Neutral Citation Number: [2020] EWFC 73

Case No: LU18C03718

IN THE FAMILY COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/11/2020

Before :

THE HONOURABLE MRS JUSTICE JUDD DBE

- -

Between :

A Local Authority	**Applicant**
- and -	
J	**1st Respondent**
-and-	
-D	**2nd Respondent**
-and-	
-E	**3rd Respondent**
-(a child acting through her guardian, Jan Lech)	

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Elizabeth Isaacs QC and Timothy Bowe (instructed by **Y Borough Council Legal Services**) for the **Applicant**
Nkumbe Ekaney QC and Alison Easton (instructed by **Motley & Hope Solicitors**) for the **1st Respondent**
The 2nd Respondent did not attend the hearing
George Lafazanides (Solicitor) of **Fahri Jacob Solicitors** for the **3rd Respondent**

Hearing dates: 5th to 30th October 2020

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Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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Covid-19 Protocol: This judgment will be handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down will be deemed to be 2:00pm on 19 November 2020. A copy of the judgment in final form as handed down will be automatically sent to counsel shortly afterwards

THE HONOURABLE MRS JUSTICE JUDD DBE

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment 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 do so will be a contempt of court.

The Hon Mrs Justice Judd :

1. I am concerned in this case with an application by the local authority for a care order with respect to a young girl, E, who has recently reached secondary school age. Her mother is J. Her father is not taking part in these proceedings. E is represented through her Guardian. This hearing has been listed for me to determine the threshold and findings of fact sought by the local authority.

Background

2. E is the youngest of three children. No concerns have been raised as to her older siblings. During the first year of E's life she suffered from an episode of acute bronchiolitis for which she was treated in hospital for several days. Nothing else notable from a medical point of view happened so far as E was concerned until she was about 18 months old when she suffered from what were diagnosed to be febrile convulsions for which she was admitted to hospital for two days. A month after that, she was again admitted to hospital briefly after suffering a probable febrile convulsion

3. During 2010, there were more episodes. In February she was admitted via ambulance for another febrile convulsion when she had chickenpox. In July the mother reported to the GP that she believed that previous convulsions may have been due to E taking penicillin. On 27th December, E was admitted to hospital via ambulance as a result of seizures, discharged the same day, and then admitted again the following day (once more by ambulance). The mother said that E had gone blue whilst fitting and had urinated. It was described as a generalised tonic clonic seizure (GTCS), and the diagnosis was of complex febrile convulsions. The hospital notes record the mother as stating that E's brother had had vacant episodes as a child, but had grown out of them.

4. Early in 2011 E was admitted again for fits, some of which were said to have been witnessed by the ambulance crew. The mother reported that E's sibling had had a fit at the age of 15, and possibly the father had had fits. Then two months later she was admitted again by ambulance for fits, and a diagnosis of seizure disorder was made. Whilst in hospital the mother pulled the emergency buzzer to say that E had been seizing for five minutes. Buccal Midazolam was administered, and she had a high temperature. The hospital notes, written by a nurse, record that the fit was witnessed by the Registrar, although her/his name is not given and there is no note from that person which one would expect. E was discharged with a prescription of Midazolam (which is a rescue medication) to be given as needed when seizures lasted for longer than five minutes. In June an MRI scan was performed where there were multiple small areas of high signal found in the white matter which were relatively soft and ill defined. The cause of this was not clear, as these findings would be expected to be more pronounced for a toxic or metabolic disorder, nor was it typical of a mitochondrial disorder. Meanwhile, E was said to be suffering from more fits and staring episodes, and also nosebleeds. She was prescribed with Epilim and midazolam for when it was necessary. E and the mother saw the Consultant Paediatrician at Y Hospital, Dr M , and E was referred for some metabolic tests as a result of the MRI findings, which showed nothing specific. In August 2011, E was found to meet the children with disabilities criteria by the Y Allocation panel, but she did not meet the criteria for a continuing care package following an assessment by RM.

5. Meanwhile E was said by the mother to be suffering from continuing seizures although they were in clusters with several weeks sometimes passing in between. The general seizures were said by M to almost always require Midazolam to stop and by the end of 2011 they appeared to be increasing and the dose of Epilim (daily) was increased. Because of safety concerns she was referred to obtain a soft helmet and had a baby monitor by her bed. Her physical development was said to be normal, but the mother did say that E had bouts of aggressive and destructive behaviour; and Dr. was asked by the GP to consider an assessment for autistic spectrum disorder (ASD) by the CDC.

6. During 2012, there were a number of episodes, and the mother continued to report that E had seizures, often requiring Midazolam. In April of that year the mother reported that E showed anxiety about change, that she was obsessed with routine and that she walked on tip toe, and during the course of the year she reported language delay and communication issues. In September E started at W Lower School but the mother was not happy with this and asked for her to be transferred to B. At various points there were suggestions that E should be assessed at the Child Development Centre (CDC) and she was seen there on 23rd January by Dr. C. Various professionals were already beginning to record that E had ASD (for example the education tribunal notes show this). Dr. C recorded a list of problems at the head of the letter that she wrote to Dr. after seeing E and the mother in the clinic, which included at number 1 'Autistic Spectrum Disorder', before going on to set out the mother's descriptions of E's behaviour below. There was no independent assessment of E's behaviour but it is clear from what happened thereafter that Dr. C's letter was taken as confirming a diagnosis of ASD by all the professionals thereafter (although there are references in some documents to the need to confirm if E did have the diagnosis).

7. During the course of 2013 the mother reported wide-ranging problems with E, including repeated seizures, nosebleeds, bowel and bladder problems, excessive sleepiness, and some wobbliness meaning she could not walk long distances (E was provided with a wheelchair later in the year). The mother was not happy with B school and wished for E to be moved to R (which she did in September). In July 2013 E had a Statement of Special Educational Needs, during the course of which the mother reported that E was having 3 to 4 drop seizures a day, and one or two tonic clonic seizures a week. Her medication was increased following a consultation with Dr. B, and E was referred to Dr. K, Consultant Paediatric Neurologist at Addenbrookes. Following the appointment with Dr. K in September, E underwent an EEG which showed no epileptiform abnormalities, and normal responses to photic stimulation and hyperventilation. In October E was admitted to hospital again for fits, and had an MRI under general anaesthetic. This showed multiple small sub-cortical lesions, predominantly in the frontal lobes. The Consultant Radiologist stated that although the appearances were not typical of tuberous sclerosis, this was the most likely differential diagnosis, and when E and the mother saw Dr. K again in November 2013 she referred E for genetic tests which were found later to be normal. At the very end of the year, E was admitted to hospital as an emergency because she was said not to be passing urine.

8. In 2014, Movicol was added to E's list of medication to relieve her reported constipation and the mother was also concerned that she was suffering from obstructive sleep apnoea. She was advised to allow E to sleep in a more upright

position and reported that E's fits improved thereafter (although absences continued). In June she was admitted to hospital as an emergency because she was said to have had a fall during an absence seizure whilst climbing over a stairgate. During the course of the year, there were a number of investigations to see whether or not E had TS, including genetic tests, an ECG, optical examinations and an ultrasound scan of kidneys and bladder. All came back as normal and in September, Dr. C, Consultant Clinical Geneticist reported that a diagnosis of TS was unlikely. She noted on examination that E was hypermobile, and stated in her conclusions that E appeared to have a neurodevelopmental disorder associated with complex epilepsy, learning difficulties and autism. In November she was admitted for a coblation adenotonsillectomy which appeared to go well although M reported that E suffered from repeated nosebleeds for which she was cauterised.

