Neutral Citation Number: [2022] EWFC 144

IN THE FAMILY COURT

Before:

HIS HONOUR JUDGE MORADIFAR

Sitting as a judge of the High Court

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

In the matter of:

Re SK (Perplexing Presentation/Fabricated or Induced illness : PP/FII)

Miss Isabelle Watson and Miss Sarah Haworth instructed by and on behalf of the applicant local authority

Mr Simon Bickler KC and Mr Paul Froud instructed by Mr. Sean Harrison of Simpson Millar LLP on behalf of the first respondent mother

Miss Jayne Harrill and Mr Tim Potter instructed by Ms. Androulla Nicolaou of ITN Solicitors on behalf of the second respondent father

Miss Paula Diaz instructed by Ms. Emine Mehmet of Duncan Lewis Solicitors on behalf of the third and fourth respondent children through their guardian.

Date of the hearing:

21 September 2022

Handed down on 24 October 2022

HHJ Moradifar

This Judgment was delivered in private. The judge has given leave for this version of the judgement to be published. The anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to dos so will be a contempt of court.

His Honour Judge Moradifar:

Introduction

1. In July 2020, the local authority applied for public law orders in respect all three children of the family. I will identify them as A who is now [X], B who is [X] years old and C who is [X] years old. The applications were made in the premise of A's challenging and unmanageable behaviour that has put herself and her family members at risk of harm. The local authority was also concerned about the parents' ability to manage her. It was alleged that she was assaulted by her father and that A had assaulted the mother. Most regrettably A's circumstances have not improved and she was made the subject of a final care order in June 2021 and subsequently a Deprivation of Liberty order in August of the same year.

2. B and C continue to live with their mother. The local authority makes a number of serious allegations about the mother's parenting that it contends has caused B and C significant harm. These are detailed in a schedule of allegations that I have appended to this judgment. These allegations are the subject of dispute. This judgment follows a fact finding hearing that was heard by me.

The law

3. I am most grateful to Miss Watson and Miss Haworth for their efforts in preparing a summary of the applicable law. This document has been agreed by all parties. I lend my support to it and apply it when making my decisions. However, there are some broad important principles that must be noted. The applicant local authority makes its allegations and must prove these on a balance of probabilities. Its detailed allegations as set out in the attached schedule inform the 'threshold criteria' as set out in s 31(2) of the Children Act (1989) (the 'Act'). This section provides that;

> ***"Care and Supervision***
>
> *(1)On the application of any local authority or authorised person, the court may make an order—*
>
> *(a)placing the child with respect to whom the application is made in the care of a designated local authority; or*
>
> *(b)putting him under the supervision of a designated local authority*
>
> *(2)A court may only make a care order or supervision order if it is satisfied—*
>
> *(a)that the child concerned is suffering, or is likely to suffer, significant harm; and*
>
> *(b)that the harm, or likelihood of harm, is attributable to—*
>
> *(i)the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or*
>
> *(ii)the child's being beyond parental control."*

4. These provisions clearly set out the important elements that must be satisfied on an evidential basis before the court can make a care or supervision order. The important elements of the threshold criteria

include the relevant child suffering or likely to suffer significant harm, the harm being attributed or attributable to the care that is given to the child which would not be reasonable to expect a parent to give to that child.

5. I have also considered and applied the additional authorities that I was referred to during the parties' closing submissions. For the sake of brevity I will not repeat the detail in this judgment. Furthermore, I have read and considered the helpful guidance by the Royal College of paediatrics and Child Health on 'Perplexing Presentation (PP)/Fabricated or Induced Illness (FII) in children 2 March 2021'. Finally, I note the enormous challenges that the mother and her legal team have faced in marshalling and managing the evidence. I am grateful to Mr Bickler KC and Mr Froud for their gargantuan efforts that have ensured the mother has been able to participate in these proceedings fully and fairly. However, it is important to note the significant stress that this family has been under and the evidence spans many stressful years, all of which will have impacted upon the parents' recollection and the quality of evidence that they have been able to give to the court.

Background

6. The father is [XX] years old the mother [XX]. They met when the mother was 18 years old. They have had a continuing albeit unconventional relationship where they have three children and have never lived together. The mother has been the children's main carer although the father has been present and involved with his children.

7. When A was about 8 years old, the mother began to notice some features of her behaviour that later came to be a serious cause for concern. B was born in [XX] and C in [XX]. C was born in very bad health and the professionals did not expect him to survive. In his early years, he remained under the close care of a paediatrician and happily made very good progress.

8. The Local authority first became involved with the family later in 2013 by which time A's behaviour had significantly deteriorated. The local authority's concern included A's violence towards her mother, the other children's safety, the father's alleged emotionally abusive parenting, the mother's low mood and general isolation of the family. By this time A was referred for an ASD assessment. B was referred to audiology and the mother was raising general concerns about her daughter suffering with pain in the limbs and possible hypermobility or Ehlers Danlos Syndrome. In December of the same year A was diagnosed with DAMP and assessed as 'high functioning ASD' with a referral to an ASD nurse.

9. In 2014 mother and A's school disagreed about the prospects of A having an EHCP and the mother instructed a private educational psychologist to undertake this work. By now the level of medical and professional involvement with the children was at its highest which included referral to a dietician and B being referred to a rheumatology clinic. Happily C continued to make good progress and was able to walk independently wearing his recommended supportive boots. The occupational health assessments of A and B had advised the use of adjuncts within the home and at school. B was provided with a wrist splint to aid her writing. B was diagnosed as meeting the criteria for

ASD and the mother questioned if B may also meet the criteria in light of the family history of ASD.

10. By 2015, the divergence of opinion about the children's presentation at school and as described by the mother at home, had become clear. The school did not observe any need to prompt A to eat and neither child appeared to use or need the various aids that they travelled to and from school with and were provided for their use during the school day. Such were the school's concerns that it raised questions about the mother's mental health and possibility of fabrication of the children's medical and health issues. By July of the same year B was diagnosed as having ASD.

11. The children's health issues continued to dominate the family's life with an ever increasing difficulty in managing A's needs. In the main hypermobility, pain and discomfort, audiology, issues around their diet and ASD were the issues that at any given time one or more of the children were assessed for. The school raised concerns about B's ASD assessment as it was not involved in the assessment by Dr O and B's description in the report appeared to be very different to the school's experience of her. Later C was diagnosed as suffering with reflux and was prescribed medication.

12. Regrettably A's behaviour continued to become increasingly unmanageable with incidents during which she had placed herself at significant risk. She was assaulting her mother, shouting and breaking items around the house causing significant concern and worry for all of the family including B and C. In [XX] 2020, A was detained under s2 of the Mental Health Act (1983). She was subsequently discharged and

with the agreement of the mother, she was placed in a semi-independent home. By now children's services were sufficiently concerned to issue these proceedings. The court permitted the parties to jointly instruct Dr Rose (Consultant Paediatrician). In his first report dated December 2020 he raised a number of concerns about the children's medical presentation and possibility of misdiagnosis. He recommended the instruction of a psychiatrist that was sanctioned by the court. The parties instructed Dr Surgener who raised a number of significant concerns about the children and the potentially emotionally harmful environment that they were living in. Subsequently the court approved the instructions of an adult psychiatrist Dr Lyall to assess the parents and Mr Crompton Consultant in Trauma and Orthopaedics. I will refer to the detail of their assessments later in this judgment.

13. By June of the same year it was clear that A could not return home and the local authority's plan for her long term placement away from her home was approved by the court by making a final care order. A's behaviour continued to be challenging and has been the subject of a number of Deprivation of Liberty Orders. Subsequently, Dr Rose provided his final report which has informed the local authority's schedule of findings. He raised a number of concerns about the children's medical history, their presentation and the possibility that the mother may fall within the definition of Perplexing Presentation/Fabricated or Induced illness (PP/FII).

