Lamb.

G) There would appear to be too many variables that need to be considered, as is particularly evident here in this case, to land so firmly on any purported interpretations of specific maternal failings and to place such unequivocal weight upon this use of the procedure as part of LIFT's assessment and by Dr Lamb in her evidence.

H) While I accept that there is undoubtedly a place for the use of the still face procedure in certain contexts (such as supportive intervention and work on parent-child interactions) and in the hands of skilled and knowledgeable experts, it is clear that the paper to which I was referred largely views it as a window into aspects and theories of children's social and emotional development and attachment and as a research tool rather than a method which can be clearly relied upon to determine very specific maternal skills or deficits.

29.6. LIFT ASSESSMENT OF M'S EMOTIONAL REGULATION

A) In terms of the further conclusions reached by LIFT regarding M having difficulty regulating her emotions, both Ms Watts and Dr Lamb were able only to give two examples upon which they based this conclusion. They were:

i) M became anxious when X cried during the Still Face exercise. The pace and pitch of her voice were slightly raised and her arm movement suggested that she was anxious.
ii) M was frustrated and upset during a conversation with Ms Watts when she described how the foster carer's male partner had visited from Germany unexpectedly. It was accepted by all parties and by the LIFT witnesses that M would naturally have been anxious about an unknown man staying in the foster-home given her own history. Ms Watts and Dr Lamb said that M should have given X to the foster carer and her partner whilst she discussed her frustrations and anxieties over the visit of the partner.

C) Ms Watts further conceded during cross-examination that although she had used what might be considered inflammatory and specialist jargon in labelling M's '*emotional dysregulation*' and '*arousal*', in fact what she was describing were degrees of frustration and upset which were not '*pathological or aberrant*' (as Dr McDermott explained are necessary components of such behaviour in order to merit the application of those labels), but were reactive to the circumstances. In effect, she was misusing specialist terms that she did not have the qualifications nor understanding to apply correctly. She also confirmed that M had only ever been polite, had attended all appointments, readily explained any frustrations and upset, and apologised appropriately, for example when she left the feedback session abruptly after learning the conclusions of the assessment, and that she had never appeared violent or out of control.

D) It is clear, from the inclusion of those terms in the report, that there was insufficient interrogation by the team or by Dr Lamb of their use and application by Ms Watts, and that Dr Lamb simply permitted those labels to be included and relied upon in the final report including in the final Opinion section.

E) None of the LIFT team were prepared to consider that the evidence of the Children's Guardian or the Independent Reviewing Officer could alter their opinion in respect of the mother's ability to manage her emotions and regulate her behaviour. This fitted with their failure in the report to reflect adequately M's motivation and commitment to receiving appropriate support and therapy that she had expressed to Ms Watt and had been recently borne out by her engagement with the sessions she had undertaken in late 2020 with ADAPT.

F) I am disappointed and concerned at LIFT's and specifically Dr Lamb's refusal or failure to consider the accounts of two highly experienced professionals who had long experience of this mother and were therefore able to contrast M as she has been presenting throughout these proceedings compared to how she had presented previously, and who each have many years' social work experience. The refusal to acknowledge or explore adequately the progression or improvement in M's behaviour and presentation meant that this highly relevant information was not properly considered either within their report or by Dr Lamb in her oral evidence. It was unfortunately suggestive of a pre-emptive decision to treat M as a lost cause, and a preference to stubbornly defend an inadequate approach in their assessment exercise and their emphatic reliance on Dr McDermott's 2018 report, by then 3 years old, rather than to contemplate any weakness in their assessment, any progress by M or any need for an updating analysis or fresh approach to M's mental health.

29.6. LIFT ASSESSMENT - CONCLUSIONS

A) I was unsurprised therefore when the parties including the LA set out their grave agreed concerns in a document shortly following the conclusion of Dr Lamb's evidence, and that the LA separately made it plain in a further document that they considered the LIFT assessment was seriously flawed, and informed the court that they did not consider that they could rely upon the LIFT assessment in their application.