9. In 2015 E was weaned off Sodium Valproate, but the mother was concerned that her seizures worsened. She also asked to be referred to Dr. P, Consultant Paediatric Neurologist at Addenbrookes, who ran TS clinic. A Child and Young Person Continuing Care Process Assessment was undertaken by SN nurses, HL and GM, which concluded that E did not meet the criteria for continuing care. E was also referred to Speech and Language therapy following concerns of a stammer, which concluded that she presented with an understanding of spoken language and expressive language skills appropriate for her age, but that she would benefit from regular speech and language therapy to develop her awareness and confidence and to learn techniques to improve her fluency. E saw Dr. P in August, and taking into account the history from the records and what the mother told him, he concluded that TS was the likely diagnosis, albeit it was atypical. In the event that seizure control was to deteriorate, consideration would be given to a trial of Vigabatrin and/or a keto diet. In November Dr. P noted that E was still having troublesome seizures although the frequency had settled, and recommended the cautious introduction of Vigabatrin.

10. At the beginning of 2016 the mother noted that following the seizures initially becoming 'haywire' they improved a great deal. She was, however, concerned about E's speech and language, her behaviour and as to way in which she was being managed at R School. E was referred to the Continence Service in May, and in the same month she was admitted to hospital because of noisy breathing at night (which seems to have been seen when she was on the ward as well as reported by the mother). The mother reported to Dr. P that breathing difficulties triggered episodes and he suggested that she should video them so they could be reviewed in the clinic. E's school placement was considered at an Educational Tribunal in June, as the mother wished her to be placed at St E School. Relations between the mother and R School became more and more tense because the school did not feel that E required the amount of monitoring over her bowels and bladder and eating that the mother was asking for, and by the end of November the mother was removing K before lunch every day. The mother reported serious difficulties for E with constipation and passing of urine, and that when laxatives were reduced, she had had a seizure. The week before Christmas, E was admitted briefly to hospital as she was said to have stopped drinking and had reduced feeding too. She appeared well on examination and was discharged.

11. In February 2017 a decision was made to start E on a ketogenic diet in March, as a result of a return in her drop seizures, an increase in GTCS to three or four a month

usually requiring Buccolam, and absences between 7 and 15 times a day. The idea was that E would be weaned from her other medication including Vigabatrin. She was admitted on 13th March for three days. E seemed to tolerate the diet well although she did have two symptomatic hypoglycaemic episodes. After this admission the mother did not return her to R school, and indeed she objected when the school nurse contacted the hospital directly without informing her. The mother reported difficulties with controlling E's blood sugars. She also asked for E to be discharged from the continence service as she did not believe that they were being supportive. In April, by consent, it was agreed to revise E's SEN statement and that she needed a school catering for children with a wide range of learning difficulties and complex medical conditions such as epilepsy. E was home schooled and during the summer the mother pressed for her care plan to be updated, although she did not wish to have the involvement of the R nurses, who she said did not understand E's needs and did not accept help or advice from specialists. The seizures appeared to improve, with about 2 to 4 TCS a month, and less frequent drop attacks. M said that E continued to have about 11 absences a day. In September E was admitted to Addenbrookes for assessment, and the mother reported improvements in seizure control. She did not want to withdraw from the keto diet because of the benefits to E. In October there was an emergency admission because of concerns that E was not drinking but she looked alert and active with moist mucus membranes, and was discharged with a prescription for antibiotics for a suspected UTI. The mother also reported that K was constipated but declining Movicol. She was admitted again at the end of the month with a fever and a history of poor food and liquid intake and was fitted with a naso-gastric tube. Worryingly, the mother described increasing seizures as well. E was discharged with the NG tube in situ, and the mother made contact with HC from Addenbrookes asking for NG tube supplies, and also asking for training so that K could be given feeds by a pump. The NG tube remained in place for a few weeks, and by the middle of December it was being used first thing in the morning, and then later on in the day. The mother told the community nurse that E had been referred for a gastrostomy at Addenbrookes. At the end of the year, further submissions were made to the Educational Tribunal as to the correct school place for E.

12. At the beginning of 2018, E was admitted to Y Hospital for the replacement of her NG tube. This was a very distressing event, for E was distressed and agitated, and it was not possible to put in the tube, even when E was sedated. It was decided that she would have to undergo a general anaesthetic. On the ward, E was said to be alert, talking, walking, eating and drinking, but she refused to go to the theatre. She was discharged home. At about this time it is clear that concerns were beginning to be raised about the mother and whether she was over medicalising E.

13. On 9th January 2018 the mother attended R with E, saying that she had refused to eat all day and only sipped fluids. When she had a NG tube put in, she had a seizure and a hypo and it came out. It was decided that E should be cannulated, but Addenbrookes said it was not appropriate to do it at home. On 12th January, E was taken to Y hospital with the same issues, and the mother was told of the options which included another NG insertion (which was not thought likely to be successful) or a permanent PEG insertion. In any event she would need IV fluids in the meantime. There appears to have been a significant disagreement between the mother and the clinicians, and the social worker was contacted.

14. E attended an outpatients appointment at Addenbrookes on 15th January. The dietician recorded that the plan was to withdraw the keto diet rather than look at a gastronomy. The FII protocol was invoked, and a professionals meeting in the absence of the mother (and without her knowledge) was organised.

15. On 28th January E was admitted to Addenbrookes as an emergency, with fever, haemoptysis and drowsiness. She was said to have had a GTCS and on examination she was found to have a rash, and audible cough, and to be dehydrated.

16. On 5th February E was admitted to Addenbrookes on a planned basis to observe her eating and drinking, and her behaviour around being encouraged to do tasks. The mother brought in a selection of keto meals. In fact E refused to eat keto meals, and she did not show signs of dehydration. The hospital staff thought her fluid intake was acceptable even if poor. No seizures were noted. E was discharged and the plan was to continue with a non keto diet. It was said that the mother had become aggressive when she was asked if E could remain in hospital for a few more days, and refused. After E was discharged, the mother told the GP that she was concerned as to how E would be weaned off the keto diet, but when she contacted Dr. P, the latter stated that E did not need to be weaned because she had managed without it at Addenbrookes without any ill effects.

17. The period following this admission marked something of a change in the way in which E and the mother were treated, and also in the mother's responses. This was undoubtedly because the professionals were beginning to question the various diagnoses that E appeared to have had, and the evidence underlying them. During the course of the year there appeared to be something of a standoff with the mother stating that E was still on the keto diet from which she needed to be weaned off with the assistance of a specialist centre, and Dr. P at Addenbrookes saying that she was not on it, and therefore no weaning was needed . Some of the other doctors were caught in the middle.

18. A section 47 inquiry was initiated. The chronology records the mother as reporting that E had started suffering from seizures again shortly after her discharge from Addenbrookes and there are some other references to the mother stating that E was having problems with disfluency and some trouble with swallowing. Reports of seizures were also made in June after what was said to be a period when they were well controlled (E remained on medication, including Vigabatrin), but after that reports of seizures were much reduced again. The mother attributed this to the keto diet. E had not been in school for a year whilst the tribunal process was in train, and the mother's hope was that she would obtain a place at St. E.

19. Care proceedings were started on 28th June 2018 and E was made the subject of an interim supervision order. Dr. Kate Ward was appointed to prepare a report. The question as to whether or not E was on a keto diet and if so, how she was to be weaned from it was a matter of discussion over many months. By November the professionals were moving towards an emergency care plan whereby E was admitted to Y Hospital so that it would be possible to see and treat any seizures that she might suffer in the course of moving to a normal diet. E had begun to attend school, and the mother was said to be concerned that the school team did not have a care plan for epilepsy, and that she could not therefore allow her to be at school full time.