Evidence

14. Professor K is a Consultant in Clinical Genetics and Professor in Clinical Genetics and Genomic Education. She saw A and B in clinic on 16 October 2014. She has had no previous or subsequent direct

contact with the family. After confirming the contents of her two statements to be true an accurate, Professor K was clear that she has no independent memory of the consultation and relied on her notes and other relevant documents. She explained that prior to the publication of the 2017 Guidance ([XX]_2017 Malfait et al), the terms Ehlers Danlos Syndrome ('EDS') type III and benign joint hypermobility were used interchangeably. The relevant guidance in 2014 indeed used the two terms interchangeably. Under the 2017 guidance these are distinguished. She undertook her examinations by using the 2014 'Oxford Desk Reference'. The Beighton test score is also subjective and dependant on the age of the patient as ordinarily with age laxity decreases. As such, she would not expect B's Beighton score in 2014 to be lower than her score in 2021. Professor K would always use the Beighton Score as a diagnostic tool. She could not explain why, contrary to her normal practice, this was not noted in her clinical notes but could not imagine circumstances in which she would not have used them.

15. Professor Tatton-Brown continued by explaining that in her assessments, context is an important factor and the family history is very important. In this instance, she took a family history that covered three generations. She also examined the mother and assessed her to be suffering with hypermobility. She agreed that such a condition can legitimately attract attention from different disciplines in medicine who may take very different approaches to it. She explained that patients with hypermobility can suffer with pain but there are those in the population who do not and consequently do not seek medical attention. Often, as it was the case here, she recommends a referral to Occupational Health services to help build and strengthen muscles to

compensate for the laxity in the ligaments. She did not anticipate that A or B would present differently to other children at school although they may present with greater flexibility in gym. However in ordinary day to day school life they would not present differently to other children.

16. Dr Z retired from practice in March 2021. Prior to that event she was a Consultant Paediatrician for some thirty years with a career in medicine for fifty years. C was her patient from [XX] 2014 when he was about twelve weeks old until March 2021. On her retirement, C was discharged to his General Practitioner. Her involvement with C included eighteen consultations, with six in the first year and thereafter six monthly. Dr Z had an established relationship with many of the therapists, dieticians and medical professionals. When assessing C she collated information from many sources that included speech and language therapist, physiotherapist, paediatric dietician, the school, the mother and her own examination of C.

17. She explained that C was born with a number of medical difficulties and *"serious issues".* He was *"lucky to survive"* and has progressed much better than expected. He was more likely to develop complications as he got older that included cerebral palsy, developmental delay that includes speech and language delay. These issues were discussed with the mother from the beginning. She continued to explain that cerebral palsy cannot be excluded until such time as the child is able to walk independently. She agreed that the records confirmed that by October 2013 that he did not suffer with cerebral palsy and any description that he did would be *"untrue".* She was glad to note that he did not require an EHCP. Dr Z disagreed with the observation that missing the first few months of education would have impacted on his development some years later. She further

explained that C was at risk of having additional needs and ASD was one such but he was not diagnosed with ASD. The mother had raised this as a concern due to the family history. Dr Z was clear that in all her correspondence with the parents, she would set out a summary of all of the diagnosis and whilst expressing some concern that NHS letters do not always reach the parents, she was clear that C has never been diagnosed as suffering with cerebral palsy.

18. In Dr Z's clear opinion C suffered with joint laxity and this was confirmed by her own physical examination of him. She explained that she would not have made referrals to Occupational Health or physiotherapy if she did not feel that C required it. The NHS resources are limited and referrals are only made when she is satisfied that they are needed and justified. She continued to explain that professionals such as school teachers and staff can often misunderstand or underestimate the impact of hypermobility on a child. It is *"quite normal"* for such a child to join in play and games at school. The hypermobility is likely to cause pain and tiredness at the end of the day and often when they are at home. Therefore, to an *"untrained eye"* the child may appear as presenting without difficulties. In her opinion C required supportive footwear and the Piedro boots are expensive. She made the referral to orthotics who also agreed that he required Piedro boots. These boots provide support around the ankle but are fitted to the feet of the child. She advised that once C had grown out of those, that he could wear ordinary brand shoes that offer support. In her opinion he was likely to require such support into adulthood. She was also clear that the advice is not that such boots are to be worn at all times as the feet need the opportunity to develop appropriate muscle tone.

19. She expressed serious doubt that C would have dislocated his joint. She explained that in the many thousands of children that she has been involved with, it has been common for parents or children to describe joint dislocation when in fact these are no more than misinterpretation of the sound or the feel of the joints that may be loose due to hypermobility. The advice is always to take the child to the Accident and Emergency Department to ensure that the child is treated and that the findings are properly recorded. There was no record of C ever attending the Accident and Emergency department for complaints of joint dislocation.
20. Dr Z expressed no concerns about C's diet or nutrition. She was clear that he was under the care of a dietician and neither had observed any concerns. His growth was appropriate and his growth centile had increased from a very low base at birth. Dr Z diagnosed him with reflux that she described as *"frank,"* denoting that it was immediately apparent on examination and did not require manipulation to observe it. She explained that reflux can often come back after periods of no reflux and may last into adulthood. In such cases, it would be treated by medication. Dr Z did not observe any issues of concern about C's toileting.
21. Dr Z was taken through a number of medical appointments that are recorded in C's medical notes and noted in the local authority's threshold document. She did not raise any concerns about those both in nature or frequency. In her opinion these were all appropriately attended. She made referrals that she had assessed as being necessary and she stood by her assessment. These were informed by information from many sources. She reflected that she would not have undertaken an x-ray of C but for seeking to reassure the mother. Beyond that all

other appointments and referrals were appropriate. She agreed that the use of supportive boots and a wobble board was on professional advice.

22. She fundamentally disagreed with Dr Rose by observing that C has ligamentous laxity, reflux and anaemia, all of which are medical conditions. As to the former, this will impact on aspects of C's life. This includes tiredness at the end of the school day as described earlier. Anaemia can also contribute to feeling tired. When she took an x-ray, she did not observe any signs of subluxation but that may have happened before or after the X-ray. Parents commonly describe subluxation as dislocation which in medicine is inaccurate. The mother's description of gentle massages resolving the so called dislocations fit with subluxation.

23. Finally, Dr Z raised her concerns about lack of invitation to Child Protection Conferences given the wealth of information that she had available to her. The mother had a few difficult years and *"it didn't seem right that they didn't discuss this with us".* She later made contact with Mr Crompton and had discussion with him about C. She was in full agreement with Mr Crompton's report. She felt it important to alert the local authority and chose to write a letter to it. Knowing that she was retiring she wanted to be sure that relevant information was available on the medical records for the next doctor who took over C's care.

24. Mr T Crompton is a Consultant Paediatric Orthopaedic Surgeon. He was jointly instructed by the parties to undertake an assessment of all three children. He confirmed that his report remained true and accurate. He could not recall any conversation with Dr Z and would not generally have such a conversation or disclose his report in the context of his medicolegal work. He agreed with much of Professor K's evidence

about the terminology and the use of the same when describing joint hypermobility prior to the 2017 diagnostic guidelines coming into effect. He explained that the latter guidelines provide a more stringent test for diagnosing EDS and that if the mother in this case has a formal diagnosis of EDS, the children would meet the criteria for diagnosis of EDS. Usually, he explains to families that benign joint hypermobility is more of a description than a diagnosis and as long as the patient keeps fit, as they age it should not generally impact on their daily lives.