B) I have taken into account the various explanations and responses put forward by the LIFT witnesses during their evidence, however I am driven to conclude, unfortunately and unequivocally, for all the reasons discussed above, that this assessment process was fundamentally flawed and cannot be relied on. Its methodology was inadequate to the complexity and issues of this case. Its approach was narrow and appeared prejudiced by the history rather than open to the developments. It is not Ms Watts' nor Dr Heap's fault, but Ms Watts should never have been given this particularly complex task. It should have been far more of a true multi-disciplinary exercise, with far greater care taken over proper planning, observation, analysis, recording and supervision, and where adequately experienced and trained individuals properly shared the task of carefully obtaining and interrogating the assessment data.

C) FPR 10 and Practice Direction 25 govern expert evidence within family proceedings. PD25B sets out the duties of the expert to the court and at paragraph 4.1(b) requires an expert to comply with 11 standards set out in the Annex to PD25B. I consider that assigning the vast bulk of the assessment to a comparatively inexperienced social worker with no specialist training nor significant experience in complex cases involving learning difficulty and mental health issues such as EUPD fails to meet standard (2): *The expert has been active in the area of work or practice (as a practitioner or an academic who is subject to peer appraisal), has sufficient experience of issues relevant to the instant case, and is familiar with the breadth of current practice or opinion.*

D) I do not consider that Dr Lamb's claim that her involvement and oversight as a highly experienced consultant child and adolescent psychiatrist adequately made up for that by the supervision and paper exercise and responsibility for the final report-writing exercise that she undertook. It is clear she relied on what she was being told by Ms Watts or that Ms Watts had written in her drafted sections of the report, and to some significant extent simply adopted it. Dr Lamb never met M as part of the assessment. The documentation of the supervision and team meetings do not reveal any adequate analysis or interrogation of the raw observations made by Ms Watts and did not demonstrate any adequate exercise that would address the concerns relating to her role in the assessment. I do not see how inadequately documented arms-length supervision, particularly where the interviewing social worker was inexperienced and lacked adequate specialist training and in the absence of detailed notes, could do so.

E) I am also driven to conclude that not all material facts, including those which might detract from the LIFT opinion such as the observations of the Children's Guardian and the Independent Reviewing Officer, were properly considered. LIFT should have taken into account all the available evidence and not simply that which they claimed to have observed, contrary to the guidance and expectations in Re W (Care: Threshold Criteria) [2007] EWCA Civ 102, and Re R (A Minor) (Experts' Evidence) [1991] 1 FLR 291.

F) Needless to say, the above problems with the LIFT assessment which caused the parties such significant and understandable concerns at the conclusion of the LIFT evidence led to unnecessary and avoidable delay and further expense.

G) I feel obliged to refer this case to HHJ Atkinson and my Family Division Liaison Judge, so that appropriate steps can be taken to ensure that those conducting LIFT assessments and the BeST? research programme managers and practitioners can be reminded of their obligations as court-instructed experts and to ensure that no families are disadvantaged and no aspect of that valuable programme is jeopardised.