20. The report from Dr Ward was received at the end of 2018, and on 9th January there was an experts' meeting between herself and Dr. Williams, during which they both agreed that E should undergo a multi-disciplinary residential assessment, which could assess her medical and/or psychological condition, and, if indicated, wean her from the keto diet and anti-epileptic drugs. Enquiries thereafter led to the identification of Young Epilepsy as a suitable venue for this assessment, and E was eventually admitted there for a twelve week assessment on 7th October 2019. I should note at this point that the mother supported this assessment.

21. E was weaned swiftly from the ketogenic diet, and shortly thereafter from Vigabatrin. Weaning from Clobozam took place in the community in the early part of 2020. After a short break over Christmas where it was agreed that E would go to her aunt and uncle, she was to return to the unit on 6th January until 12th January, and then go back to her aunt and uncle pending the finding of fact hearing. On 27th December E was said to have had a drop seizure at the home of her uncle and aunt which led to her falling over in the shower.

22. A detailed assessment of E for autistic spectrum disorder was conducted at Young Epilepsy in November 2019, and concluded that a diagnosis was not supported as per the DSM5 criteria. She also had an IQ within the normal range although she was said to be very behind educationally. She was seen to be physically able and did not need a wheelchair. She also was not observed to have any fits during the course of the assessment.

23. Since discharge, E has been living with her aunt and uncle, with contact to the mother supervised by them. E has not been on any anti-epileptic drugs, nor the keto diet. Lockdown intervened, so there has been a prolonged period when she did not attend school, but she has been back at C school since September.

The local authority case

24. In a detailed threshold document, the local authority alleges that the mother, on a number of occasions between 2011 and 2018, has given medical professionals an exaggerated or wrong account of E's health, including that she suffered very frequent and serious seizures, including tonic clonic seizures, drop seizures and absences. Some of these were said to have required emergency medication (Midazolam) as they lasted for several minutes. Secondly, it is alleged that the mother gave exaggerated or wrong descriptions of E's behaviour which were consistent with autism, such as being obsessed with routine and had difficulties with social interaction, toleration of loud noises, and speech problems. It is also alleged that she stated wrongly that E had difficulty opening her bowels and passing urine.

25. The mother is said to have perpetuated the notion that E had uncontrolled epilepsy and autism as well as stating on individual occasions that she had Doose syndrome, a blood disease, and septicaemia. The effect of the mother's actions was to lead to E being wrongly identified as a child with serious medical, social and educational needs, with medication, a ketogenic diet, adaptations to the home, a wheelchair, medical equipment and disruption to her schooling . She also had invasive medical treatment including and MRI, a lumbar puncture, an operation for removal of her tonsils and adenoids, and a naso-gastric tube.

26. As a result of this, the local authority contends that E suffered and is likely to suffer from emotional and physical harm.The mother denies causing harm to E, or that she is likely to suffer harm in her care. She denies exaggerating or fabricating seizures, or misrepresenting or misreporting other symptoms such as sleep problems, autistic behavioural traits, eating or drinking problems or urinary retention or constipation. She has, she states, reported what she has seen.

27. It is pointed out on her behalf that she had a legitimate anxiety over E's health due to her suffering numerous febrile seizures at a very young age. It is also pointed out that there is objective evidence of the early seizures, and also some later ones, such as one in hospital witnessed by a Registrar, and also at school. Moreover, E had a worrying MRI scan in 2011 revealing abnormalities in the subcortical areas, and is a carrier for galactosaemia. The diagnosis of probable tuberous sclerosis was made by Dr. P, and it was Dr. C's letter which led the medical and other professionals to assume that E had been diagnosed with ASD. The mother never sought out a diagnosis for E, nor did she seek or administer medication to her wrongly, or induce any symptoms. She did not seek for E to be put on the keto diet, or to have other medical interventions. She only used a wheelchair for E because there were times when she became very tired.

28. She supported the multi-disciplinary assessment at Young Epilepsy and has never done anything to undermine E's placement with her uncle and aunt.

The law

29. In a fact finding case the burden of proof lies upon the party making the allegations, in this case, the local authority. The standard of proof is the balance of probabilities. In the case of Re JS [2012] EWHC 1370 (Fam), Baker J (as he then was) drew together and summarised the principles to be drawn from the case law, as follows:-

"36.In determining the issues at this fact finding hearing I apply the following principles. First, the burden of proof lies with the local authority. It is the local authority that brings these proceedings and identifies the findings they invite the court to make. Therefore the burden of proving the allegations rests with them.
37. Secondly, the standard of proof is the balance of probabilities (Re B [2008] UKHL 35). If the local authority proves on the balance of probabilities that J has sustained non-accidental injuries inflicted by one of his parents, this court will treat that fact as established and all future decisions concerning his future will be based on that finding. Equally, if the local authority fails to prove that J was injured by one of his parents, the court will disregard the allegation completely. As Lord Hoffmann observed in Re B:
"If a legal rule requires the facts to be proved (a 'fact in issue') a judge must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1."
38. Third, findings of fact in these cases must be based on evidence. As Munby LJ, as he then was, observed in Re A (A Child) (Fact-finding hearing: Speculation) [2011] EWCA Civ 12:
"It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence and not on suspicion or speculation."

39. Fourthly, when considering cases of suspected child abuse the court must take into account all the evidence and furthermore consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss P observed in Re T [2004] EWCA Civ 558, [2004] 2 FLR 838 at 33:
"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."
40. Fifthly, amongst the evidence received in this case, as is invariably the case in proceedings involving allegations of non-accidental head injury, is expert medical evidence from a variety of specialists. Whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. The roles of the court and the expert are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence (see A County Council & K, D, & L [2005] EWHC 144 (Fam); [2005] 1 FLR 851 per Charles J). Thus there may be cases, if the medical opinion evidence is that there is nothing diagnostic of non-accidental injury, where a judge, having considered all the evidence, reaches the conclusion that is at variance from that reached by the medical experts.
41. Sixth, in assessing the expert evidence I bear in mind that cases involving an allegation of shaking involve a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem. The court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers, where appropriate, to the expertise of others (see observations of King J in Re S [2009] EWHC 2115 Fam).
42. Seventh, the evidence of the parents and any other carers is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and the impression it forms of them (see Re W and another (Non-accidental injury) [2003] FCR 346).
43. Eighth, it is common for witnesses in these cases to tell lies in the course of the investigation and the hearing. The court must be careful to bear in mind that a witness may lie for many reasons, such as shame, misplaced loyalty, panic, fear and distress, and the fact that a witness has lied about some matters does not mean that he or she has lied about everything (see R v Lucas [1981] QB 720).
44. Ninth, as observed by Hedley J in Re R (Care Proceedings: Causation) [2011] EWHC 1715 Fam:
"There has to be factored into every case which concerns a disputed aetiology giving rise to significant harm a consideration as to whether the cause is unknown. That affects neither the burden nor the standard of proof. It is simply a factor to be taken into account in deciding whether the causation advanced by the one shouldering the burden of proof is established on the balance of probabilities."
The court must resist the temptation identified by the Court of Appeal in R v Henderson and Others [2010] EWCA Crim 1219 to believe that it is always possible to identify the cause of injury to the child.