25. When examining the children, he took the history from B and the mother at the same time. Less so with C given his age. He continued by explaining that as regularly as two times per week in clinic, he may hear complaints that children have dislocated their hip joint when in fact this is medically incorrect. The hip is one of the strongest joints and any dislocation would usually be caused by trauma with associated soft tissue injury. However the sensation and sound of the movement of the ligament across the joint may be misinterpreted by a child or parent as dislocation. On examination, he did not find instability of joints or subluxation in the children. However, 'hypermobile children' can find particular position in some joints such as the shoulders, that would allow for subluxation and at times may even become a *"party trick"* for them. However, given that the ligaments are lax, he did not expect there to be any associated pain.

26. Mr Crompton could not reconcile any particular connection between hypermobility and pain. He estimated that in his clinic he has similar complaints of pain from children who have joint hypermobility and those who do not. Nocturnal cramps and pain (growing pains) is common in all children and such a complaint would not lead to an examination for hypermobility. The child may wake up in pain and a

gentle massage would relieve the pain. However, he agreed that an active child with hypermobility may present as entirely normal but suffer with more pains and aches at the end of the day where the muscles surrounding some of the joints, such as the shoulders, may have worked harder to stabilise the joint during those activities.

27. Dr S is the paediatric clinical lead and the neonatal clinical lead at the hospital in which C was born. He was involved in C's treatment from birth until [XX] April 2015 when his last consultation with C took place. C was born with serious medical issues that included serious hypoxia requiring ventilation, Meconium Aspiration Syndrome resulting in an acute insult on the kidneys and consequent renal failure, changes to the brain due to hypoxia and a severe risk to his life. His parents were both present for the first twenty four hours and thereafter, the mother was the only parent who interacted with Dr S. He found the mother to be caring and appropriate. She followed all the advice that was given to her and in the main, C's progress was due to her care.

28. Dr S was not surprised that C's teachers may not have picked up on some of his difficulties. As he progressed, these became harder to recognise even for junior doctors looking and assessing the same. He explained that C "*would not stand out in the crowd"* and an "*untrained eye"* may not pick up on his difficulties without spending some time getting to know him. He could not recall any conversation with Dr Z about a Child Protection Conference. He first became aware of those conferences when he was asked to prepare a written statement in these proceedings which caused him to look through the hospital records.

29. Dr O is a Consultant Community Paediatrician and the nominated safeguarding doctor at the hospital in which she works. Dr O confirmed that she had read the parts of Dr Rose's report that relate to B. Dr O

explained that she assessed B in 2015. The assessment relied on a number of sources of information that included information from the mother, early years contact with the nursery, referral letter and her own assessment that were conducted over four observed sessions. She would have liked to have seen B at home but this is no longer an option due to demands at work. She observed that it was usual for children to behave differently in different settings. For example some children may behave differently in the more structured setting of the school and this may explain the difference between the mother's observation at home and those by the school. Children also learn to mimic other children leading to the school stating that they have not observed the behaviours that are reported by the parents. However, children with ASD do not mimic their sibling's behaviour who may also have a diagnosis of ASD. Each are individuals and different. She explained that is why it is important to have as much information as possible from different sources and professions to enrich the assessment. With younger children greater emphasis will be placed on the parental report whereas with older children, they are better able to engage in the assessment. She assessed B in three clinics which lasted at least one hour. She also saw her at school although this was after she had made her diagnosis.

30. Dr O continued by stating that no assessment tool is entirely reliable. At the time she was DISCO trained and used this to assess B. However, she also observed that the assessment must be holistic and flexible. Dr O did not feel that it was usual for parents to commission their own private Occupational Health report but this was not novel. She felt that the mother wanted a diagnosis of ASD and her observations were detailed. However, Dr O was clear in her diagnosis of ASD. She explained that it was her normal practice to share a draft report with the

parents for suggested corrections or amendments. However, she was very clear that she would not include anything in her report that she did not agree with.

31. Dr S J Rose is a Consultant Paediatrician and a jointly instructed expert in these proceedings. Although he retired from clinical practice in June 2020, he continues to provide the courts with the benefit of his considerable experience as an expert witness. Dr Rose confirmed that having read all of the updating reports, his opinion remained unchanged, namely that there remains a possibility that the mother has fabricated or exaggerated the symptoms of the children's conditions and in doing so she has harmed them. After a significant period in the witness box this opinion did not change and remained as a possibility that the court would have to adjudicate upon. When asked about Dr Surgenor's opinion influencing his, he observed that Dr Surgenor had raised this as a possibility.

32. Dr Rose did not mount any challenge to the opinion of Professor K as they each fulfil different roles and have different expertise. However, he expressed some puzzlement at the suggestion of there being confusion over the use of the term EDS. He explained that this is not a new diagnosis and has been around for over a hundred years. It has always been understood to be distinct and separate to hypermobility. He further explained that whilst EDS of whatever grade is formal medical diagnosis, hypermobility is a description and not a medical diagnosis. He maintained his concerns about such a confusion even in light of the 2014 guidelines and opined that this will ultimately depend on the circumstances and the individual practitioner. He later accepted that he was not aware of the 2017 guidelines and happily deferred to Mr Crompton. Dr Rose continued to explain that hypermobility

encompasses a range and it is a continuum. As humans age they become less flexible and less mobile.

33. Dr Rose discounted any suggestion of the main joints such as the hip being dislocated. He agreed with Mr Crompton that the hip joint is very stable and any dislocation would require considerable force. What the mother had described as dislocation could not have been a dislocation in medical terms. Similarly there could not have been dislocation in the knees or the ankles without causing considerable trauma to the joint. Dr Rose deferred to Mr Crompton and agreed that both he and Professor K had the advantage of first hand examination of the children. However these cannot be considered in isolation and must be looked at as part of the whole picture.

34. He did not take issue with Professor K's clinical experience of the families who struggle with pain in the presence of hypermobility. Similarly he agreed that children with hypermobility may expend more energy in active periods to compensate for their hypermobility and later present as more tired. However, he further observed that there may be psychological reasons why a child would present with pain and hypermobility is not medically relevant. Whilst he accepted that nocturnal pain or 'growing pains' are common, there is no reason to connect this with hypermobility especially as such pains are usually associated with the 'middle of the bone' and not the joints.

35. Dr Rose was taken through a number of examples of how the mother is said to have behaved reasonably and on professional advice. Dr Rose agreed that the number of medical appointments were not excessive, accepted that the adjuncts had been provided on professional advice but questioned why the school did not see any use for them. He sympathised with the mother in the difficult circumstances that she found herself and

thought it reasonable that she should question the possibility of C having ASD when her two older children had a diagnosis for the same. He was clear that he was not challenging the diagnosis of ASD for B but questioned it in light of Dr Surgenor's report. Similarly, having been made aware of the professional advice for C to wear supportive footwear he did not seek to criticise the mother for this. Furthermore, he agreed that Dr Z having had a prolonged interaction with C and given her concerns, a multidisciplinary approach was appropriate. Moreover, he stated that it didn't appear that the mother was exaggerating any concerns about B's audiology and in fact she was reporting no concerns. There did not appear to be evidence of the mother seeking a diagnosis and her actions in respect of the cardiology concerns for B were appropriate. Broadly, he did not see that either B or C has been inappropriately or unnecessarily been exposed to medical professionals.

36. He continued by explaining that pain is very subjective and this becomes more difficult to assess in younger children who have limited abilities in abstract thinking until about seven years old. This makes the parental interpretation all the more significant. That in turn will have to be considered in the context of all of the evidence. In this case the children had been provided with a number of adjuncts that were not used in school and appeared to be unnecessary. He further observed that the use of the wheel chair and the bath hoist was equally unnecessary. The latter would be harmful in a hypermobile child who needs to use and strengthen the muscles to create greater joint stability. Whilst expressing sympathy for the family's circumstances and the challenges of dealing with A's behaviour, Dr Rose was concerned that the use of the wheel chair may have made B feel less capable than she is.