30. LEGAL FRAMEWORK & EVIDENCE
31. This application is governed by the Children Act 1989. X's welfare is paramount and no order should be made unless it is in his interests. In coming to my decisions in this case I have borne in mind the factors in the welfare checklist set out in s1 Children Act 1989 and that delay should be avoided as not being in a child's interests.
32. Delay has been unavoidably incurred in this case, but fortunately not to X's overall detriment given that he has lived and will continue to live with his M.
33. Each family member's European Convention for the Protection of Human Rights and Fundamental Freedoms Article 8 rights to respect to private and family life are engaged, and any intervention of the court must be to promote those rights, to balance competing rights, and in doing so to give appropriate precedence to the welfare of X and ensure that any intervention is necessary and proportionate. It is essential to bear in mind the principle that it is preferable, while also considering a child's needs, for them to be brought up within their own family.
34. I have borne in mind the helpful summary of the relevant law that was approved recently by the Court of Appeal in Re FS (A Child: Placement Order) [2021] EWCA Civ 1212 at paragraph 10 (https://www.bailii.org/ew/cases/EWCA/Civ/2021/1212.html), which refers to the guidance in Re BS [2013] EWCA Civ 1146, and the helpful analysis of the President of the Family Division in Re R [2014] EWCA Civ 1635, where a 'global' 'holistic' approach, based upon a sound and thorough evidential basis, looking at the pros and cons of the realistic options in terms of A's welfare interests (including being brought up by his natural family), must all be considered, and must take into account what support might be provided to assist.
35. Those cases, and Re BS in particular, reflected on the case of YC v UK (2012) 55 EHRR 33 which stated that family relationships should be preserved, families rebuilt and family ties only severed in exceptional circumstances, and that it is not enough to say that a child could have a more beneficial environment for their upbringing elsewhere. If a child's parent is able to provide good enough parenting then their upbringing ought to be undertaken by them.
36. A requirement before any section 31 orders may be made, is that the court must be satisfied that the threshold test set out in section 31(2) Children Act 1989 is met, either by agreement or by findings, namely: at the time protective measures were put in place in December 2020, X had suffered and/or was likely to suffer significant harm and that harm or likelihood of harm was attributable to the care given to him or likely to be given to him, if an order was not made, not being what it would be reasonable to expect a parent to give him. I have seen and am satisfied with the agreed final threshold document which sets out the history relating to X's parents' vulnerabilities and failings and the impacts upon his older siblings and the consequent risk of significant harm to X.
37. In relation to any findings: the standard of proof is the civil standard i.e. the simple balance of probabilities; and where I have described events or made findings, I have applied the balance of probabilities, the burden of proof being on the party seeking the finding. In making any findings I have considered all the evidence and submissions, even if every potentially relevant factor may not be specifically cited (see paras 37 and 39 per Black LJ in Re T-B-N (Children) [2016] EWCA Civ 1098).
38. I have been provided with core bundles containing statements, reports, ancillary documents, and key documents from the previous proceedings. I have also benefitted from position statements and skeleton arguments prepared by counsel. I have heard oral evidence from Ms Watts, Dr Heap, Dr Lamb and Dr McDermott. I have not had to hear oral evidence from the social work team, M or the Children's Guardian in the circumstances of the current agreement on the principal issues in the case.

39. WELFARE CHECKLIST CONCLUSIONS
40. I have read analyses by the social worker and Children's Guardian in this case and been updated as to their detailed positions and opinions. I have found them helpful and insightful, and I accept their opinions and recommendations.
41. I have seen lovely descriptions of a delightful little boy who is lively and well, meeting his developmental milestones and into everything. I have seen some beautiful photos. I note the warm and loving relationship that he has with M, and how he seeks her out for comfort and care. I note that she has cared for him since birth and has met all his practical needs to a high standard, and has been noted to do so with warmth and love, and I am certain that he would wish to continue to be cared for by her.
42. X is almost 2 years old. He is a little boy of dual heritage: white British and black British. He has six full siblings, some of whom are in care, and an adult half-sibling. He has the typical dependency needs of a little boy of his age. Unlike his older siblings he has not experienced damaging trauma or neglect. He will need enhanced support in terms of his relationships with his older siblings, and monitoring of his M's ongoing abilities to meet his needs.
43. The social worker's concluding statement thoughtfully sets out areas of strength and vulnerability, notes efforts that M is successfully making and areas where she is in need of further support. I note that M has been doing her very best to work hard in meeting the expectations of professionals, and to meet X's needs and develop her own abilities to enable her to continue meeting those needs, and to seek appropriate help and support along the way. It will be important that she continues to make the right choices, attend all the appointments, seek out and accept any further help and avoid falling back into old patterns. Importantly, she has shown during the recent course of these proceedings this summer that she can undertake therapeutic work alongside maintaining good enough care for X. She has shown she can work well with her advocate, her family support worker, her mental health professional, her GP, her therapist and the social worker.
44. Pressures exist in terms of the relationships with and between M's older children and wider family. This is an area in which M has been seen to struggle with conflicting obligations and feeling torn in terms of meeting X's needs but managing her older children's issues – for example, a recent move of her oldest daughter into M's home, and which is identified as an anxiety and stressor for M. The social worker has identified that M has been appropriately open and accepting of advice. This will require careful management and support, with the assistance available under the Supervision Order, to help M prioritise X's care and her own mental well-being and capabilities.
45. M has avoided abusive intimate relationships, but F will be released in due course and there are the anticipated problems from F's current partner. She has also worked hard to avoid old friendship groups and to develop new relationships via baby groups and appropriate activities given that her support network is currently small and her move into the community has been to a new area. The social worker confirms that M shares information and seeks support appropriately, but that this will be an area of ongoing support and monitoring.
46. The main concern and her biggest challenge is in continuing to maintain and develop her emotional stability, her confidence and her ability to trust others particularly professionals now that she is re-established in the community. Continuing along this path will better enable her to continue to prioritise X, to attune well to him and his needs, and to make better choices to meet her own emotional needs and manage her relationships. It is clear that M is compliant with her treatment and therapy and seeks appropriate mental health support which the social worker intends to follow through with her.
47. I am sure she is keen to do the right thing and continue her progress and is equally keenly aware of what might happen if she does not. I am satisfied that her motivation and engagement is genuine, and