29. In Lancashire County Council v C, M and F (Children; Fact Finding Hearing) [2014] EWFC 3, Jackson J, after citing Baker J above, added this,
" To these matters, I would only add that in cases where repeated accounts are given of events surrounding injury and death, the court must think carefully about the

significance or otherwise of any reported discrepancies. They may arise for a number of reasons. One possibility is of course that they are lies designed to hide culpability. Another is that they are lies told for other reasons. Further possibilities include faulty recollection or confusion at times of stress or when the importance of accuracy is not fully appreciated, or there may be inaccuracy or mistake in the record-keeping or recollection of the person hearing and relaying the account. The possible effects of delay and repeated questioning upon memory should also be considered, as should the effect on one person of hearing accounts given by others. As memory fades, a desire to iron out wrinkles may not be unnatural – a process that might inelegantly be described as "story-creep" may occur without any necessary inference of bad faith". These words echo the words of Leggatt J in Gestmin SGPS v Credit Suisse (UK) Ltd [2013] EWHC 3560 as to the fallibility of human recollection, and the limitations of human memory.

30. In Re H-C (Children) [2016] EWCA Civ 136 at paragraph [100], McFarlane LJ elaborated on the principle set out in R v Lucas (which required four conditions to be met before a lie could amount to corroboration) above–

"100. One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of R v Middleton [2001] Crim.L.R. 251. In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt".

The hearing

31. I have read all the statements and medical reports in the case, and all the pleadings submitted by the parties, including the detailed chronology prepared by the local authority. I heard oral evidence from Dr. A , Consultant Paediatrician at Y Hospital, EH, epilepsy care nurse, Dr. K, Consultant Paediatric Neurologist at Addenbrookes, Dr. P, Consultant Paediatric Neurologist at Addenbrookes Hospital, HR, Deputy Head at R, Dr. R, Consultant Community Paediatrian, GM, special needs nurse, CJ, social worker, AP, Manager at Young Epilepsy, RM, complex health nurse, AW, Children's Community Team Manager, LW, teacher at the C School, Ms H, social worker, Dr Ward, Consultant Paediatrician, and the mother.

32. This is a complex case, and it is worth noting that the mother has brought up three children apart from E, about whom there has been no concern about inappropriate illness behaviour (for the want of a better term). Nor was there any concern about the mother's presentation of E to medical professionals in the months after her birth. The first recorded seizure was in September 2009, when she was 17 months old, and she did thereafter suffer from a cluster of seizures between then and early 2010, and then

further febrile convulsions at the end of 2010 and then again in early 2011. Some of these seizures were witnessed, for example by the ambulance crew in February 2011.

33. It was during the course of 2011 and thereafter that E became to be diagnosed with an increasing number of conditions. By the beginning of 2018, and just a few months before care proceedings were started, E had been diagnosed with probable Tuberous Sclerosis and epilepsy and Autistic Spectrum disorder. There were times when the mother reported that she had very frequent fits and several absences a day. She was prescribed Vigabatrin, Clobazam, and also Buccal Midazolam as an emergency medicine. She was supposed to be on a ketogenic diet. She had a statement of Special Educational Needs and attended R school which was a school for children with physical disabilities, medical conditions and associated communication difficulties, until March 2017. An independent OT report described E as having learning difficulties, behavioural difficulties, obsessive behaviours, sensory processing difficulties and physical/motor difficulties. She had a wheelchair (and was transported to and from school in it), and there was medical equipment in the home such as a ceiling hoist which Dr. Ward stated was what might be expected for a profoundly disabled child. E had attended some events with the Y Cerebral Palsy society. She had been withdrawn from R and the mother was pursuing a place elsewhere, such as St. E which caters for children with epilepsy.

34. In addition to the problems I have set out above, E was also said to have difficulties with her bladder and bowels. At R, the mother had asked the teachers to help E to wipe her bottom and to supervise her at all times when she went to the toilet, but the teachers believed that she did not need it and it was an intrusion. In late 2017 the mother was reporting that E was refusing to eat and drink and she was fitted with a naso-gastric tube as a short term measure. The mother reported that E was being referred for a gastronomy.

35. After a residential assessment at Young Epilepsy which took place over a period of twelve weeks between October 2019 and January 2020, it has been found that (apart from possible dyslexia and a little learning delay) she is to all intents and purposes, a normal young girl. She does not have a diagnosis of active epilepsy and has been weaned off all her medication and the ketogenic diet. She does not have autistic spectrum or any other disorder and she is physically fine apart from some possible minor issues with her feet. She does not need a wheelchair or any specialist equipment. She has no eating problems, no behavioural problems and sleeps well.

36. It is as if she is a completely different child to the one described by the OT. How did this happen? Did E have a number of conditions that she has grown out of? Was she misdiagnosed by the doctors, leading the mother to believe she had all these problems when she did not?

37. The local authority case, as I have set out above, is that root cause is the mother's exaggeration and fabrication of symptoms. The mother denies it.

The evidence of Dr. Ward

38. Dr. Ward has provided this court with several very thorough and detailed medical reports and she gave oral evidence to this court. She has been clear that E most certainly suffered from febrile convulsions in her early years. The MRI scans

conducted in July 2011 most certainly showed abnormalities, the aetiology of which was (and is) very difficult to know. Moreover it is difficult to know what the consequences of such abnormalities as seen would be, save to say that they remain now, and E does not seem to be suffering any ill effects. Another important point that Dr. Ward has said in her reports is that the ketogenic diet can lead to the permanent cessation of fits.

39. In her first report (which was before E's admission to Young Epilepsy) Dr. Ward noted a number of occasions when the mother appeared to given a history which is not supported by the records, including stating that E's first seizure was much earlier than it was, that E had been thought to have a brain tumour, that she was not able to have radiotherapy because of the quantity of the tumours, that she had not passed urine for several days, and that she was not getting enough oxygen at night. Dr Ward was also concerned as to the use of a wheelchair for E. Dr. Ward was not able to say whether the history of seizures was completely fabricated, exaggerated, or accurate, and although she had identified areas where there was evidence of fabrication and exaggeration, she was not able to say that all of E's symptoms were fabricated, or at least a result of the mother providing misleading information.

40. After E's discharge from Young Epilepsy, Dr. Ward prepared further reports in March , May and June 2019 and July and August 2020. The reports in 2019 related to the period before the admission to Young Epilepsy. The reports in 2020 dealt firstly with the significance of the lesions seen on the MRI scan, and also with the findings of Young Epilepsy.

41. So far as the brain lesions are concerned, Dr. Ward, having considered the report of Dr. McConachie, took the view that it was possible that the previous seizures and mild dyslexia symptoms were related to them, but stated that there was little research which would assist in proving a definite link. In her report and her oral evidence she pointed out that incidental intracranial findings on MRI of the brain were a topic of interest in the profession and that in control groups of healthy children unexplained white matter hyper-intensity was found in children who were considered to be neurologically and medically intact. Given the lack of progression of the lesions and E's current status, there is no reason to anticipate future deterioration or consequences.

42. Dr. Ward also conducted a review of the data recorded on E's blood sugar machine in comparison with the hard copy of the results on the daily log between 27th September 2018 and 1st November 2019. She noted that between September 2018 and July 2019 the blood ketones were frequently below 2mmol/L often falling below 1. She stated that this suggests that a therapeutic ketogenic state was not maintained during this period and that compliance and efficacy of the diet was inadequate. These findings, she concluded, support the opinion of Dr. P to that effect. Dr. Ward also said that adequate ketosis was not maintained prior to E's admission to Young Epilepsy, although there was some improvement in blood ketone levels prior to admission in September 2019. She stated that it was entirely reasonable for Dr. P to suggest that the ketogenic diet should be discontinued on discharge from Addenbrookes in February 2019. E had been subject to some dietary limitation as well as the regular blood testing which would have caused some discomfort, and her

attendance at school had been limited by her mother's insistence that there should be blood testing equipment there, and that the staff needed to be trained.

43. Dr. Ward's written and oral evidence has been of the highest quality, thorough, careful and balanced. I wish to extend my thanks to her for the assistance she had given to the court.