37. Ms E is an Occupational Health therapist who undertook an assessment of B in 2016. She has detailed her involvement in the relevant notes that were made at the time and her recent statement in these proceedings. She confirmed that the contents of all of those documents to be accurate. C's referral to her services were made by B's Speech and Language Therapy services ('SALT'). She assessed B by reference to the general headings such as gross motor skill, fine motor skills and self-care. Her assessment was based on the information that was provided to her in the referral documents, what the mother stated and her own observations. C's assessed needs were not *"hugely significant"* and the required programmes could be completed at home and in education.
38. Ms E confirmed that she advised using a seating (wobble) cushion, ear guard and a chew. Each of these were required to address certain issues. If those issues resolve then there would be no need to continue to use those. However she observed that some of these including the seat cushion and the chew could be most likely longer term tools. She would have advised the mother of her findings and recommendation at the end of the session but would have written formally thereafter. Sometimes, on reflection, she may make additional recommendations in her written export. The referral is kept open for eight weeks during which time the parents or others such as teachers may seek further advice when further recommendations may be made. The referral will close automatically if no further enquiries are made during this period.
39. Ms F is also an Occupational Health Therapist who assessed B in the period between 2016 and 2018. She confirmed her statement and the records of her involvement as accurate. Whilst she recalled the mother and A, understandably she did not recall the detail of her involvement. She stated that the mother's concerns were largely around B's reported

sensory issues and balance. Ms F was able to make some observations of her own although the clinic setting gave her limited information about the issues of balance. She did not see her fall over as described by the mother. She also observed B at school with seeing her at 'carpet time' when B practiced her phonics and later from afar in the playground. She commented that she found B to be *"heavy footed"*. She had recommended a splint to be used when drawing or writing which assisted with her hypermobility and pain. This was support for specific activities and she didn't expect B to wear a splint at all times. Later in June 2017, when she had a new splint made, B commented that she was embarrassed to wear a splint. She also recommended ear guards to be used when required. She was clear that these are not always a short-term measure and some children continue to use such support as they age. Ms F observed generally that educational establishments are not consistent in their approach to such support. She also accepted that a child may be too embarrassed to ask or use such items in the class-room. It may be embarrassing to ask the teacher for access to such support.

40. Ms G is an Occupational Health Therapist who was involved in assessing and providing a programme of support for B in 2014. Having confirmed her statement and professional documents that are within the court bundle to be accurate, she was clear that she had no recollection of the family and was reliant on her notes when giving evidence. She first assessed B in February 2014 and this was updated in April and July of the same year. Her assessment was informed by the information that was provided by the mother, particularly on B's asserted sensory issues, referral documents and her own observations.

41. She observed B in clinic and saw her running quickly and falling over which confirmed the mother's concerns about B's issues with balance.

Whilst the assessment in clinic is not ordinarily repeated, the assessment was updated as she reflected on the case and further information came to light. It is quite usual for the support plan to be amended through this process. In her view it was unusual for parents to give their children Nurofen *"every night".* She assessed B's needs to be *"moderate on the scale of mild, moderate to severe".* She recommended a programme of support. This included the use of a small thumb splint to support B with her writing and drawing. She explained that B was hypermobile in her thumb and this assisted her with stabilising her thumb when undertaking such tasks. She was fitted with the splint on 30 April 2014. She observed that it is not unusual for children to be resistant to wearing a splint and for the resistance to vary in different settings. During her involvement, she did not observe a marked improvement in B's identified issues. She confirmed that based on her discussion with other therapists, she held the view that it was not unusual for 'hypermobile children' to suffer pain. She confirmed that the mother did ask about a 'bearhug vest' and that she together with a colleague explained that this was not appropriate due to C's hypermobility and associated pain.

42. Ms N is a Speech and Language Therapist ('SALT') and was involved in assessing C in 2015 to 2017. She confirmed the contents of her records and the statement filed within these proceedings to be true and accurate. She described C as an *"average"* child who is referred to her clinic. She assessed C's needs as '*medium'*. Apart from her own observations, she relied on the mother's descriptions of C and the information that Dr Z had provided her with.

43. In her general view the mother engaged well in the assessment. She stood by her findings of the areas in which C required support. She

remained involved with C due his assessed need for support with his language skills. In her assessments she would typically spend thirty to forty minutes with the child and this includes speaking with the parents. She was alert to C's *"extra sensory needs"* where such children would put things in their mouth. She recalled reports of C licking a car and a lamp post. Consequently she referred C to an Occupational Health Therapist.

44. Ms H is currently a SENCO and in 2015 she was the assistant SENCO in nursery where C attended. After confirming the contents of her statement to be accurate she stated that she had little direct involvement with the mother. Most of the communications with the mother were undertaken through a 'communications book' which was used to *"cover themselves"* describing the mother as *"negative".* She undertook three to five minutes of activities with C on about three days each week. These were largely the activities that were recommended in his Individual Educational Plan ('IEP'). She recalled the C's progress with nappy training was slow as the mother insisted that C should be put back in nappies.

45. Ms H had no recollection of C's medical issues or his early years experiences and difficulties. These may have been discussed with C's SENCO. Ms H did not observe C suffering with pain nor did she observe him at lunch. She recalled the mother using a buggy that she described as larger and higher than the standard buggy. She was clear that those that were shown to her in photographs were not the buggy that she saw. She could not recall ever observing any medical issues in C and did not feel that C needed any additional support. Ms Phillips recalled the mother using the buggy *"once or twice ... perhaps a few occasions".* She never discussed the buggy with the mother.

46. Ms T was the deputy manager of C's nursery class and has been working in the same establishment for twenty-four years. She explained that in 2015, there were twenty-four children in the class. They were attended to in smaller groups. Usually she would normally spend about twenty to thirty minutes each morning with C. She had a short conversation with the mother when she dropped C off in the morning. She recalled a 'transition meeting' in which the mother raised her concerns about C becoming accustomed to wearing a school uniform. She suggested that the nursery could put him in uniform so that he would become accustomed to it. She did not believe that the mother ever sent a uniform but may have sent a pair of grey shorts and a white T-shirt. She reflected that it was possible that the uniform was provided by the school and not the mother.
47. Ms T was involved in most of the toilet training and followed the practice of taking C to the toilet every twenty minutes. C wore baby grows but this was not unusual for children in nursery. The mother would bring C in a buggy. She did not recognise the buggies in the photographs that were shown to her and described the one that she recalled as being larger and higher. She carried C out of the buggy to the reception door but not all the way. She recalled on one occasion the mother was describing C and C was shaking his head. She did not recall C *"shutting down"* as described by the mother. When upset, as he was on one occasion about his boots, she would speak with him calmly and this would resolve the issue.
48. Mrs I is a very experienced teacher and was involved with B in 2014 and 2015 when she was in nursery and in reception class. She was unaware that B was diagnosed with ASD but knew about EDS or hypermobility and weak joints. She did not observe any behaviours in

B that would be suggestive of her suffering with ASD, nor did she require pain relief. She did however use a splint to help her with her writing and this was used in school and she seemed happy to have it. Mrs I recalled being concerned about B not attending school full time and missing out on phonics lessons.

49. She also recalled being told by the mother that C had autism and reflux which was set out in a 'report'. Although C was quiet and shy, he joined activities with other children and had no difficulty in communicating with other children. It took him longer to integrate as he was on shorter days. School lunches were available, but he brought his own packed lunch. On occasion the school replaced the packed lunch as the bread was mouldy. She made the ear defenders available to him but could not say how often he used them. She also accepted that the mother may have mentioned that C was being assessed for ASD. She expressed her surprise at observations that recorded C as being two years behind with his expected writing and maths. She disagreed that this would be due him missing school in the reception year. She was unaware of any medical opinion about his global developmental delay. She recalled C becoming more confident.