the steps she has been taking have clearly been bearing fruit. These are opinions held by the professionals in the case that have developed over time and experience of working with M.

48. I have seen a final care plan, bearing agreed amendments suggested by the Children's Guardian and M. I am satisfied that the care plan is appropriate and helpful. It provides for a wide range of advice, assistance and befriending of this family. M and X will be supported by a family support worker, Schema therapy and Theraplay work, as has been advised by the experts. Contact with siblings is appropriately included as and will require sensitive management. Contact with F is proposed at twice yearly once risk assessed, albeit he is not currently wishing to have contact. This will all be kept under regular review. I have been impressed at the social work team's ability to adapt and look afresh at each stage of this difficult case and I am confident that they will do their best to continue to support X and to support M in caring for him.
49. There are no doubt risks associated with this plan, and it will be harmful for X to be exposed to any significant deterioration in his M's abilities to meet and prioritise his needs. However, he will undoubtedly benefit from being brought up by his own mother so long as she can maintain the progress and engagement she has shown in these proceedings. The effect of granting the Supervision Order with this plan will be to provide X with support to remain well and safely cared for by his M, and to minimise the identified risks. It provides a statutory and social work framework for that advice, support and assistance, from which X and M have already begun to benefit, alongside ongoing monitoring and review.
50. I have considered other orders, and in particular a Special Guardianship Order with his paternal aunt, a care order or making no order. The Special Guardianship assessment was positive, but no party is advocating that this is now the right course for X. He currently has no active relationship with his paternal aunt, and there are historic tensions between her and M and between her and some of X's older siblings whom she cared for. I note that it would prevent X being brought up in foster care and would permit family links to be maintained, albeit not without friction and difficulty. His attachments would be disrupted and would have to be refocussed on an unknown family member. A care order would grant the LA parental responsibility, but with X living at home and where M is currently co-operative and welcoming of social work support and input. There would be considerable local authority input, albeit that is already anticipated under the Supervision Order, but with the added tension of shared parental responsibility and higher intervention under statutory frameworks that run beyond that which is considered necessary. Neither of these orders appear to be better suited to meeting X's needs than the agreed plan. The former would not meet X's emotional needs, and the latter represents too heavy and unjustified an intervention in the current circumstances.
51. To make no order would leave X inadequately supported by the absence of a support plan and the services identified in that plan, and where the history clearly poses risks and concerns that require close help, support, advice and monitoring. It would be harmful to X not to grant the Supervision Order that underpins the important provisions set out in the plan, and it is clearly in his interests to do so and appropriate to put as much as possible in place to support M's care of him. This will also enable M to be assisted in dealing with any challenges to her progress, and with the additional complications that might arise in the wider family and when F is released. A period of 12 months is the longest period that can be granted at this stage and is clearly appropriate in the circumstances of this family.
52. Accordingly, this interference with each family member's ECHR Article 8 rights to respect for their privacy and family life is necessary and proportionate bearing in mind the history, the circumstances of this case and X's overall welfare interests.

HHJ LAZARUS

5.10.22