The mother

44. In her evidence, the mother was insistent that E had suffered from seizures in the way she had described to the doctors over the years, and that she had exhibited difficult behaviours (again as she described, which had led to the 'diagnosis' of autism), as well as problems with tiredness, drinking and eating, dysfluency and sleep apnoea. She denied telling anyone that E had Doose Syndrome or liver damage, and said that her references to E suffering from septicaemia were always couched as 'suspected septiceamia'. She also denied telling any professionals that E's older brother had been investigated for seizures or epilepsy, or telling Dr. P that a cousin in Canada had been diagnosed with tuberous sclerosis (as opposed to such being suspected).

45. When questioned about E having and using a wheelchair the mother suggested that she had responded to an invitation for an assessment by wheelchair services and that it was they who had recommended an Action Junior wheelchair. She said that it was used when they went out as a family, and she could not carry E if she was sleeping during the day, or she had a seizure and wet herself.

46. She stated that the wheelchair was taken to school at the school's request because E would often fall asleep on the way home from school, and on long outings. I felt she minimised the amount and significance of its use, and indeed the significance of other equipment (for example a hoist) in the home.

47. Time and again when questioned about what is was said to have said in contemporaneous records, the mother said that professionals had not used her words, for example when asked about her apparently describing E as 'violent and destructive', that E's previous convulsions may have been caused by penicillin, or that autistic tendencies were discussed at a meeting with Dr. A in May 2012. She also flatly denied saying some things attributed to her in the records, for example that E was being considered for a gastrostomy or had been referred for one (there were several records relating to this, written by different people), or that she had ever said E had Doose syndrome.

48. On many occasions the mother also suggested that others rather than herself had noted issues with E's behaviour or pressed for investigations. For example, she said that her description of E walking on tip toe (which is a symptom which may relate to autism) was given in response to being asked 'lots of questions', and that the school (B) were responsible for suggesting that E might have autism, because they were having trouble getting E into the hall or the classroom (although when challenged the mother said that the school were not necessarily saying these were autistic behaviours). She said that she had taken E to the Y Autism playscheme because she was advised to do so by Dr. , LH and CJ. It is true that Dr. A encouraged the mother to attend, but this was on the basis of the history she was being given. She said that the 'statementing conversation' had happened at nursery school, and that it was the professionals who

had suggested that E should go to a special school rather than being initiated by her. She suggested that R had been concerned about E's language, and said that the class teacher had made a referral because of her stutter. The mother also said that it was the doctors who had asked for her to be referred for SALT, denying that this was because she herself had pressed for it.

49. The mother was also asked about her behaviour during the admission to Addenbrookes in February 2018, and also her behaviour following discharge when she was insisting that K remained on the ketogenic diet and should not be weaned from it without specialist support. She disputed Dr. P's evidence that she was eating normal food in hospital, and said that her GP had advised her that E should stay on the diet until she could be weaned in a proper way (the note in the strategy meeting records the GP as saying that he felt pressured to write to Great Ormond Street Hospital). When questioned about Dr. Ward's analysis of the blood results from September 2018 to July 2019, she said that she was using the ketogenic diet to the best of her ability and that she had been advised to keep E's blood ketones at around 2 to avoid hypoglycaemia (Dr. Ward stated that having blood ketones below 2, which they frequently were, suggests that a therapeutic ketogenic state was not maintained during this period).

50. The mother accepted that E is a very different child now to the one she was before 2017, but she attributes that to the ketogenic diet, and states that has not been understood in these proceedings.

51. The mother produced a number of lovely photographs of E together with other members of the family, on various special occasions, holidays and visits. These photographs show E doing quite normal activities, including physical activities and certainly demonstrate that she was not treated as physically disabled in all aspects of her life.

The other witnesses

52. I have not set out the evidence of the remaining witnesses on an individual basis, although it should be clear during the following paragraphs that I have taken into account all that I have heard and read. I make reference to various aspects of that evidence below.

Discussion

53. This is a complex case, for it arises in a family which had not hitherto attracted the attention of the local authority, and where the mother had successfully brought up other children. Additionally, there were no concerns about the mother's care of E in her early years.

54. From the age of about 18 months it is clear that E suffered from a number of febrile convulsions. Some of these convulsions were witnessed both in hospital and by ambulance staff. The mother described to me exactly what she and the family were doing the first time E suffered a seizure, and there was no doubt in my mind that she was describing a real event. In April 2011 E was diagnosed with a seizure disorder, and in July of that year that she had an abnormal MRI. These are all genuine events; none of them brought about as a result of anything done by the mother. Whilst we

may now know that the MRI findings have a limited significance and indeed that E no longer has seizures, the effect upon the mother of all this cannot be underestimated. The seizures/convulsions must have been extremely frightening, and coupled with an abnormal scan the mother must have feared the worst. Added to this the mother was going through a very difficult time with the breakdown of her marriage and harassment from E's father.

55. This being said, for the reasons I set out below, it does appear that at some point around or shortly after the diagnosis in 2011, the mother developed a pattern of exaggerating and sometimes fabricating E's symptoms and behaviour. With so many medical and other professionals involved in E's life the mother's repetition of inaccurate information from one to the other had a snowball effect.

56. Some of the mother's exaggerations are minor and by themselves would have little significance (indeed I suspect a measure of misinformation and exaggeration is not uncommon in the general population). One good example of such is the mother's saying (as I find) that E's older brother had been investigated for seizure or possible epilepsy. Other examples include her repeated statements to professionals that E had had septicaemia in May 2013, that E had spent most of May 2013 in and out of hospital (when she had spent five night there in all), that E had been diagnosed with Doose syndrome, that E had an unknown blood disease, that she had liver damage and that she was being monitored for anaemia. The mother denied much of this, but these statements were recorded contemporaneously, and often by more than one witness. Cumulatively they begin to have more significance, as they also do when it can be seen that a misleading statement contributed to a doctor making a diagnosis of and then treating, an illness or disorder. An example of that is the mother stating to Dr P that she had a cousin in Canada who had been diagnosed with Tuberous Sclerosis.

57. I will look at the various matters as alleged by the local authority in turn, although in the chronology of events, many of them ran alongside each other.

E's use of a wheelchair

58. Between 2011 and 2018 when care proceedings were started, E had the use of a wheelchair although she is perfectly able bodied. The mother said in her evidence that it was others who suggested that E should have a wheelchair, for example the school or 'wheelchair services' who had assessed E and suggested that the Action Junior wheelchair would be suitable. She also stated that the wheelchair was not regularly used, save for when the family went on long trips or when requested by the school. An analysis of the contemporaneous records and the evidence of other shows, however that it was the mother who was the driving force behind obtaining and using the wheelchair. The mother repeated to various professionals that E needed a wheelchair because she was often very tired, which in itself triggered seizures. She also said that E would become unrousable once she had fallen asleep (something she repeated in her oral evidence). The mother's account that it was R School who requested that E come into school in her wheelchair was rejected by Ms R, the Deputy Head of R who said that she came in the wheelchair at her mother's request, evidence which I accept. There is a wealth of evidence that the mother was portraying E as being dependent on a wheelchair. Ms J, E's social worker recorded in a report for E's EHC plan on 1st June 2017 that 'E is totally reliant on her wheelchair when out of

the home. In the house she tries to walk around but often fails due to her poor balance and coordination. When she is unable to walk she uses the wheelchair in the house. She also has to wear her epilepsy helmet'. In her oral evidence Ms J stated that she had taken this information from what the mother told her. By 2015 the mother was seeking to obtain a tilt wheelchair for E on the basis that she used it on a daily basis and the current wheelchair was not good for her to sleep in. Although I accept that the use of the wheelchair declined during 2018, it was still being used on occasion up and until the admission to Young Epilepsy.