50. Miss J was C's teacher in 2019 and 2020. She confirmed that she had awareness of the provisions of Special Educational Needs through her continuing training. C had an Individual Education Plan ('IEP') in which she had set targets for him to attain. She described C as *"academically low"* but not worryingly so. She noted that the mother did not appear to meet the expectations of reading with C at school.

51. She recalled C stating in class that he was special and he had ASD. She stated to have a clear recollection of this and recalled that the school SENCO confirmed that C had no such diagnosis. She did not observe

any behavioural traits in C that would be consistent with known ASD traits. She was unable to explain why this was not noted by her anywhere in the school records or indeed in her statement in these proceedings. She could not recall if she had spoken to the mother about this. C did not need any aids at school.

52. Miss J, having raised issues about C wearing supportive *"clunky boots"* further stated that she did not observe any obvious need for C to wear these boots. However, when challenged, she stated that she had no awareness of the medical opinion that C had global developmental delay, suffered with hypermobility or that the boots were provided on advice from an Occupational Health Therapist.

53. Having raised her concerns about C missing school in 2020 during the national lock down, despite the school records showing that he attended school in that period, she was unable to recollect or accept that C did in fact attend school. She further stated that C was less supported during this period as the family did not have internet access. She was unable to recollect or accept that this was limited to a two week period.

54. Miss J maintained her views about the mother telling the school that C was absent due to a broken foot after he attended with mother to collect his sibling. Despite the relevant medical note being available confirming the same Miss J appeared to question this matter and cited her duty of care in the context of poor school attendance. When it was put to her that her school reports were very positive, she explained that these were not intended to raise issues of concern but was unable to explain why her concern has not been raised with the local authority. Finally, Miss J explained that the school staff who were required to give evidence in these proceedings, met jointly with the applicant's solicitor

to go through the court process and to ask any questions. She denied discussing the detail of her statement with anyone.

55. Mrs K was also a teacher at the children's school and taught both C and B in separate years. She was aware of the IEPs for the children but, consistent with usual practice, she was not privy to the discussions or decisions about the IEPs. She recalled B having a wobble cushion and a thumb splint that assisted her with writing. She had seen this before with other children and commented that if an aid is recommended through an IEP, then she would implement it. Neither seem to use their ear defenders. She was not aware of any health issue or medical diagnosis. She confirmed that she continued to teach and support C and B at school when they attended during the national lockdown. She specifically recalled C stating that *"my mum said I am special because I am autistic".* She raised this with Miss J and never spoke about it again. She recalled B struggling to come to school which was more akin to a tantrum. She was upset stating that her sister was at home.

56. Miss SW was the children's allocated social worker between August 2020 and October 2021. By the time of her involvement A was placed away from her home in an unregulated placement and the local authority were trying to find her a suitable placement. She readily accepted that A's difficulties had made the home environment extremely difficult. Miss SW did not read all of the records at first but did so after her first two meetings with the mother. She found the children to be more guarded at home and less so when she saw them at school.

57. She felt that the school had been very supportive of the mother and had sought to put in place such support that they could identify. She had no awareness of the conflict between the school and the mother until the

report of Dr Surgenor was completed. She agreed that this was a turning point in this case and combined with Dr Rose's report, the focus of concerns was on 'FII'. Miss SW regretted that reports from the treating team had not been included in the child protection meetings and that none of the treating medical team had attended. She was concerned that she was accused by the mother's legal team of inappropriately sharing information with the treating medics but reflected that their views should have been included in discussions that took place months earlier before her team received a letter from the treating doctor. She was clear that she had not had any conversations with Dr Rose or Dr Surgenor before they completed their reports.

58. Mrs AB was the current school head teacher. She qualified as a teacher in 2006 and between [XX] to [XX] she was the SENCO and was involved with both A and B. She became the head teacher in [XX]. She confirmed that she spoke to Dr O during her school visit when assessing B. She was not aware of what followed although she had read a report in which she diagnosed B as having ASD. She had no involvement with C and was not aware of his health issues or an IEP. She observed that B's progress was on par with her peers. She commented that due to his age, C and his peers' progress have suffered as consequence of the national lock down but she did not see C as *"significantly behind".* Mrs AB confirmed that the concerns about the children did not reach a level that required reporting. Her main concern was the reports of the children's needs which were not observed in school and different to what was reported by the *"parents".* She later stated that she had no direct involvement with the father.

59. Mrs AB recalled that the mother was concerned to obtain an EHCP for A and that the school did not see any merit to this request. The school

felt that A was *"doing well".* The mother did take the school to a tribunal and won. She agreed that the mother is a '*fierce advocate for her children'*. She was A's SENCO and did not share the mother's views about her abilities. She was aware that she had a dietician but unaware of her hiding food up her sleeve. She could not recall her involvement with the tribunal hearing. She maintained her stance that the school can only proceed on what it sees.

60. The witness was taken to the events that followed after A left school. Whilst accepting that within a short time the new school were observing the same behaviours as reported by the mother, Mrs AB maintained that this was not observed in her school and speculated that some children can find the transition difficult. She maintained that the observations within her school did not evidence any complex needs and denied that the school was resistant to recognising those needs.

61. Having accepted that she was responsible for collating the information for the local authority in these proceedings, she was unable to explain why the CPOM records were not disclosed until the hearing had commenced. She continued by accepting that she had a meeting with Dr Surgenor. She accepted that her latter observations were similar to the school not accepting the mother's account that A was diagnosed with ASD. She was not aware of the family's difficulties when commenting about B's reluctance to attend school. Mrs AB was taken through the use of some of the adjuncts and did not raise any criticism or issue about those including B's thumb splint, ear defenders or C's supportive boots. She also stated that there was an agreement with the school that C should start part-time and had hoped that he might have attended full time by the end of the first term but by agreement this did not happen until later.

62. She wasn't sure if B and C were at school during lock down and readily stated that P is now *"doing well"* despite the previous assertion that he was behind due to his lack of attendance at school. She was unaware that C was suffering with reflux and unaware of C's medical issues as she was not his SENCO. She believed that during the transition meeting there was a mention of C having Cerebral Palsy but otherwise she could not say how she had gained this knowledge.

63. The mother began her evidence by giving some detail of the history starting with how she met the father and some of the detail of their relationship which ended about three years ago. The mother accepted that the father had told A to hit the mother to calm down. She also confirmed the details of the incident in October 2019 when the father hit A. She first noticed some of A's difficulties coming to the surface when A was about seven or eight years old. As time went on, her difficulties were more pronounced but the school did not agree with the mother's views which lead to the Tribunal proceedings which found against the school. Sadly, the school did not provide any further support and A only stayed in that school for six months before she moved to her next school. A's behaviour was very difficult and had a serious impact on the whole family. Her behaviour included assaults upon the mother, breaking and throwing items. The mother expressed her serious concern about the impact of this on B and C.

64. The mother further explained that the family lived in a small two-bedroom flat which was inadequate for the needs of her family. Given A's difficulties, she required a bedroom of her own leaving very limited space for her and the two youngest children. She had difficulties with a neighbour and made every effort to move without success. With a very heavy heart, the mother had to accept that A's needs were beyond the

mother's abilities and agreed that she should be placed in the care of the local authority. She sees A regularly and her behaviour remains a huge cause for concern. The mother and the two youngest children remain living at the same address and the home is much calmer now. B and C are presenting as more confident and socialising more with their peers by having friends visit. The mother accepted that the condition of the home remained unsatisfactory including the egg boxes remaining fixed to the walls in A's old room. She expressed concern that she has had little time to deal with all of these matters. She further stated that she is on medication for anxiety and low mood. Although this is managed well she accepted that at times of stress these can deteriorate.

65. The mother was challenged about her perception and assertions concerning the children's medical conditions. The mother explained that given the circumstances of C's birth she was given a lot of information. She was unsure who told her that part of C's brain was '*dead'* and there was a possibility of him suffering with cerebral palsy. She accepted that C does not have cerebral palsy and reflected that she was never told this by any of the medical professionals. She accepted that she may have mentioned this *"by mistake"*.

66. She continued by accepting that in June 2019 on her instructions the father bought a wheelchair for B. This was her idea after she had discussed this with other parents. The mother readily stated that B did not need a wheelchair and this coincided with the date of a doctor's letter in support of her application for a blue badge for B. She accepted that this was a *"very bad decision".* It was kept in the garage and was only used on two occasions. It was intended to help with getting B out of the house quickly when A's behaviour became dangerous. Having reflected further she stated the wheelchair;

" would have made her (B) *think that she was not as capable and that may be I didn't think she could do things that she was capable of doing and this made her feel very sad .. I hope that this wasn't harmful and was only used on those occasions when the situation at home was so bad, but she hasn't actually mentioned anything to me about those times and is fully aware that the wheelchair was not needed and we got rid of it a long time ago …"*

She accepted that this would have been very upsetting and harmful to C seeing his sister in a wheelchair and this would have affected how they saw themselves and functioned. The mother denied that B or C ever had any specialised buggies and produced photographs of their buggies that were purchased in shops without any modifications.

67. Having reflected on the expert evidence, the mother accepted that neither B nor C have ever suffered with a dislocation of their joints. She explained that this was the only way that she could describe what she understood to be occurring but readily accepted that these were not dislocations. She was advised to take the children to the Accident and Emergency department of their local hospital if they were in significant pain. The mother maintained her position that for want of a better term she had wrongly used the term '*dislocation'* but denied that this was an attempt at exaggerating or misrepresenting the children's condition.

68. The mother accepted that her description of B's behaviour that were related to ASD were not observed at school. She explained that given A's circumstances, the mother was concerned for B when observing her behaviour at home. B's assessment was undertaken by Dr O and involved four sessions. She denied exaggerating or fabricating B's observed behaviours. She reminded the court that Dr O is a professional and saw B at school. The mother was concerned that B should have any

support that she needed. The mother accepted that she was over protective of C but was also concerned that he may be displaying behaviour that would be consistent with ASD traits. She strongly denied ever telling C or making him believe that he was diagnosed with ASD. The mother also reflected that given her difficulties with the school over support for A, her relationship and communication with the school had become limited and strained.

69. The mother accepted that in 2020 B was registered as a young carer. Although she helped to look after A, the registration was intended to gain her more support. Whilst C and A were identified as children needing the support, the mother did not expect B to provide such support. She accepted that it would be harmful for C to believe his sister to be less capable than she is. The mother was taken through some of her requests for referrals for B. On both of these issues the mother's evidence became very evasive and unclear. She recalled her interactions with Professor K more clearly and was reassured that her assessment did not identify any serious medical issues for the children. She accepted that other than reflux with which C suffers, none of the children have any underlying medical conditions. The mother was taken through some of the recommended adjuncts but accepted that some that were used at home such as the weighted blanket were not recommended by professionals.

70. The mother was taken through a series of questions about a number of medical referrals particularly relating to B. The mother's memory was understandably vague on all of the historical details. The main thrust of her evidence continued with a denial that any of the reported symptoms or description of the children were exaggerated or falsified. The mother explained that the bath chair was recommended by the occupational

health professional after speaking with B alone. She did not use it much and A was usually in the bathroom. However, she agreed that B did not need this. She accepted that it is inappropriate for her to continue to share a bed with C and described this as probably convenient rather than a specific need for doing so. The mother's explanations about using Makaton with C so as to be more inclusive were unrealistic and evasive. However, there is no reliable evidence that this would have caused C harm. When asked about whether C has been academically 'held back', the mother was clear that she was pleased with his progress and the improved circumstances in her family.

71. The father was the last to give evidence. He stated that he met the mother whilst on holiday in [XXX] and began a relationship. He was delighted when she was pregnant with A and described his relationship with the mother as *"terrific".* They have never lived together and their relationship has fractured over the ensuing years, although they have remained amicable throughout the proceedings. The mother did not think highly of his family and would not allow the children to have a relationship with them. There was some unfounded professional concern that the father would kidnap the children by taking them to another jurisdiction. Consequently, despite requests from the children, they have never visited his property.

72. He reflected with much sadness that he is not seeing A at present and described the 'tipping point' to the incident whilst away in 2019. He expressed his profound regret about this incident and wished that he could *"turn back the clock".* He was adamant that he would accept any help that could be offered to address the difficulties in his relationship with A. Happily he was able to reflect more positively about his relationship with his younger two children.

73. The father was clear that he was not privy to the medical information about his children until these proceedings were started. He was not invited and nor did he attend any medical appointments. He reflected on the very difficult early days and years after C was born and how they did not think that he would survive the first twenty-four hours of his life. He is now a *"a happy go lucky boy, obliging and nothing is too much trouble for him, a sheer joy".* He had no involvement with the children's school until he was granted parental responsibility.

74. The father stated that the medical advice was to strengthen the muscles around the joint by the children walking and not using the car. The mother was very busy and B often got tired when walking. A friend of the mother's had suggested using a wheelchair and the father bought one after finding one on offer. This was only used for short periods when her legs were hurting and did resolve a lot of the issues. The father denied that this could lead to a distorted self-image for B. He also recounted purchasing a buggy for C from Mothercare and this was a standard buggy. He confirmed that C did not have a specialist buggy.

75. When challenged about his views about the children's medical issues, the father became quite guarded. He thought that it was *"commendable"* that the mother had sought medical attention for B's apparent heart issues after he saw her at home with electrodes attached to her. When asked about C suffering with cerebral palsy, he was careful never to say that he was suffering so but stated that there were signs in C that would be consistent with such diagnosis. He was clear that a nurse stated in his presence that part of C's brain had died. However he accepted that C does not suffer with cerebral palsy. He was clear that the mother has never stated that C did suffer with cerebral palsy. They were never officially told that he did not have cerebral palsy.

76. He expressed no surprise that B was diagnosed with ASD. He reflected on his own experiences and stated that these were consistent with such a diagnosis. For example, when taken to trampolining, an activity that she really enjoyed, she would *"dart out"* due to the noise and how busy the sports hall was. The father considered that all three children "*may have ASD to varying degrees*". He was also aware of the adjuncts which the mother had said were advised by professionals. At a certain point he considered that B may be copying A, but her intolerance to noise, crowds and bright lights were consistent with her diagnosis. He was clear that both C and B are active children but do complain of aches and pains in their joints. This often depends on the activities that they have undertaken. He recalled carrying C up the stairs on an occasion.

Analysis

77. The local authority's allegations are detailed and the schedule of those allegations contains over one hundred and eighty paragraphs. Despite concerted efforts by its legal team, the local authority has been unable to reduce the number of these allegations and argues that each of the allegations form an important and integral part of this case. As the lead expert in these proceedings, Dr Rose warned against what he termed *"bacon slicing"* the evidence and expressed a strong view that the case must be considered with the totality of the evidence in mind. I respectfully agree. Several authorities spanning many years have made it clear that the court must weigh each piece of evidence and consider it in the context of the wider evidential canvass or the totality of the evidence that is before the court. This approach does require the court to analyse the constituent parts of the wider canvass. To do otherwise, would be a fundamentally flawed approach.