59. Although it is not strictly a medical point, I accept Dr. Ward's evidence that the use of a wheelchair is a significant issue for a child, because it does send a message to others and E herself, that she is physically disabled. I also note what Dr. Ward and Dr. Williams said about the hoist in the home, something that you would only expect to see for a child who had serious mobility issues. In the experts' meeting, Dr Williams commented of his visit to the family home that "I kind of kept looking around expecting to see a child with major quadriplegia".

Autistic spectrum disorder

60. The 'diagnosis' of autistic spectrum disorder was not something that was invented by the mother; it came about as a result of a misconception amongst the professionals from a letter written by Dr. C following a consultation with the mother and E at the Child Development Centre on 3rd December 2012. At the top of the letter he wrote to the paediatrician after the appointment he set out a list of problems, the first of which was stated as 'autism spectrum disorder'. Although no formal assessment had been carried out, it was assumed by other professionals including Dr. A and Dr. R that the description at the top of the letter meant that there had been a diagnosis. The history which led to the referral to the CDC, and indeed the description of autistic spectrum disorder as a problem, was, however, obtained as a result of the history given by the mother. The mother told Dr .A that E was obsessed with routine, anxious about change and that she walked on tiptoes. Dr A described this history as containing some 'red flags'. The mother told Dr. C that E liked to stick to a routine, that she did not like loud noises, that she lined everything up, she had some sensory issues, and that she would take language literally. There are records of the mother giving a similar history to various other professionals at different times.

61. When all assumed the diagnosis had been made, the mother embraced and promoted it on the basis of seeking the best assistance for her daughter, (including the suggestion that the autism could impact on her epilepsy). Records of her conversations with professionals and emails she sent them are replete with statements about E having autism. I think this led to a situation whereby all those involved lost sight of the source of the diagnosis and the evidence (or lack of it) which underpinned it. The behaviours recorded by the mother were not independently noted by others who had contact with E, most notably at R School, which E attended for about three years from September 2013.

62. The Deputy Head at R, HR, told the court in her evidence that E's teachers took the view that she was more able and independent than the mother gave her credit for. Indeed the opinion of most of the staff was that the mother was underestimating her

ability and exaggerating her problems. Ms R stated "E was able to communicate very clearly and her speech was very good in school. She was able to read the body language of peers and adults alike. She had excellent communication skills". She said that the school did not agree with the diagnosis of autism (they had two teachers who were particularly experienced in the field) and that E did not need the visual timetable or schedule the mother wished her to have, nor did she need to have supervision over her toileting. They told the mother so, but she chose to reject their opinion and to argue very persistently that the school was failing to meet her needs.

63. Although her attendance there was disrupted, R was the school that E attended for the longest. I find the evidence from Ms R to be very telling about the mother and her attitude towards E. It is consistent with other evidence in the case. As late as 2019, the assessment for autism at Young Epilepsy revealed a significant gap between the information that the mother provided about E, which supported a diagnosis of autism, and that which was independently witnessed, which did not.

Obstructive sleep apnoea/snoring

64. The mother first raised concerns about E's breathing when she was asleep in 2013, following which she had a sleep study which raised no concerns. The issue was raised again by the mother in 2014, and it appears that she repeatedly chased the professionals to ensure that E had been referred to an ENT specialist. When E was first seen by the ENT surgeon at hospital, Mr. H, he was sceptical about the benefits of surgery, but the mother opted to see Mr. J for a second opinion (I should note here that the referral to A hospital was also because of E's epilepsy and need to be seen in a tertiary referral centre). On 9th July 2014 E's paediatrician, Dr. R, advised the mother not to rush into surgery but notwithstanding this E underwent an adeno-tonsillectomy in December of that year. Dr. Ward noted that before there was an opportunity to assess the effect of this operation, the mother was suggesting using oxygen therapy, something that was highly inappropriate, and also that the mother had told Dr. R that E had been taken to R Ward and give oxygen as an emergency (there is no record of this). As with other aspects of E's health and behaviour, the mother was pushing for medical interventions for E in relation to sleep apnoea, and I do not accept her contention that she was simply following the advice of the doctors. Although the mother did seem to turn her attention to other matters following the operation in 2014, it is instructive to note that the issue did not entirely go away. In 2016, for example the mother told Dr. R, that the problem had recurred and that E seemed to swallow less, have increased secretions (if she did not use this term she used something to indicate this), and that this could or would lead to E suffering seizures.

Speech and Language therapy

65. From about 2013 onwards the mother began to report that E was suffering from some speech and language difficulties. On 24th February 2014 the mother requested a referral to a speech therapist, saying that she felt that there had been a change in E's speech. During 2015 and 2016 E underwent a number of SALT assessments. In her oral evidence the mother minimised her own role in instigating these, suggesting that language difficulties had been noticed by others, particularly the school. She suggested that it was E's teacher who had expressed concerns about a stammer, and the school who had made the original referral to SALT. The SALT initial report in April 2015 does state that the class teacher made the referral, although the body of the report demonstrates that the mother was giving an account of a severe stammer at home. The class teacher stated that E used initial sound repetitions when she was

telling her news or trying to explain something in class. The mother also said that there were many references to it in the communication book between the mother and school, copies of which she had but have not been produced in these proceedings. The records produced by the local authority demonstrate the mother reporting to various professionals (for example Dr. B, Dr. R, MC, CMW), that E had problems such as stammering or dysfluency, but when she was independently assessed the problems were not considered to be particularly significant. An assessment in March 2016 recorded that when E was observed in the classroom and playground her speech was fluent at all times and did not impact upon her ability to communication functionally. In a one to one situation when the language demands on E were increased, her stutter did become more apparent, characterised by part and whole word repetitions of which she did not seem to be aware. It was recommended that it was not appropriate to work on E's fluency at this time, although some strategies were put forward to assist, for example for the adults to slow down their speech to provide a positive role model. Despite this advice, there are later records of the mother seeking speech therapy for E, and becoming combative with Y Speech and Language therapy when this was not provided – for example in April 2018 where there is a record of the mother complaining that nothing had been done for the past year.

66. At Young Epilepsy only a single episode of dysfluency was noted during the assessment they carried out, and the therapist, KMl concluded that E's language and communication skills were within the average range for her age.

67. The pattern here of the mother reporting that E had difficulties with her communication and speech is similar to her behaviour in relation to other matters. Certainly she appears to have over interpreted what she saw, and until these proceedings, was unwilling to be reassured or deflected from taking matters to another level.

Tuberous sclerosis

68. The abnormalities demonstrated on E's MRI scan clearly exist, and as I have said above, I have no doubt that those findings – whatever the doctors said, coupled with E suffering genuine febrile convulsions at an early age, must have been very worrying for the mother. Mr Ekaney QC and Ms Easton for the mother point out that on 28th October 2013, the Consultant Radiologist, Dr. S, stated that the most likely differential diagnosis for the findings on the MRI scan was tuberous sclerosis. This was without the mother giving any description of E's symptoms, and before any referral to Dr. P. I accept their submission that the mother was not responsible for E being diagnosed with this condition, or indeed with epilepsy. No doubt this caused her great anxiety.

69. Nonetheless, the mother (wittingly or not), gave accounts to professionals about what she had been told by other professionals which were embellished. There is a record compiled by ET of the mother telling her that E was unable to have radiotherapy for the tumours she had, because there were too many. This was the day after a consultation with the Dr. K, the Paediatric Neurologist, who was clear that she had never said such a thing to the mother. Indeed Dr. K's letter to Dr. A is careful to say that the findings on the MRI may represent tuberous sclerosis rather than that they did. After this E went on to have a number of tests, including genetic tests, the results of which did not support the diagnosis.