78. In June 2021 A was made the subject of a final care order. The agreed 'threshold' findings included the following;

> As at 16 July 2020
>
> [A] *has not received the care that would be reasonable to expect to receive*
>
> **[REDACTED]**

These findings provide a very helpful starting point and an important lens through which some of this family's lived experiences can be viewed.

79. In 2012, the mother began to notice the first signs of difficulties in A's presentation. At this time B was very young having been born in [XXX]. In 2013, the local authority first became involved as a consequence of the deterioration in A's behaviour. By now C was born with significant medical issues that presented the family with additional significant challenges. In the ensuing years the mother became an advocate for her children and sought to find such help and assistance as she could. It is important to note that in the first four years and against the odds, C made significant progress. As it has been attested to by the relevant witnesses, this progress was in no small part due to the care that C received from his mother.

80. It is also clear that at times, the mother's efforts were overanxious or overzealous. Undoubtedly, this has placed her in conflict with some professionals and has marred their views of the mother. This was clear in the evidence from the witnesses from the school who did not share the mother's concerns about the children's needs and ability. What they

observed in school, in so far as any of the witnesses had directly observed the children, was very different to that which the mother described at home.

81. I have no doubt that the school through its staff has remained fully committed to providing the children with the best that it thinks would meet the children's respective needs. However, the school's perception of the children's needs has not always been accurate. This is perhaps best illustrated by the final decision in the tribunal proceedings that found in favour of the mother. In my judgment, this was a significant milestone and it was all the more surprising that none of the school witnesses including the head teacher who was involved in those proceedings, had any meaningful recollection of those proceedings or the decision of the Tribunal.

82. Furthermore, the continuing escalation in A's behaviour is also illustrative of this issue. A's needs and behaviour are multifaceted and complex. She left the school within six months of the tribunal decision and the complexities of her needs and the demands of the same were immediately obvious to her new school. Cross examination of the witnesses from the school, clearly illustrated that in the main, the school's assessments of the children were based on the school observations without any relevant knowledge of the medical investigations and advice from the treating teams. Inevitably, this has led to a greater sense of isolation and frustration by the mother. This was palpably clear as I listened to the mother's evidence who was measured in her criticisms of the school.

83. With the mounting daily challenges and the children's difficulties particularly A and C, the mother found an open door and greater support in the medical profession. I have no doubt that she gained greater

security and certainty through the diagnosis of medical conditions and the recommended treatment plan. The evidence of the treating team whether medical or quasi medical are bound by a consistent thread that show the mother as genuinely concerned for her children, acting appropriately on medical advice and not unreasonably seeking or searching for a diagnosis.

84. However, as accepted by the mother, there are features of her conduct that have been inappropriate and harmful to the children. Most notably this included the purchase for B, use and storage of a wheelchair. As she accepted this was harmful for B, and for C to view his sister as less capable than she is.

85. The mother was evasive in her answers to questions about some of her narrative of the children's conditions and I formed a clear view that at times these had been exaggerated or she had embellished some of the children's issues. Her description of the children's needs and their role within the family when applying for the '[XXX] Card' or a blue badge were clearly inaccurate. There is no evidence that at any point B had assumed the role of a carer for any of her siblings. I was also concerned to hear her evidence about C suffering with Cerebral Palsy. Whilst it is clear to me that this may have been raised as a possibility, it was concerning to note that the mother who is otherwise in charge of a great deal of detail, chose not to make any enquiries about this and proceeded on what was clearly an incorrect premise. Furthermore, whilst I accept that the mother did not tell C that he has ASD, the evidence of C mentioning this in school speaks to a home atmosphere where the children are exposed to and involved in medical concerns. I found the mother to be reliable in this regard and there are many reasonable scenarios in which a child such as C my say such a thing. Although,

perhaps understandable, mistaken use of medical terms such as dislocation would have added to this concern and the children's views of themselves.

86. However, whilst these issues elevate the levels of concern for the children in their home environment, the fundamental issue is whether this has caused or is likely to have caused the children significant harm. If so, whether this can be attributed to the mother's parenting which was not reasonable to expect a parent to provide the children with. The height of the local authority's evidence is the 'possibility' of the mother presenting with PP/FII as raised and attested to by Dr Rose whose views are informed by a detailed analysis of the children's medical records and other experts including Dr Surgenor.

87. Early in this hearing and with the consent of the parties, I limited the scope and the role of Dr Surgenor in this hearing. One of the relevant issues that she raises in her report concerns the integrity of the ASD assessment that was undertaken by Dr O. Having had the benefit of hearing directly with Dr O, I do not share these concerns. I am entirely satisfied that Dr O had undertaken a robust assessment of B and her diagnosis at that time was reliable. It may well be that a reassessment is justified for the purposes of any welfare determination, if indeed such a determination is required, however I do not find that the mother's contributions to this assessment had such an influence on Dr O's independent assessment to bring its validity into question. Whilst the majority of the issues that Dr Surgenor raises fall outside the remit of this hearing, I am confident that her report and views have made a significant contribution to the trajectory of this case.

88. For entirely good reasons, Dr Rose has not met the children or examined them. His report contains a detailed analysis of the children's records.

He properly defers to and relies on Mr Crompton's assessment as the third jointly instructed expert in this case. I found Mr Crompton's evidence to be fair and balanced. In his evidence, I did not find any criticism of the mother. Similarly, the treating medics have made positive observations about the mother. I found Professor K a most helpful and learned witness who was very careful to give an accurate testimony and limited her evidence to that which was within her considerable expertise. Dr Z was in my judgment uniquely placed to attest to C's circumstances and displaying a detailed knowledge of C, the medical investigations, referrals and the use of recommended adjuncts. The evidence from the Occupational Health Therapists was equally clear that the use of adjuncts was a recommendation made by them which founded in the assessments that they had undertaken.

89. Whilst the local authority's schedule of findings has a great many subparagraphs, the main thrust of it can be contained to what Mr Bickler KC and Mr Froud have come to characterise as the 'pillars' upon which the local authority's case rest. In my assessment these may be categorised as falsification and exaggeration of the children's medical and quasi medical conditions that have caused an over medicalisation and unnecessary medical or quasi medical investigations of them, the professional disagreement with the Mother's presentation of the children which is mainly associated with the school's observations and finally conduct within the home such as the use of adjuncts or medical terminology. Although this may be a helpful summary of the local authority's case, it is important that closer attention is given to the elements that make up the local authority's schedule that contains several important and relevant examples of the mother's alleged behaviour.

90. The first of the local authority's examples is the mother's alleged pursuit of a diagnosis for [RA] for B. The examples start in March 2014 and conclude in December 2014 during which time B was examined on three occasions. The mother appears to have accepted the conclusion of the investigations during this period without seeking any further referral. C was referred for investigation on one occasion in 2020. In my judgment, there is no evidence under this subheading that would justifiably support the local authority's assertions in paragraphs 2 and 3 of its schedule of findings.

91. The next subheading concerns B and referrals to audiology. There are inaccuracies in the first pleaded examples that start in January 2013 and conclude in August 2013. In this period there was one referral from the health visitor resulting in two examinations in April and August of the same year with the latter being a review by the audiologist. Arguably the first referral was instigated by the mother's reports. There is no evidence before me to support a finding that the mother's reports were inaccurate or exaggerated save that the investigations did not identify any issues. On any view, although distressing for B, the local authority's case does not reach the required evidential threshold for such a finding to be made.