70. It was in these circumstances that E was referred to Dr. P, who ran a TS clinic. He too came to the conclusion that (although the appearances were not typical) the most likely diagnosis was TS. In his oral evidence to me he made it clear that his diagnosis was reliant upon the history given to him by the mother. I accept Dr. P's evidence that the mother told him that her cousin had been diagnosed with tuberous sclerosis and that he found this to be significant. I reject the mother's case that she simply told him that her cousin had suspected TS for I do not think Dr. P would have had any reason to state the diagnosis so confidently in the contemporaneous documents if this was not what he had been told. There may have been confusion either from the mother's story or possibly Dr. P himself as to whether it was a first or second cousin (or indeed both), but this does not undermine my conclusion on this particular point.

Seizures and epilepsy

71. As I have said above, there can be little doubt that E suffered from a number of febrile convulsions when she was very young. After the first occasion when she was about 18 months old she suffered repeated seizures when she was 20 months old, 22 months old, and then on at least two occasions when she was over two . These seizures appeared to last for several minutes. They were associated with E having a high temperature, and the episode in February 2011 was witnessed by the ambulance crew. In April 2011 E was diagnosed with a seizure disorder; and prescribed medication. These episodes and the diagnosis appear to be entirely genuine. I have also found, above, that the diagnoses of epilepsy and tuberous sclerosis were made (certainly initially) on solid evidence, not exaggerated or fabricated by the mother.

72. After this point (2011), the mother's reports of seizures increased very extensively although they varied in severity and intensity over time. She also began to report behavioural difficulties. I have to decide whether or not, in time, the mother's accounts became exaggerated, or even fabricated.

73. Factors suggesting exaggeration or fabrication are first that E's EEG was normal. Even though it is quite common to have a normal EEG with epilepsy, it is notable that there was no sign of epileptic activity despite the sheer number of seizures the mother sometimes reported. More importantly, very few of them were witnessed, certainly after about 2013, despite E being seen in a wide variety of settings.

74. I am clear that E did have some genuine seizures in 2013 because these were observed on two occasions at B School, on 18th January and on 1st February 2013. After this, however, the only evidence of anyone other than the mother witnessing seizures comes from R School which E attended between September 2013 and March 2017 and two of the mother's friends who have made statements in these proceedings. Despite the length of time E attended R (albeit her education there was significantly disrupted) only occasional moments of absence were observed. No drop or tonic clonic seizures were seen.

75. Neither of the mother's two friends was called (or required by the local authority) to give oral evidence to me although I encouraged this. I am therefore reliant on the statements they have made. The first witness, JC said she had witnessed two seizures in 2016. The first time she described E dropping to the floor on the way out of the

cinema although there is no detail as to how K presented during or after it (save that she was put into her wheelchair with the assistance of the staff). On the second occasion she recounts seeing E slumped in the car having what she describes as looking like a tonic clonic seizure. There is no further explanation or detail as to what happened or why she thought that this is what it was. The second witness, SA said that between 2009 and 2017 she regularly saw small seizures which she described as E 'blipping out', and having drops and 'petit mals'. Some of what Ms A has said in her statement appears to have come from what she was told by the mother. In the absence of any exploration of or challenge to the evidence of these witnesses, it seems to me that I must accept that K did, on occasion demonstrate behaviour that a lay witness might construe as a seizure. I note that absence seizures may be very easy to misconstrue, but the witnesses also noted occasions when E dropped to the ground. I accept that this did happen on occasion, but I believe that if it had been a frequent event, it would have been noted by others in other settings (such as school or in hospital). In the absence of any reason as to why JC believed E to have suffered a tonic clonic seizure, it is difficult to know what to make of that evidence.

76. No seizures of any sort were witnessed during E's various inpatient admissions to hospital after 2013. E had no seizures at Addenbrookes in March 2017 or February 2018, nor did she suffer any at Young Epilepsy for the 12 weeks that she was there in 2019/20. She has had no seizures since despite being weaned off all her medication. I note that E's current carers believed that she might have suffered a drop seizure when falling over in the shower, but that has been discounted and in any event has not recurred. The mother's case is that there have been no further seizures because E's condition was transformed by the ketogenic diet. I have to say that I find this an unlikely explanation for the evidence suggests that she was not on it strictly or for very long. I accept the evidence of Dr. P that E did not appear to have been following a strict ketogenic diet prior to her admission to hospital on 5th February 2018, and that she did not follow it in hospital. I also accept Dr. Ward's evidence that for much of the time from July 2018 to September 2019 E was not in a state of therapeutic ketosis. In any event, even after the start of the diet in 2017 the mother continued to report E as suffering from seizures although I entirely accept that it was reported they had become far less frequent. In May 2017 she reported that 'last Sunday' E had about 40 drop seizures in one day, and also that she had 2 to 4 tonic clonic seizures a month. In October 2017 the mother reported that E was having increased seizures again (with illness), and in January 2018 the mother reported that E had had a generalised tonic clonic seizure (again with a recognised illness). She reported in June and July 2018 that E had had more seizures, including one when she was said to have fallen off her scooter.

77. The picture so far as seizures are concerned is therefore somewhat mixed. E has had a number of genuine seizures, and additionally she has also exhibited behaviours from time to time which a lay party might well construe as either an absence seizure or a drop seizure. On the other hand, there is a very significant discrepancy between the mother's reports as to what she saw and what was seen at school and elsewhere.

78. Given the evidence overall, and the mother's obvious propensity to exaggerate other features of E's presentation, I have come to the conclusion that the mother has at times given misleading accounts of E's seizures (whether or not she did it deliberately). I think she exaggerated their number and type, and also that she was

quick to misconstrue and then describe ordinary events, including accidents, as seizures. In saying this, I do bear in mind that she had good reason to believe that E was suffering from epilepsy and either tuberous sclerosis or some other rare condition, and as a result, there is a danger of 'hindsight bias'. The mother's exaggerated accounts of E's seizures led to her taking significant amounts of medication over several years, and to her being placed on the ketogenic diet.

Eating, drinking and the ketogenic diet

79. As a result of her diagnosis, E was regularly prescribed anti-epileptic medication, namely Clobazam and Sodium Valproate, supplemented by Midazolam as a rescue medicine. Later she was prescribed Vigabatrin by Dr. P on the basis of the working diagnosis of tuberous sclerosis and the fact that the other medication did not appear to control her seizures. When this did not appear sufficient, E was commenced on a ketogenic diet in March 2017. The ketogenic diet is a high fat specialist diet which not only requires the parent to cook very particular food, but also to carry out very regular monitoring of the child's blood sugar and ketones. The diet was commenced by admitting E as an inpatient to Addenbrookes for two or three days. Following her discharge she was kept off school (R) as the mother reported she was having major issues with control of her blood sugars, and was arguing in any event that R was no longer suitable for her.

80. During the months after the diet was commenced the mother reported a very significant improvement in E's seizures. She also reported that there had been an increase in her autistic behaviours and that E was not drinking properly (indeed the mother is recorded as saying at one point that E had not had a drink for two weeks) and was constipated.

81. Although various professionals had clearly found the mother very trying to deal with at times, it does not seem as if any of the doctors harboured doubts that E suffered from severe epilepsy (whether or not this was a result of tuberous sclerosis), or indeed that she was a child with a variety of special needs, until late in 2017 when E was admitted to Y hospital following the mother expressing concerns that she was not drinking and chronically constipated. E was also suffering from a fever, the mother said she had not passed urine for two days and she also reported that E was experiencing increased seizures. The decision was made for E to be fitted with a naso-gastric tube to ensure a sufficient intake of food and fluid. It was intended to be a temporary measure for about 7 days, and E was discharged with the NG tube in situ. Two weeks later, however, the mother was requesting further supplies and equipment, including a feeding pump. The mother also told various professionals that E was waiting for an appointment for a gastrostomy (or stomach PEG) at Addenbrookes, something that was quite untrue. The mother denied saying this to anyone but I am confident that she did. As in so many instances in this case the contemporaneous records are very clear, and compiled by individuals who are unlikely to have recorded a positive assertion that was never made. Also, similar recordings were made by different people at different times. A single professional might make an error or misunderstand something, but it is very unlikely that two people acting independently of each other would do so.

82. At the beginning of January 2018, despite the initial advice being for naso-gastric feeding to be discontinued after 7 days, attempts were made to fit E with a replacement tube. I am not sure how this came about, but it was obviously sanctioned by the doctors at Y . E was very resistant to this procedure and because of her distress, it failed. Another attempt was made to insert the tube whilst she was under sedation, but this still did not succeed. The event was obviously highly distressing for E and it is to the mother's credit that she refused to agree to any further attempts.

83. The mother's case is that in permitting E to be fitted with and use a naso-gastric tube she was simply following the advice of the doctors. It is also quite properly pointed out by Mr Ekaney and Ms Easton that E was genuinely ill and blood tests showed signs of moderate dehydration. Nonetheless the history given by the mother went somewhat further than the evidence demonstrated, and it without doubt had a bearing upon the decision for E to undergo such an invasive procedure. Once fitted with the tube, the mother appeared keen to keep it, until E resisted the insertion of a replacement so forcefully in January 2018.

84. During the first part of 2018 the mother was still continuing to report that E was resistant to feeding and fluids, and as a consequence a decision was made that she would be admitted to Addenbrookes for observation in February.

85. I accept the evidence of Dr. P that the medical findings did not support the history given by the mother that E was not drinking or eating properly before or during her stay at Addenbrookes. She was weighed on admission to Addenbrookes and was said to be the same weight as she had been on 28th January (although there is a record of 5th January at O244 suggesting that she had lost weight) and she did not show clinical signs of dehydration when she was admitted. She also did not seem to be in a state of significant ketosis, and ate non ketogenic foods from the trolley on the ward. E was observed to be drinking (albeit not large amounts) although the mother stated that she was not. After three days, E was eating a normal diet without any obvious ill effects and when she was discharged the mother was advised by Dr. P not to resume ketogenic feeding. The mother stated that E was on a version of the ketogenic diet called the MAD diet, which was a less rigorous version, but Dr. P rejected this, and so do I.

86. Once E was discharged from Addenbrookes in February 2018 there was what I would describe as a 'standoff' between the mother, Addenbrookes Hospital and the local specialists about how to deal with E's diet. The mother insisted that she needed assistance for E to be weaned, but Dr. P equally insisted that there was no weaning to be done. Nor had E had any seizures as an inpatient. This argument took an enormously long time to unravel, so that it was not until E was admitted to Young Epilepsy eighteen months later that she was finally and unarguably weaned from it (and indeed all her other medication). Despite the mother's assertions, Dr. Ward's analysis of the blood results shows that E was not in a state of ketosis for much of the time between February 2018 and October 2019.

The overall presentation

87. I have considered the detailed evidence surrounding the various conditions that E was believed to suffer from above, but it is also instructive to stand back and look at the situation overall. After E was separated from her mother and admitted to Young

Epilepsy in October 2019, it became rapidly clear that she is very much a normal child. She has been weaned off all her medication, and as much as she was on it, the ketogenic diet. She does not have a diagnosis of active epilepsy. She does not have any traits of autism. She is physically quite normal and energetic. She does show signs of dyslexia and is behind educationally, but the latter is almost certainly because she has suffered so much disruption to her schooling.

88. The contrast to the E that the mother described to all the professionals from 2012 onwards is enormous. I simply cannot accept that the difference can be ascribed to the ketogenic diet, or even the passage of time for conditions such as ASD do not just disappear. In her evidence the mother was very resistant to acknowledging this, but the truth is that she was bringing E up and presenting her to the world as a disabled child with a life-limiting condition, who needed a wheelchair and other special equipment, a special school, speech and language therapy, a ketogenic diet and for a while at the end of 2017/beginning of 2018, artificial feeding. It is not difficult to see how the mother could have been very worried that E did have a serious condition because of her seizures and the MRI findings, but somehow this escalated and snowballed, so that the mother convinced most of those around her that E suffered from not just one, but many debilitating conditions. I do bear in mind that E was taken on outings and holidays by the mother, and that she was allowed to be active within that context. I also bear in mind that E has shown herself to be a delightful child, something for which the mother must take credit. Still, the overall picture portrayed was a very worrying one and affected every part of E's life.

89. Mr Ekaney and Ms Easton argue that the local authority has failed to demonstrate a sufficient nexus between the mother's actions and the harm or risk of harm that E has suffered. They submit that in this complex situation a multiplicity of factors fed into the genesis of the medical investigations, diagnoses and treatments and procedures, and that that these cannot be attributed to the mother.

90. I entirely accept that the early investigations and treatments afforded to E were the consequence of genuine symptoms and findings. I also accept that she continued to have some seizures from time to time, and that this mother had cause to be very worried about the combination of this and the findings on the scans. Such a worry might easily lead a parent to over-interpret some behaviours or accidents as seizures and also to wonder about some of E's other behaviours too.

91. The mother's behaviour over time, however, went far beyond that of what was reasonable for a parent in all the circumstances of this case. E was with her mother all the time, and even without the benefit of hindsight bias it should have been apparent to the mother (as it is to everyone now) that she was not the child that was being presented to the world. I cannot say at this point what was driving the mother to portray her child as having so many problems – whether it was a distorted belief system prompted by anxiety, a yearning for help in some way or another, a manifestation of more widespread distress or something else entirely. This is something which will fall to be assessed at the next stage of the case.

92. I am clear that in the words of section 31(2) of the Children Act 1989, at the date of the application for a care order, E was suffering, and was likely to suffer significant

harm attributable to the care given to her, or likely to be given to her, not being what it would be reasonable to expect a parent to give. E is still at risk of suffering significant harm. As a result of the mother's exaggeration of her behaviours and symptoms, she has been subjected to excessive investigations and assessments, she has been given medication that she might otherwise not have been prescribed (including Vigabatrin which could have affected her eyesight), and she has had severe disruption to her schooling. She was led to believe she needed a wheelchair, and all sorts of other unnecessary equipment and portrayed as a profoundly disabled child. There is a clear risk that without some change in the way that the mother treats and/or perceives E, that she will suffer significant harm in the future, both physically and emotionally, and by the impairment of her development.

Next steps

93. As I have found the threshold criteria have been met, the case will proceed to the welfare stage, which will very much be looking to the future as opposed to the past. I note the mother has successfully brought up three older children, and that E has told the Guardian that she wishes to return home. Of particular importance is the mother's statement that she accepts the findings of Young Epilepsy, for her ability to bring up E as the girl she really is will lie at the heart of future decision making.

94. It is my hope that the parties will be able to agree the identity of an expert to carry out further assessments. This is something that will no doubt be a matter for discussion, and I propose that the case is listed at some point in the week commencing 9th November for further directions.

95. Finally, I wish to thank counsel for their great assistance they have given to the court in this complex case, including the preparation of numerous detailed documents, both in advance of the case, and for the excellent written submissions I received from all at the end.