92. Mobility has been one of the more serious concerns in this case and has spanned a greater proportion of these children's history. However, this is broken down into separate elements the first of which refers to B and referral in 2013 for investigations into Dyspraxia. This example is clearly inaccurately recorded and on the correct reading of the documents cannot be sustained. The next examples under this heading are between January 2018 to June 2018 with a missed appointment in September. Having carefully considered these referrals, it is hard to see

how the local authority can show that the mother has falsified or exaggerated her accounts and even if she did, how the court can find that this has caused her significant harm where there were nonintrusive recommendations that the mother appears to have followed and indeed the mother did not pursue any further investigations thereafter. However, as accepted by the mother and detailed earlier in this judgment, the purchase of the wheelchair for B, its use and storage in sight of the children was an extremely poor decision which has in my judgment caused B and C significant emotional harm. However, I do not find that there is evidence that meets the requisite evidential threshold for a finding that this was significantly or otherwise physically harmful to B and certainly not to a degree that would come close to justifying a threshold finding. The issues concerning the bath hoist were concerning but the evidence of the mother which I accept was that this was a chair and not a hoist and was not used. Although its presence may have contributed to the overall presence and use of adjuncts, I do not find that there is evidence that would justify a finding as sought that meet the evidential requirements.

93. The local authority's schedule next tackles the more detailed allegations under Occupational Therapy and Speech and Language Therapy. For B the allegations cover the period between October 2013 and June 2017. In this regard, I have had the benefit of hearing the oral evidence of two of the allocated therapists, Miss F and Miss G. Their evidence is summarised earlier in this judgment and do not on any view support the local authority's allegations under this heading.

94. Under the same subheading, the local authority's allegations in respect of C also extend to the Speech and Language intervention on C that started in February 2015 and include an extensive list of examples in

respect of the occupational health intervention. Having had the benefit of hearing from Dr Z and Miss E together with a detailed consideration of the documents that are relied upon in this regard including those that the mother has referred to in her response, I cannot find that the local authority's case is proved in this regard.

95. The cardiological investigations of C appear to be in part due to the diagnosis of EDS and in main the mother's reported presentation by C. They span several years and the significant part of those include reviews that were undertaken on medical advice. There can be no doubt that this could have been distressing for C especially when this involved monitoring at home. Similarly, the referrals for eye examination and dyslexia appear to have been mainly founded on the mother's report of the children's presentation.

96. I will consider the issue of the history of joint dislocation and EDS together. I have read and heard considerable evidence about these two issues. In my judgment, Dr Rose properly deferred to Mr Crompton on the appropriate issues that were within Mr Crompton's expertise. Similarly, albeit to a lesser extent he deferred to Professor K. Where there was a conflict in the evidence of the latter witness and Dr Rose, Professor K's evidence was far more consistent with that of Mr Crompton's. Furthermore, the totality of the relevant evidence when considered together with these experts causes an insurmountable evidential hurdle for the local authority's allegations under these two main subheadings. I accept that the mother's description of dislocations was inaccurate but given the diagnosis and the professional advice, the mother's actions are not open to such criticisms especially the support that the expert evidence lends to the mother's conduct.

97. The issue of ASD has been raised by the mother (and father in respect

of B) and this forms another subheading in which the local authority cites a number of examples of B and C having unnecessary investigations and the mother exaggerating of fabricating symptoms. Much of the local authority's case in this regard relies on the questions that were raised by Dr Surgenor and the differences in the observations of the school and others to that which the mother has described. There is no doubt that among several diagnosis, A has been diagnosed as having ASD. It seems to me entirely reasonable for parents to have considered this as a potential diagnosis for B and C. The latter has suffered with developmental delay which may share some attributes with ASD although these are different conditions and B now has a formal diagnosis of ASD that has been found on the strength of the evidence to be reliable. In the circumstances, I cannot find that the local authority's criticisms of the mother under this heading are justified.

98. The allegations about the mother's conduct in respect of C span a number of years, starting in 2014 when he was under the care of the neonatal services and concluding in 2018. It is noteworthy that this is the period during which C was under close observation of the medical professionals, particularly Dr Z when he made significant progress. C has been diagnosed with reflux which is another important factor to consider given Dr Z evidence about this issue. The inconsistency of the mother's account can arguably reflect the expected and unexpected changes in a developing child who has had significant medical difficulties. In my judgment, the local authority's allegations in this regard are not sustainable.

99. The heading concerning the frequency of visits to the General Practitioner over a number of years does not by itself demonstrate on any view that the children have suffered significant harm as a

consequence of such visits that on the face of it appear to fall within the norms that are expected by the parents as attested to by Dr Rose. Similarly I do not find the allegations about C's nose bleeds to be relevant to the significant issues in this case.

100. As for C's educational attainments, the evidence of Dr Surgenor which informs the local authority's allegations is based on her assessment at a time when C has already made significant progress whilst in the care of his mother. The IEP and his transition from preschool to reception, were agreed by the relevant professionals at the time. The evidence does not suggest that this was insisted upon or forced by the mother. Whilst I accept that some in his school may have wished for his full-time attendance to be earlier, no one in evidence has sought to seriously criticise the mother for the agreed plan nor to provide any evidence that C has suffered as a consequence. The allegations about B's anxiety in school is not supported by the evidence of the witnesses who gave oral testimony on behalf of the school.

Conclusion

101. All of the above must be considered in the context of the wider canvass of the evidence. Each of the above considerations have informed my decision about whether the threshold criteria as set out in s31(2) of the Act is met. For reasons that I have set out above, I have no doubt that the mother has done all that is in her power to provide the best for her children. In many respects she has been very successful at this task and has a great deal to be proud of. In other respects, the challenges that she has faced, have been beyond her capacity and ability to meet. The difficulties that she had to address over many years have undoubtedly impacted on her health, perception and abilities as a parent. I have no doubt that she has found

support and comfort in the services that the medical profession has been able to provide her family with. It is also clear to me that she has on occasions exaggerated or fabricated the children's presentation and behaviours. A clear example of this is found in her description of the children and their role within the family when she applied for an [XXX] card and the blue badge. However, such examples do not begin to satisfy the 'threshold test' whether by themselves or as part of consideration of the wider canvas. There has to be a causal link between the mother's parenting of the children and the significant harm that they are said to have suffered.

102. I have no hesitation in finding that both B and C suffered significant harm by the poor choice of the mother to purchase a wheelchair for B. The father clearly contributed to this by acting on the mother's instructions and not challenging her. Furthermore, this clearly satisfies the 'threshold test'. However in all other regards the evidence of substandard parenting that would satisfy the threshold criteria is less than clear. The children clearly have a number of properly diagnosed medical and behavioural difficulties. I am confident that their daily lives were occupied with consideration or management of those issues. Sadly, there were significant periods when the demands of looking after A has over-shadowed all else within the children's home. However in my judgment, there are considerable evidential difficulties in the local authority's allegations. In the main, there is no direct evidence that the children suffered any significant harm that can be attributed to the mother or her parenting. Secondly, where there may be arguments that there is evidence of significant harm being suffered or likely to be suffered by the children, there is little evidence to suggest that the mother's conduct or parenting was not reasonable for a parent to provide. Therefore, I do not find that the threshold criteria pursuant to

s(31)(2) of the Act is crossed save in the following respects which includes what has already been accepted by the father;

a. B and C have suffered or likely to have suffered significant harm by reason of the findings in respect of A that are set out in paragraphs 1, 2 and those related to A being beyond parental control of the agreed schedule of findings.

b. The mother unreasonably and unnecessarily caused the Father to purchase a wheelchair that was used by B and stored within the home causing her significant emotional harm by making her believe that she was less able than she was and caused significant emotional harm to C by making him witness and believe that his sister was less able than she was.

c. In October 2019, the Father reprimanded [A] for creating a mess while the family were away on holiday, and said to her "I wish you wouldn't be a bull in a china shop". This comment caused [A] to lose control and to damage property and kick the Father. The Father has accepted that he lashed out at [A] in front of [B] and [C], and that the children had been traumatised by the incident.

Schedule of findings that are sought by the applicant local authority (anonymised)

[REDACTED]